Impending Loss of Insurance Coverage is an Indication to Proceed With Complex, Expensive Surgery

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Introduction

Robert M. Sade, MD

Reading any given newspaper on any given day gives one the impression that financial issues compose all or nearly all of the problems related to health care, especially in the last couple of years because of financially focused political efforts to reform health care. Many aspects of health care generate questions of ethical behavior, and ethical issues range over much broader territory than finance, covering a wide variety of problems related to responsibilities and obligations of physicians, patients, and third parties. Financial difficulties sometimes can be ethically challenging by bringing ethical principles into conflict with one another.

The first principle of medical ethics relates to physicians’ fidelity to patients: “A physician shall, while caring for a patient, regard responsibility to the patient as paramount” [1]. The principle of beneficence tells us that we should do what is best for the patient, but what do we mean by the phrase “best for the patient?” Do we mean what is medically best, a determination that is within the domain of the physician’s expertise, or do we mean what the patient believes is best? Usually, the patient gets to choose among available therapeutic alternatives, but some alternatives that are desired by a patient may not be available. For example, a patient who asks for a prescription for antibiotics in order to prevent the sniffles that just appeared from turning into a full-blown upper respiratory infection actually is requesting an irrational therapy. The physician should not provide the desired prescription, but instead should provide an explanation of why it is not indicated.

Similarly, when a patient faces loss of health insurance coverage, a cardiothoracic surgeon could find himself flirting with the boundaries of ethical behavior. We describe below a patient with a known surgical disease who asks a cardiothoracic surgeon to repair the problem because he will soon lose his health insurance coverage. The problem is that standard indications for surgery are not yet present, which raises the question of whether the surgeon should operate as the patient requested, on financial grounds. The surgeon wants to do what is best for the patient, but is the patient asking for something the surgeon should not provide?

The Case of the Premature Operation

William Hochman, a 22-year-old college senior, will graduate in a few months. His health needs have always

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been covered by his father’s health insurance policy, which is a benefit of his work as a janitor in a local apartment building. The insurance has reimbursed most of the expenses associated with the diagnostic testing that led to the diagnosis of Marfan syndrome a few years ago. When his last computed tomographic scan and echocardiogram showed slowly expanding diameter of his ascending aorta and a leaking aortic valve, William asked his internist to refer him to a surgeon who has a great deal of experience with aortic surgery.

The surgeon, Dr. Karl Geschickt, has now reviewed William’s history, examined him, and thoroughly inspected his computed tomographic scans and echocardiograms. The surgeon tells William what he already knows: his ascending aorta has expanded from 3.6 cm two years ago to 4.0 on last week’s scan, and his echocardiograms demonstrate mild aortic regurgitation. He definitely does not need an operation now, but at this rate of progression, an operation almost certainly will be needed within a few years.

William explains that, as an art history major, he expects to have a hard time finding a full-time job when he graduates, and on the day of his graduation from college, he will no longer be eligible for coverage under his father’s policy, and neither he nor his parents can afford to buy an individual health insurance policy. He tells the surgeon that he understands the nature of his disease and the future need for aortic surgery, but because of his insurance and financial situation, he needs to have the inevitable operation now rather than in a few years. Should Dr. Geschickt accommodate this young man’s need? Should he operate now?

**Pro**

Anthony L. Estrera, MD

We all know the ethical principles that guide our clinical decisions: autonomy, beneficence, non-maleficence (do no harm), and justice [2]. In carrying out our medical duties, we as clinicians identify maladies and plan treatments in order to improve the patient’s well-being. At the same time, the treatment applied must minimize the risk for complications and death for the patient, otherwise the treatment should not be undertaken. Prior to doing so, we establish a contractual agreement or informed consent with the patient for this service.

The decision to perform the procedure will generally depend on two factors: the medical indications for the procedure and patient preferences. Albert Jonsen and colleagues [3] define medical indications as the “data about the patient’s physical and psychological condition that suggest diagnostic and therapeutic activities aimed at realizing the overall goals of medicine: prevention, cure, and care of illness and injury.” Thus, “medical” facts justify the diagnostic and therapeutic interventions. Two critical questions regarding the “medical facts” are the following:

1. How are the medical facts determined?
2. Can the medical facts be affected by factors not traditionally considered medical?

