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Church/State Interference in the Physician-Patient Relationship: View from Behind the Surgeon's Mask

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Doctor Mayschak participated in a panel on “Church/State Interference in the Physician-Patient Relationship” at the 1981 NFCPG annual meeting in San Antonio. His topic was “View from Behind the Surgeon’s Mask.”

My delight in being invited to participate in this annual meeting of the National Federation is augmented by being in the beautiful city of the Alamo. It is both my pleasure and privilege to present this contribution to the program.

An apologia pro vita sua is needed preparatory to the observations and ideas I am about to share with you, for my view is somewhat jaundiced by the position from which I look around. Unlike the majority of physicians participating in this meeting, I am a resident-in-training, specifically a resident in general surgery. The locus of my activities is not an office nor a private hospital. It is, rather, an academic institution, a teaching hospital, a quasi-charitable organization. As such, the hospital provides not only for my care but also, as material for my apprenticeship, a cross-section of clients from the whole community. They may be the private patients of a faculty surgeon, or so-called staff patients. All the patients, however, are housed, investigated and treated in the huge and often confusing institution that is the University Hospital.

As a surgical resident, I have been exposed to the full medical school curriculum and channeled into the more precise pedagogic and practical learning situation of the residency program in general surgery. There are certain axioms that pervade the atmosphere of such a program, and these are subtly inculcated into the young surgeon’s thinking by aphorisms such as: “The successful surgeon is an aggressive surgeon,” or, “A chance to cut is a chance to cure,” and “Don’t ever let skin stand between you and a diagnosis.”

It is not surprising that in the minds of many of the common people there lies the suspicion that surgery falls into the category of mala in se... mala prohibita. Now the strictly legal sense of that
phrase means that an act which is in itself a criminal act and therefore unlawful, cannot be rendered lawful because the person to whose detriment it is done consents to it. The formal meaning is not what I intend. Rather, it may be construed as a material evil in itself, in the sense of an act of violence. The common folk see it this way when, in anticipation of undergoing surgery, they verbalize it thus: “Well, tomorrow I go under the knife.” Accordingly, there is a growing attitude that “surgery is now too important to be left in the hands of the surgeons.”

But how does the surgeon tolerate his craft being wrested from his hands? And by whom?

Consider the daily scenario of the operating theater. One may argue, quite rationally, the necessity of delineating the operative field in sterile fashion. By reason of sterile precautions, however, the anonymity of surgeon and patient is symbolically maintained, thus mollifying the violence of the surgical act. Nonetheless, some opine that the surgeon frequently finds himself either operating in the shadow of the criminal law and its unclearly defined assault and negligent homicide jurisdiction, or plying his craft under the pall of religious and moral criticism, with its often antiquated notions of surgical practice.

Thus, at least on an implicit level, there appears to be equivocation about regarding surgical procedures as prima facie assaults, or in fact bona fide. How does the surgeon cope with this popular thinking? Where does this leave the surgeon who is practicing in an academic institution? In short, it entrenches him in a position of autonomy. At first blush, that may seem to be an unlikely conclusion, for, unlike the private practitioner, the institutionalized physician is buttressed and protected by the institution’s legal division and a host of ancillary services. Within that framework, however, it is he who calls the shots.

Let us clarify these notions with the help of a concrete example.

Transplantation

Clinical transplantation has largely been lifted out of the realm of experimental surgery. Whether one is dealing with homotransplantation, living-related donor transplantation or cadaveric organ transplantation, there are a number of issues commonly encountered: 1. organ procurement; 2. distribution or allocation of transplantable organs (a special case of Arthur Dyck’s allocation of scarce life-support resources); 3. definition of death; 4. technical expertise; 5. auxiliary procedures to insure graft survival (for instance, lymphocyte-depletion systems). The last two are wholly technical and reserved to the surgical and medical sphere.

Procurement of organs from living-related donors, when it is a question of paired organs, provides little difficulty from a medico-legal
point of view, although in some cases religious objections are encountered. Cadaveric organ procurement is obviously intimately connected with the definition of death. Declaring a person “brain dead” while support measures still maintain a “physiologic preparation” to preserve vital organs, is fraught with legal, religious and moral ramifications. It is said that “death is an event where medicine, religion and law meet around a human being in his last minutes.” The majority of commentators, however, seem to agree that the definition of death is a medical one only, to be applied by the physicians in attendance. Definitions of death, as proposed by various medical societies and associations, include certain common elements: 1. lack of spontaneous cardio-respiratory and motor function; 2. cessation of cerebral function by clinical standards; and 3. presuming the absence of anesthetic or sedative drug influence, the absence of cerebral activity as demonstrated by electroencephalography. Those determinations are made by the physicians in charge—not the transplant surgeon—based on medically proposed definitions of clinical death.

