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sentinal goods of the individual and the community. Just what does this obligation involve?

For the medical student during his university formation: the obligation of seriously applying himself to study that he may acquire the requisite theoretical knowledge as well as the practical ability necessary to apply it.

For the university professor: the duty of teaching and communicating to his students in the best possible way knowledge and its applications. He must never give a diploma certifying professional ability without being assured of this ability beforehand by a thorough and conscientious examination. To act otherwise might involve serious moral fault because it might expose both private and public health to very grave dangers.

For the doctor in practice: the obligation of keeping abreast of developments and progress in medical science. To this end, he should read books and scientific journals, participate in conventions and academic courses, converse with his colleagues, and consult with professors of medicine. This obligation of striving constantly to better himself binds the doctor in practice insofar as it is reasonably possible for him to fulfill it and insofar as the good of his patients and the community require it. You should manifest a knowledge and professional ability that is second to none. Indeed, you should excel for, in this way, you will convince others of the moral principles you hold.

Conclusion

Luke, whom St. Paul called "our most dear physician" (Col. 4:14), wrote in his gospel: "And when the sun was setting, all who had been sick with various diseases brought them to Him; and laying His hands on each of them He cured them" (Luke, 4:40-41). Although he does not possess such a miraculous gift, a Catholic doctor of the kind that his profession and the Christian way of life demand will be sought out as a refuge by the afflicted. They will seek care at his hands. God will bless his learning and skill that he may cure many. And, though he may fail in this at times, he will at least sojourn those in distress.

With the hope that God may grant you such gifts in abundance with a full heart, We impart to all of you here, to your families, to your dear ones, and to the sick entrusted to your care Our paternal Apostolic Benediction.

The Resident Surgeon and the Private Patient

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WHAT restrictions would moral theology impose upon the surgical activity of student doctors in residency training? Apparently the question is of more than ordinary concern to physicians at the present time, since in varying forms it has been asked with a remarkable frequency within the past year or so.

The problem, as I understand it, emerges from an accumulation of several facts, the first of which is the imperative need that hospitals, for the good of medicine and consequently for the common good, engage in educational programs. Secondly, it is beyond question that a sine qua non of any such program is the provision of actual surgical experience for resident surgeons. And, thirdly, it is alleged that the number of service patients in some hospitals is not sufficient to provide residents with the amount of surgical experience desirable in the ideal order. Hence I am convinced that what doctors really want to know when they ask questions such as this is whether it is morally permissible to make use of private patients in the training of surgical residents.

For the sake of clarity let me suggest two hypothetical cases:

1) While traveling, Mr. A is stricken with severe abdominal pain and nausea. Proceeding to the nearest hospital, he is examined by an intern whose diagnosis of appendicitis is confirmed by a staff physician. Mr. A authorizes the hospital to provide surgery, and the appendectomy is performed by a resident surgeon under the supervision of his chief.

2) Advised by his physician that an appendectomy is imperative, Mr. B engages Dr. X, a surgeon of considerable repute, to perform the operation. Dr. X is present in a supervisory capacity during the entire procedure, but allows Dr. Y, a senior resident with a brilliant record, to perform the appendectomy.

Concerning each of these cases the question is the same: is the resident surgeon justified in doing what he does? Or perhaps the question should be worded: is the qualified surgeon justified in allowing the resident to do what he does in each case?

TWO RIGHTS OF THE PATIENT

In attempting to solve a problem such as this, the moralist would instinctively begin his thinking in terms of two fundamental rights of the surgical patient: (1) his innate right to be protected from all unnecessary surgical risk, and (2) his contractual right, if any, to be treated by the surgeon of his own choice.

Of these rights, the first is the
inviable prerogative of any and all surgical patients, once they have been accepted as such either by an individual physician or by a hospital or clinic. The second, however, is properly reserved to the patient who de facto has engaged an individual surgeon for a particular operation — the so-called “private patient.” The question of resident surgery will and must be solved according as these rights are respected or violated in particular cases.

GREATER RISK?

From a practical and realistic point of view, it would be silly to contend that greater risk to the patient is necessarily involved in every concrete instance in which a resident, rather than a qualified surgeon, is allowed to operate. The resident surgeon cannot be written off as a rank amateur. He is a doctor of medicine with a certain amount of surgical experience behind him. It is true that the resident is less experienced than the qualified practicing surgeon — and presumably the less capable of the two if one compares the totality of their respective surgical abilities. But that difference in total experience and skill need not necessarily be a vital factor in a certain number of particular surgical procedures, especially at the level of what doctors would consider routine surgery. Except for a certain facility and confident familiarity with which the more experienced man would approach such a bit of surgery, his work in a particular instance might not differ substantially from that of a resident under proper supervision.