Advocates of unrestricted advocacy, such as ethicists Albert Jonsen and Eric Cassell, suggest that these contextual factors should not be considered when determining clinical decisions. Cassell [4] maintains that “the sick are sick not because of human agency and intent but overwhelmingly because of the actions of fate.” Jonsen and colleagues [3] also note that factors external to the patient-physician relationship should never be decisive over patient welfare. In essence, supporters of unrestricted advocacy believe that only medical facts should determine clinical care.

In contrast, proponents of restricted advocacy note that considerations of justice do furnish a moral basis for individual action, because principles of professional ethics derive from roles specified by just institutions. Ethicist Norm Daniels, a proponent of restricted advocacy, points out that “dispensing with justice is not an option, because justice inheres in our very conception of the professional’s moral role” [5]. In essence, contextual factors do influence our decisional capacity.

I believe that medical recommendations are based on clinical judgments, but these judgments may be influenced by contextual factors such as economics. Our choices as physicians do have economic consequences on our patients and will ultimately influence ours and the patients’ decisions. What happens if one does not consider, at least in part, economic factors in the clinical decision?

Generally, we have assumed that “medical” facts were what we traditionally accepted as the physiological, pathological, and psychological events related to the patient. Although this is what we were taught in medical school, the “medical” facts are not the only factors that contribute to the patient’s wellbeing. I submit to you that just as important, and critical to the patient’s well-being, are the social and economic issues immediately at hand.

It is often impossible for us to be completely empathetic with our patients, especially this patient, Mr. Hochman, who has Marfan syndrome. It is likely he has learned as much as he could regarding his condition and realizes that although his aorta is not enlarged enough to indicate surgery (so he is told), his aortic root has enlarged from 3.6 cm to 4.0 cm. Knowing that his aorta has enlarged must be an overwhelming concern for him. In addition, he has also learned that having his abnormally
enlarged aortic root places him at risk for rupture and early death. Although Dr Geschickt cannot tell him with any certainty what these risks are, he is informed that future surgery will be needed within a few years. He further realizes that even if his aorta does not rupture, he may still suffer an aortic dissection and that if this occurs, his long-term prognosis worsens. He further realizes that the rest of his aorta may be at risk for further aneurysmal degeneration and that he will most likely require further interventions to replace the remainder of his aorta. He lives in fear. How can one say that this fear does not affect his well-being?

Medical “indications” are driven by the “fear” of the unknown. There is no way we can predict the future, but as clinicians we attempt to do this every day. It is the anticipation of what may happen in the future that often dictates what we do in the present. This is the nature of our profession.

Breast cancer is a significant burden on our society, and the medical profession has developed screening regimens to attempt to identify breast cancer early and ultimately to decrease mortality. No one will refute that the presence of a breast cancer is an “indication” for intervention. But as technology advances, we are now able to determine at a genetic level whether one has a greater risk for developing breast cancer in the future. With identification of the BRCA1 and BRCA2 genes, we know that a woman has a greater risk for developing breast cancer. If a patient has this risk factor, some patients are willing to undergo a bilateral prophylactic mastectomy with possible flap reconstruction (a complex and expensive procedure) even though no cancer has ever been diagnosed.

What are the facts? The penetrance of BRCA1/BRCA2 is 56%, which is significant, and the lifelong risk of developing breast cancer may be as high as 50% [6]. This is a real threat, but the counterview is that 50% may not develop breast cancer. Interestingly, a woman with either BRCA1 or BRCA2 who does not undergo a bilateral prophylactic mastectomy has a 10% chance of dying from the breast cancer [6].

The patient accepts this, and we as physicians accept this. Why? Because the fear of the patient developing advanced breast cancer influences us. (It is the potential consequences that drive us.)

In thoracic surgery, a solitary pulmonary nodule (SPN) in a 50-year-old patient has up to a 50% chance of harboring a malignancy [7]. A patient who smokes is sent to your office with a new SPN, with results of a needle biopsy, and positron emission tomography/computed tomographic scans that are negative for malignancy. The patient asks you to resect the SPN. Would you? Again the emotion of fear (of cancer) drives your decision.

For this same patient, it is December 21, 2009. You have seen him and offer him surgery (you are an expert in thoracoscopic techniques) and he understands the potential need for a thoracoscopic lobectomy—a complex, expensive procedure—on January 4, 2010. But . . . He asked you to perform the procedure as soon as possible; ie, before the end of the year. This is because he has already paid his deductible ($250) and his out-of-pocket expenses ($1,250) for the year have been covered; if the procedure is performed before the new year he will not incur any added expenses. Would you accommodate him? How does this differ from impending loss of insurance coverage?