Allocation of organs is determined by two factors: 1. blood and tissue typing to provide a pool of prospective recipients, and screening those people by a committee to determine suitability of particular recipients; and 2. matching between recipient and donor tissues. Obviously there is a question of priorities here. First of all the operations themselves are costly and time-consuming in regard to their pre-operative preparation, operative exigencies and post-operative care and hospitalization. Transplant operations and related procedures supplant a host of routine operations. Furthermore, there is a cost-benefit ratio which, in the minds of some, has not been adequately justified. What are we offering people, and to whom is the service being rendered? The mind of the people, the common sense, if you will, is seldom consulted.

Probably the most sensitive area in this scheme is the procurement of cadaveric organs. In order to successfully negotiate the demanding task of establishing a relationship with the shocked and grieving families, communicate the hopelessness of the situation, request donation of organs from the body of the loved one, follow through with the necessary but frustrating paper work, and walk at least part way with the family in its grief—to do this without giving the impression that around the corner hungry transplant surgeons lie in wait, impatiently whetting their knives, usually requires a Herculean effort. Indeed, a rapport and relationship must be established, and rapidly, for otherwise the project is unlikely to succeed, at least not without anger, guilt and recrimination. In this, the surgeon must view his contract with patients and family as well-nigh sacramental and inviolate. He brooks no interference from without. He wants that sanctuary reserved for this communion with patient and family.
Daily Rounds

I have used transplantation as an illustration, perhaps almost as a caricature. I had entertained discussing other illustrations, some of which have already been addressed in this meeting: allocation of scarce resources, allocation of not-so-scarce resources, euthanasia and life support decisions, medical experimentation. All of these are more or less popular topics. They are, however, rooted in a much more fundamental phenomenon, namely the daily routine of the physician-surgeon. What is more, those larger issues differ only in degree from the issues and decision-making the surgeon confronts in his daily rounds. It is here that he is buffered from the interference of government regulations and ecclesiastical norms.

Follow the academic surgeon in his daily trek. He moves from office to operating room, to ward, to emergency room, to office, to clinic, to meeting, to laboratory, describing a maze not only of geographical pathways but also of conflicting interests. Value judgments are inevitable. Simply the time he devotes to reading, research or paper work is time no longer available for seeing patients, assisting junior residents in the operating room, helping those evaluating emergencies. What determines to what extent he will allow his subordinates to manage the surgical service, to perform the operations, to delegate their own authority?

Despite objections to the contrary, there is, in fact, a distinction made between the private and the staff patient. The policy is that all patients receive the same quality of care. The reality is that the faculty physician rarely, if ever, sees a hospitalized prison inmate until the patient is in the confinement of general anesthesia. The fact is that when a private patient is being operated on, the staff surgeon must be in attendance and usually is the primary operator. If you or I, or our wife, husband or parent were the patient in question, we would laud the practice. But were we of the anawim, God’s penniless, would we not object? But to whom? Who would be our advocate? Other examples bear out the double standard: the privilege of private patients to remain in hospital for inordinate periods of time, while others are more readily discharged to care for their wounds at home; the reassignment of interesting or attractive patients to a private service; follow-up in the one-on-one private clinic instead of in the staff clinic where each week one may see a different doctor.

Residents, although hungry for experience, are not strangers to the double standard. For example, given a young, attractive patient, the junior or senior resident may well finish the entire case by meticulously closing skin with a subcuticular stitch guaranteed to leave a hairline scar. On the other hand, the ordinary staff patient may provide the opportunity for the intern to teach the medical student how to use the stapling device to close the incision.
We are aware of, and talk about, other subtle processes. Take the young black man brought into the emergency room with his second or third stab wound to the abdomen, or the jobless, reckless, drunken person who has totaled his cycle or auto in an accident that may have sacrificed or threatened innocent lives. Approaching these people does not bring a rush of warm feeling and empathy. Yet we triage and treat and take to the operating room—admittedly, perhaps, with a bit more roughness than is warranted, but we explain this by insisting on the need to expedite matters—and in fact we may perform a flawless operation. But what are the motivations active here? And what, if any, are the guiding principles? Often there is great ambivalence. As we work to save this person’s life we ponder: “What are we doing to the gene pool by spending 70% of our operative time on recidivists, social deviants, other ‘undesirables’?” Is not the governing factor in how expertly the surgery is performed or the patient managed no more than the surgeon’s self-image, his pride, even egotism, or the fear of having to account for embarrassing post-operative complications?