Economic issues do influence our decisions and thus should be considered when deciding to operate.

Impending loss of insurance coverage may be of great importance to some patients. No one will disagree that our current medical system is broke. This includes our moderator [8]. And the fact that up to 47 million US residents do not have adequate health care coverage is real [9].

We all accept that heart disease is the number one killer in the US followed by cancer. Note that breast and prostate cancer killed 40,000 and 30,000 Americans, respectively, in 2007 [10].

Lack of health insurance might kill up to 45,000 Americans per year. Wilper and colleagues [11] analyzed 9,000 surveys from 1986 to 1994, then followed through 2000 and identified that the uninsured had a 40% higher risk of death than those with health insurance. Extrapolated to 2005 census data, this accounted for 44,789 deaths. The authors speculated that these deaths occurred because uninsured patients did not seek medical attention for fear of not being able to pay for it.

In another study, Himmelstein and his colleagues [12] found that 62.1% of all bankruptcies in the US have a medical cause, which had risen 50% since 2001. Because of the fear of death, and the fear of bankruptcy (economic devastation), impending loss of health insurance becomes very important and cannot be ignored when deciding to perform surgery.

In summary, the moral argument that impending loss of insurance coverage is an indication to proceed with complex, expensive surgery is valid, and is consistent with these principles of medical ethics:

1. Beneficence: Loss of insurance coverage as one of the indications for surgery will provide a benefit for Mr Hochman and eliminate the risk for proximal aortic dissection and rupture.
2. Nonmaleficence: In the hands of a skilled surgeon (Dr Geschickt), the procedures can be performed safely.
3. Justice: Performing surgery prior to loss of insurance is fair because the patient (or his father) has already paid for surgical benefits.
4. Autonomy: In my opinion this is the most important principle in this case, and it is exercised by both Dr Geschickt and Mr Hochman.

Thus, impending loss of insurance coverage is an indication to proceed with complex, expensive surgery.
The ethical dilemma presented in the case of William Hochman is whether or not the patient should be offered preemptive (and costly) cardiovascular surgery while he has medical insurance coverage, to avoid future possibility of needing surgery and not being able to pay for it, even though the surgeon deems the operation to be not medically indicated.

We argue that a patient should not receive preemptive cardiovascular surgery that is not medically indicated because such an act would violate basic tenets essential to the appropriate practice of medicine. Brett [13] succinctly states the issue in this way: “It is important to recognize that the structure and regulation of medical practice in the United States clearly reflect a broad social mandate for clinicians to exercise independent professional judgment and to resist the patient's requests for harmful or non-beneficial interventions.” Accordingly, the proper role of the surgeon is to do what is best, both from a medical and moral point of view, for the health of the patient. This is based on the fundamental principle of beneficence or nonmaleficence as repeated in our medical oaths which express promises made by the medical profession to the members of societies in which they practice. The principles of beneficence and nonmaleficence date back to the Hippocratic oath (4th century BC) and resurface in the American Medical Association Code of Medical Ethics (1847 to 2010), the American College of Surgeons Fellowship Pledge (1913), and the World Medical Association’s Declarations of Geneva (1947) and Helsinki (1964), to name a few [14].

The cardiac surgeon, upon consideration of the patient’s suitability for surgery, must determine the risk-to-benefit ratio of the procedure. Surgery is not medically indicated if it is determined that the risk(s) of undergoing surgery outweighs the potential benefits of such treatment for the patient’s health. Thus, to recommend or proceed with such surgery would constitute a violation of the commitment to nonmaleficence. Surely it is always safer (and thus of optimal nonmaleficence) to NOT perform surgery that is not absolutely necessary!

The obligation of the cardiac surgeon to promote the patient’s cardiac health is paramount over non-health related considerations. When a requested procedure is unacceptable by current standards, as in Mr Hochman’s case, non-health related considerations become entirely irrelevant. In addition, we maintain that it is inappropriate for someone whose expertise lies in a specific clinical application to make value judgments about another’s economic condition; especially when such judgments impact the physical health of that person. The poor economic state-of-affairs which exists in this country does indeed affect individuals’ access to health care. However, this is a social problem to be addressed by society as a whole; the burden should not lie on the shoulders of individual physicians to fix our socioeconomic problems whether they affect access to health care or not. Such considerations are secondary at best and are not strictly speaking within the scope of the individual surgeon’s duties.