The state speaks of rights and injustices, and thus proposes liability as a governing force in its regulation of medical practice. Religion highlights the value of the person in se, and thus advocates care and concern, a certain altruism, as the capital consideration in evaluating motivation. The medical system, however, fosters fear, self-satisfaction and personal gain as primary motivational factors; it discourages legal interference or religious incursions except as they support the above motives.

It is within the confines of a strong physician-patient relationship that such a system can flourish. Surely, pride and egotism may have a lead role, but the doctor has at least opened himself to the possibility of true care and concern. Witness the results. Recently a middle-aged man with the Zollinger-Ellison syndrome was operated on for an abdominal aortic aneurysm. He had known gastrinoma metastases to the liver. Intraoperatively, his primary surgeon inspected the patient’s liver and decided to perform a partial liver resection. Legally liable? Yes. Ethically reprehensible? Perhaps. Presumptuous? Assuredly. But the surgeon evidently knew the mind of his patient, and between the two existed such rapport that afterward the family could only laud the decision. Is this not a testimony to what many consider obsolete, namely the relationship between a physician and his patient?

One may wonder where all these processes are examined with any objectivity, criticism or ethical analysis. Usually it is in the context of the morbidity and mortality conference. Ours, by tradition, is composed of housestaff and representatives from the departments of anesthesiology and pathology. No others are ordinarily invited. Medical student attendance is tacitly discouraged. The “M and M” conference is wholly intramural Those cases, however, that involve forensic pathology naturally presume state interference in the post-
mortem discussion. Mistaken diagnoses, complications, and deaths outside the coroner's jurisdiction receive the attention only of the surgical family. Attitudes come to light in unexpected ways in these situations. For example, recently, as we were discussing the plethora of medical chart notes written by members of ancillary services, one elderly faculty member joined in the lament with the comment: “Yes, and we would be a lot better off if we got all the ecclesiastics out of the hospital so we could get on with our work!” Thus in a forum wherein surgical practice and practices might benefit from modulation of an internal critical apparatus, outsiders are systematically excluded.

Summary

So you see, the day-to-day work of a surgeon depends primarily on the relationship with his patients. The expertise of his practice is held up for criticism or commendation largely within a closed forum of evaluation. The need for intervention on the part of secular or religious authorities represents a failure of the patient-physician relationship. (For example, the clergyman is called if there is difficulty obtaining consent for an autopsy, or if the physician cannot quite handle an effusive grief reaction.) These dynamics differ only in degree from the larger medical, legal and religious issues more popularly discussed.

Conclusions

We can make some conclusions from these observations. The conclusions, however, generate further questions.

1. There is a need for governmental regulations in medical practice, in general fashion, however, as merely proposing guidelines.
   Question: Is not actual implementation of guidelines best carried out by regulatory bodies within the profession?

2. Pastoral or religious intervention is often necessary, but generally unrelated to daily medical decision-making, and, in fact, is usually unwanted by the professional community.
   Question: Where lies the prophetic mission of churchmen in exposing injustices within the system and the false pride of some of its practitioners?

3. Particular decision-making is largely a medical matter, demanding medical expertise and collaboration.
   Question: Is that enough? Why are para-medical advisers discouraged from having anything more than a subordinate and subsidiary role?

4. The physician-patient relationship is of primary importance and at the crux of effective medical practice.
   Question: How well does the physician understand his own
motivations underlying value judgments and moral decision-making?

5. The double standard in medical care is a reality, and it implies an all-embracing set of values regarding the importance, usefulness, productivity and worth of particular patients.

Question: Is such a standard inevitable? Is it, in fact, morally unacceptable? How can it be effectively criticized?

6. Autonomy is a primary value for the physician, and the religious or even humanistic doctor can probably function adequately on his own.

Question: What, however, is the physician's own support system, and how effective can it be? Before whom does the surgeon drop his mask?

The queries raised here are of crucial importance for the integrity of medical practice, but they cannot be answered in a facile manner. They must prick our moral conscience and occupy our ethical reflections for a long time to come.

REFERENCES


SAMPLE MEDICINES FOR THE MISSIONS
WOULD BE WELCOMED BY:

Plasencia and Holy Spirit Missions
P.O. Box 122 Convent of the Holy Spirit
Marshalls Creek, PA 18335 Techyn, IL 60082