The risk-to-benefit ratio factored into a decision of whether or not to proceed with surgery is arguably the most relevant piece of information the patient will receive from the surgeon in terms of making this choice. If the risks clearly outweigh the potential benefits of having a major operation when it is not indicated, as they do in this case, it is doubtful that the patient would choose to proceed. The surgeon may deflate the importance of this information by giving serious weight to (irrelevant) nonmedical risks or benefits, but doing so constitutes a violation of the fundamental (Kantian) duty of respect for persons because the patient's autonomous decision-making capacity has been biased by irrelevant information. For Kant [15], autonomous persons are “ends in themselves” who determine their own futures and thus are never to be treated merely as means to the ends of others. Respect for autonomy is a very important ethical principle, perhaps the most important in the surgeon-patient relationship. We honor it by not accepting as germane and important irrelevant facts that bias the patient's decision-making process.

Moreover, who can say with certainty that the patient in this case will definitely need the anticipated surgery? It might turn out that surgery never becomes medically indicated. While specific data are lacking regarding the natural history of the progression of ascending aortic aneurysms related to Marfan syndrome, it is generally felt that ascending aortic diameter greater than 5.0 cm is predictive of elevated risk of either aortic dissection or rupture and thus surgical intervention would be appropriate at this aortic diameter [16]. In the present case, with an ascending aortic diameter of 4.0 cm, the patient in question does not satisfy the “accepted” criteria for surgical aneurysm repair. The probability that this patient’s ascending aorta will ever reach 5.0 cm in diameter is unknown but likely is less than 100%. As such, the possibility exists that the patient is an “anomaly” and does not experience sufficient additional aortic dilatation so as to require surgery. Also, it is currently unknown exactly how long it would take for the aneurysm to reach 5.0 cm in diameter and (or) what the patient’s risk of dissection would be over this time period. Moreover, during this indeterminate period of time, new advances in medical therapy may become available which could reduce or halt the tendency toward aneurysm formation and hence prevent the requirement for surgical interven-
tion. For example, while beta blocker therapy has long been the mainstay of treatment of patients with Marfan syndrome, evidence is accumulating that inhibition of the transforming growth factor-beta (TGF-β) intracellular signaling cascade can significantly slow the natural progression of aortic aneurysms in this population. A clinical trial is currently underway [16] assessing the efficacy of losartan (which has TGF-β inhibitory effects) in reducing ascending aortic dilatation in Marfan syndrome patients. Addition of this agent to the mainstream of medical therapy for Marfan syndrome may thus reduce the requirement for surgical intervention in patients like Mr Hochman.

Also, who can say with certainty that the patient will not be able to afford surgery after his medical insurance has expired? The patient may win the lottery or receive an inheritance or have a friend or family member who offers to pay the costs. Though perhaps unlikely, the point is that the decision to have surgery should not be based on future uncertainties (whether medical or financial) but rather must be based on what is presently known to be medically indicated.

Another major ethical concern arising from this case, in which the patient receives preemptive surgery due to present affordability and future financial uncertainty, is one of social justice. Here we are concerned specifically with a principle of distributive justice defined as “a matter of the comparative treatment of individuals' characteristic of modern democratic theory” [17]. Justice is providing access to treatment for all patients who need it (or for whom surgery is medically indicated). Injustice is sometimes providing access to treatment for patients on the basis of need (or for whom surgery is medically indicated) and sometimes providing access to treatment for patients on the basis of something other than need (or for whom surgery is not medically indicated). We contend that allowing for the impending loss of insurance coverage to be an indication for surgery poses a clear injustice as it allows for a qualification for surgery that is NOT applied equally across the patient population.

Assume that that patient accepts the risk(s) and proceeds to undergo major surgery. Let us further assume that the patient fares well, even though we cannot assume that this will always be the case for patients with similar risk-to-benefit ratios. This patient will have been very fortunate. What would happen, then, if other patients who opt for surgeries they do not really need were willingly operated on by surgeons throughout the medical field? Will surgeons appear less skilled at what they do because they take on higher risk-to-benefit cases? If cardiac surgeons start operating on patients for whom surgery is not medically indicated, what kind of reputation would they develop? Is this the kind of “surgeon model” we want in our medical system? Would this be fair to surgeons who do not feel that it is appropriate to take on certain higher risk-to-benefit cases? This may pose a serious threat to the social justice that is sought within the medical community.

In terms of health care distribution within the broader social community, if cardiac surgeries that are not medically indicated are allowed (like cosmetic surgeries), then cardiac surgery allocation becomes morally problematic because a system would be created in which society’s members who need surgery but cannot afford it are bumped by those who can afford (albeit temporarily in this case) but do not really need it! If the primary goal of medical practice is to heal the sick then surely the allocation of life-saving medical resources to those who do not require them is an unjust form of distribution, not to mention a financial waste.

Consider the converse possible outcome in which the patient undergoes surgery and does not fare well. Choosing to operate on patients when not medically indicated may place the surgeon on very unstable ground from a medico-legal standpoint where the law chooses to define this operation as failing to meet an appropriate standard of care. If the patient (even though he requested the surgery in the first place) or the family decides to sue for medical malpractice it is likely that, in a court of law, “expert” witnesses, presumably experienced thoracic aortic surgeons, will not agree with the decision to proceed with a nonmedically indicated operation based on pending loss of insurance.

What this would mean for our medical insurance companies is also important. There is the possibility that insurance rates would escalate drastically if cardiac surgeons make a practice of operating on patients who request surgeries before their insurance policy terms expire. This would present a social injustice to those who have worked hard for years to pay for decent medical coverage but have been fortunate enough not to have needed major surgery and hence the coverage to pay for it. Why should their rates go up? Preemptive surgery may end up costing society more with respect to medical insurance premiums. Conversely, from the standpoint of physician reimbursement, while it is clear that expanding the scope of operative indications to patients proven to not require surgery has the potential to benefit the surgeon financially, the long-term consequences may be dire. It is highly likely that this practice will be detected and could lead to charge of fraud with the potential for loss of the right to care for patients altogether [8]. It is also possible that the payor, upon review of the case, may deny payment on the basis of breech of the standard of care. Because many institutions submit billings on behalf of the surgeon, the institution, in addition to the surgeon, may assume culpability for fraudulent billing practices should an audit be conducted.

Conclusion

Although fiscal matters must dictate much of how the medical system functions, it is not in accordance with our medical ethical principles that such matters dominate decisions at the cardiac surgeon-patient level. In the case considered herein, concern for Mr Hochman’s present ability to pay for his operation must not precede or occlude concerns for his cardiovascular health. Patients should not receive cardiovascular surgery that is not medically indicated. We conclude, then, that impending loss of insurance coverage does not serve as an indication to proceed with cardiovascular surgery.
Concluding Remarks

Robert M. Sade, MD

The Arguments
The Belmont Report of 1979 [18] was the first national statement on research ethics; it was stimulated by revelations about the Tuskegee Syphilis Study and other unethical research. Belmont identified three ethical principles relevant to research: Respect for persons (respect for autonomy), beneficence, and justice. In the same year, Tom Beauchamp and James Childress [19] split off from beneficence a fourth principle, nonmaleficence. These four principles, often referred to as the Georgetown Mantra, are commonly used in ethical analysis. Both discussions of the William Hochman case are based on these principles, but they reach very different conclusions.

For Estrera, harm is avoided by doing the operation, as it can be carried out safely in the hands of Dr Geschickt and future complications of the disease process are circumvented. Ikonomidou and Ikonomidou insist that Dr Geschickt provide the patient with accurate medical information and exclude irrelevant (all nonmedical) factors, which they believe truly respects the patient’s autonomy by leading to genuine informed consent that will result in withdrawal of the request.

On the basis of beneficence, Estrera would have Dr Geschickt do the operation, thus eliminating future risk of aortic dissection and rupture and eliminating fear of complications, at the same time removing the likelihood of financial loss and the fear of the consequences of being uninsured. Ikonomidou and Ikonomidou, on the other hand, believe beneficence dictates that the surgeon persuade the patient that an operation at this time would be unwise because the risks outweigh the benefits.

For Estrera, who values and preferences seem clear—he wants the operation now. If the patient is persuaded, there is agreement and no operation is done. If, however, the patient is not persuaded and still wants the operation, Dr Geschickt has the option of agreeing to operate or of refusing. If he chooses the first option, they agree, but if he chooses the second, the patient is left with two choices: not having the operation or finding another surgeon. Both the patient and the physician are autonomous individuals and, while they seek consensus, which is usually achieved, agreement might not be possible. The surgeon might be correct in his belief that the risk-benefit balance weighs more heavily on the side of risk, but the patient might be willing to take that risk because the benefit, in this case, avoiding the need for

The Analysis
One of the difficulties of using a prescriptive analysis of ethical issues, such as the Beauchamp-Childress formulation, is illustrated by the discussions above; the defining terms are open to many different interpretations, sometimes diametrically opposed. Nevertheless, such discussions provide a useful starting place for analysis. The opposing authors disagree on the points noted above, but they agree on at least two issues: standard indications for operating on Mr Hochman are not present at this time, and nonmedical factors should generally be considered in treatment deliberations (they disagree, however, on whether such factors should be considered when a specific treatment is not indicated by standard criteria). Who has made the stronger case for or against operating?

The disagreement between the two positions can be attributed in part to language, namely, the meaning or usage of terms such as benefit, unnecessary surgery, and standard of care. The ambiguity of those terms allows divergent usages, leading to critical questions. Whose valuation of benefits versus risk counts? If the indications for operation are outside current standards, should nonmedical factors be excluded? Is an operation that does not meet standard indications unnecessary, and are unnecessary operations automatically unsafe? We might also ask how the risks borne by the surgeon and society at large should be weighed in the deliberations.

Whose Valuation of Benefits Versus Risk Counts?
A widely accepted method of making decisions in medicine is “shared decision making.” Different interpretations of how this method should work have been described; in general, it means that the physician and the patient exchange information and reach agreement on the best treatment option [20]. The physician supplies information based on his expertise and the patient supplies information about his values and preferences. Applying this model to the current case, Mr Hochman’s values and preferences seem clear—he wants the operation—and if Dr Geschickt agrees with the patient, he will do it. If Dr Geschickt disagrees with the patient, believing instead that an operation at this time would be wrong, he can, as Ikonomidou and Ikonomidou suggest, try to persuade the patient to abandon the idea of an operation now. If the patient is persuaded, there is agreement and no operation is done. If, however, the patient is not persuaded and still wants the operation, Dr Geschickt has the option of agreeing to operate or of refusing. If he chooses the first option, they agree, but if he chooses the second, the patient is left with two choices: not having the operation or finding another surgeon. Both the patient and the physician are autonomous individuals and, while they seek consensus, which is usually achieved, agreement might not be possible. The surgeon might be correct in his belief that the risk-benefit balance weighs more heavily on the side of risk, but the patient might be willing to take that risk because the benefit, in this case, avoiding the need for
paying out-of-pocket for surgery in the future, carries much more weight for him than for the surgeon. If Dr. Geschickt refuses to do the surgery, he does so on the basis of his own value system, not the patient’s; that is, he exercises his own professional autonomy.

If the Indications for Operation Are Nonstandard, Should Nonmedical Factors Be Excluded?
Estrera and Ikonomidis and Ikonomidis agree that nonmedical factors such as the patient’s preferences should be weighed when there is more than one acceptable surgical option, but they disagree when the surgery being requested is “not absolutely necessary.” Estrera still weighs those factors, but Ikonomidis and Ikonomidis discount them entirely on grounds of safety: “Surely it is always safer (and thus the optimal nonmaleficence) to NOT perform surgery that is not absolutely necessary!”

An enduring difficulty with this position has been the meaning of the words “necessary” and “unnecessary.” The most ambitious attempt to define these was made by the US Congress in 1976 [21], when a committee investigating cost control in health care listed six definitions of unnecessary surgery. A storm of protest resulted, challenging the committee’s list [22]. No broadly accepted definition has surfaced since then; precisely defining the terms seems to be a political rather than medical problem. The single one of the six definitions of unnecessary surgery that might fit the current case is this: an operation is unnecessary “where indications are a matter of difference in judgment and opinion among experts” [21]. This was one of the most vigorously disputed of the controversial criteria, and it is likely that no surgeon would accept it today as a valid definition.

There seems to be no solid ground for asserting that an operation indicated by parameters outside standard limits is ipso facto unnecessary. Underlying the question of whether Mr Hochman’s operation should be considered unnecessary is the question of whose values weigh more heavily, the patient’s personal values or the physician’s medical standards. Unnecessary to whom and by what measure? This question circles back to the discussion of shared decision making, leaving us with the quandary of adjudicating firmly held opposing views of physician and patient.

Is an Operation Outside the Standard of Care Automatically Unsafe?
“Unsafe” implies a risk-benefit ratio greater than 1. We can define the medical risks of a procedure accurately with medical evidence, but “benefit” can be measured either exclusively by medical criteria, such as operative survival, long-term survival, and quality-of-life measures, or by those criteria plus the patient’s values and preferences. The two sides of this debate agree that the patient’s values and preferences play an important role in determining the benefit side of the ratio; Ikonomidis and Ikonomidis, however, exclude them when the requested treatment lies outside the standard of care. Standard of care is a legal, not a medical term. It has been stated in different ways, but a basic formulation is this: “‘Standard of care’ … is generally defined simply as what a reasonably prudent physician (or specialist) would do in the same or similar circumstances” [23]. How many reasonably prudent cardiothoracic surgeons would side with Estrera and how many with Ikonomidis and Ikonomidis? We do not have that information, but if we did, we might have a clearer legal perspective of the situation, but not necessarily a moral one. Moreover, this case was constructed for the specific purpose of dividing our specialty into two roughly equal sides, so a survey of our specialty might find a majority on one side and a large minority on the other.

How Should the Risks Borne By the Surgeon and Society at Large Be Weighed?
My discussion thus far has focused on the risks and benefits confronting the patient, but at least two other parties have a stake in this decision to operate or not: the surgeon and society at large. Doing this operation exposes Dr Geschickt to certain potential harms, according to Ikonomidis and Ikonomidis. If the procedure is determined to be below the standard of care, he could face a charge of fraud by the insurance company when he submits his bill. If the operation results in serious complications, unlikely though this is, he could face a lawsuit for malpractice. Society could be harmed by violations of social justice through unjust allocation of resources if the rich can satisfy their desires for unneeded procedures and preempt the use of those resources by patients who are less well off, according to Ikonomidis and Ikonomidis. But there are no legal regulations or hospital policies that prohibit Mr Hochman’s operation, so, as Governor Richard Lamm has argued in these pages, the surgeon should do what he and his patient think is best until authoritative sources (for example, government agencies and medical centers) make laws, regulations, or policies that dictate otherwise [24]. A trend among bioethicists toward giving a preponderance of weight to social considerations in medical decision making has been evident for quite some time, but the primacy of the patient’s welfare has withstood such tests so far [25].

Conclusion
The persistently indeterminate meanings of several terms (eg, unnecessary surgery, benefit, standard of care) leave us with no clear solution to Dr Geschickt’s dilemma: whether or not to do the operation Mr Hochman requests. We can advise him to follow the primary principle of medical ethics, do what is best for the patient, but that would be begging the question, for what is best for the patient is precisely the disputed issue. In advising Dr Geschickt, neither Estrera nor Ikonomidis and Ikonomidis provide the final answer; both sides were making the strongest arguments they could. But ethical deliberation is not like solving a simple equation.

Dr Geschickt would be well advised to consider the counsel of both the Pro and the Con sides, because the route to the right answer is not a straight line. He can do an ethical analysis based on the outlined four principles, agree with the patient that the requested operation is
reasonable, and schedule it before graduation day, as Estrera suggests. Alternatively, he can analyze the situation, consider all the relevant factors, and find the requested operation to be unreasonable. He can then converse with the patient and attempt to persuade him that the operation is a bad idea, for the reasons Ikonomidis and Ikonomidis have enumerated. If the patient is persuaded, he leaves with gratitude for having been saved from making a bad choice. If he is not persuaded and persists in his request, Dr Geschickt can reassess his own reasoning, again consider the risks and potential benefits to the patient, consider the risks and benefits to himself, and consider the social consequences, giving them weight in accordance with his own social conscience. In deliberating on these factors, Dr Geschickt is exercising his professional autonomy, and can choose either of the available options: reverse his initial assessment and schedule the operation, or part ways with the patient, freeing Mr Hochman to seek the services of another surgeon.

The informed consent that is so familiar to us is not a signed piece of paper, as many residents seem to believe, but is a process grounded in two ethical principles: respect for the patient as an independent moral agent and beneficent guidance of the patient toward choices that are right for him. As surgeons, we also are moral agents, guided by our own values, knowledge, and professional judgment in dealing with our patients. Out of respect for one another, neither patient nor physician should attempt to impose unwanted options on the other. That is why Dr Geschickt could rightfully choose either of the two options that are open to him, and also why he should listen to the advice of both Estrera and Ikonomidis before making his decision.

References