It would be a different matter, of course, with more complicated or more delicate operations where high skill and long experience really count. But no conscientious surgeon would think of deputing that type of operation to a relatively unskilled and inexperienced underling.

The point to be made here is this: there are surely many cases where a staff surgeon could honestly and prudently judge that a certain resident is quite capable of performing a particular type of surgery without additional risk to the patient. Presumably this is the only kind of operation which a reputable surgeon would allow a resident to perform. Granted, therefore, a careful selection of cases according to the resident’s known ability — and granted, too — proper supervision throughout the course of the operation — it is entirely possible that the patient’s right to be protected from unnecessary surgical risk can be adequately safeguarded, even when a resident surgeon is allowed to operate.

CONTRACTUAL RIGHTS OF PRIVATE PATIENTS

A considerably greater difficulty, however, is posed by the contractual right of the private patient to be treated by the surgeon of his own choosing.

By “private patient” I understand the individual who prior to surgery has explicitly engaged a specified surgeon to operate. That, I believe, is the generally accepted meaning of the term in contrast, for instance, to the service patient for whom the hospital, as authorized agent, provides a surgeon of its choice. To what is the private patient in justice entitled by virtue of the contract he has made with an individual surgeon?

Let us suppose that such a patient should expressly stipulate — as reasonably he might — that no one but the surgeon himself perform the actual operation. Would not the physician, once committed to the case on this explicit understanding, be in conscience bound to observe that part of his contract? Now even though that stipulation may seldom be expressly stated, to me it seems obvious that implicitly uppermost in every private patient’s intention when he chooses a surgeon is the desire to secure for himself all the surgical skill (manual skill included) of this particular doctor, and not that of any substitute. Such a patient, I am sure, goes to surgery confident that the surgeon he has engaged will actually perform the operation, at least in its substantial essence. And if that is the essence of the contract which the patient wants and for which he is paying, that is the service he is entitled to receive. Ultimately it is the violation of this right of the private patient to receive treatment from the surgeon of his own choice that constitutes the essential malice of ghost surgery.

I have heard it suggested that all the patient really wants his surgeon to provide is successful surgery, regardless of the hand that performs it, and that implicitly he is willing to allow a resident to operate under the surgeon’s supervision if in the latter’s judgment the resident is competent. This interpretation of intention might possibly be verified in a limited number of cases, but to my mind presumption is very strongly against it. It certainly would not be my own intention if, as a patient, I were to make a choice of surgeon. Nor do I think that doctors themselves would readily undergo surgery on that understanding. And I doubt very much that a surgeon who might defend that presumption would agree to put it to the test by openly informing a patient that a resident would perform, or had performed, the actual surgery even under supervision.

It has also been alleged that, because the surgeon accepts all medical and legal responsibility for a resident’s surgery, he has in no way betrayed his patient’s interests. That argument is simply irrelevant. It is not only the surgeon’s acceptance of responsibility for which the patient has contracted, but also the surgeon’s own operating skill. To deny him the latter is a breach of contract.

Hence whatever concession may be made in regard to a resident’s ability to perform certain operations without adding notably to the patient’s risk, it cannot be said that no real injustice is done the private patient if, without his knowledge and consent, a resident is allowed to take the surgeon’s place at the operating table. In all probability doctors would agree that the likelihood of obtaining explicit consent from a private patient for such an arrangement is at best minimal. And if private patients in general would be aghast...
at the open suggestion that a resident be allowed to perform the operation for which a qualified surgeon is being paid, there seems to be no justification for proceeding on the basis of presumed consent.

**RULING OF ACS**

If, in the opinion of some surgeons it savors of the ivory tower to restrict the surgical training of residents, I can only refer them to the ruling of their American College of Surgeons. In December 1953, the Board of Regents of that College formulated definitions of several unethical practices, among them that of ghost surgery. Commenting on these definitions, Paul R. Hawley, M.D., wrote as follows:

Their formulation was not accomplished without serious consideration of their impact upon wholly ethical requirements of surgical teaching and practice. The Board espoused the definition of ghost surgery upon resident training around the most concern: yet the Regents decided unanimously that honesty demanded that no exception be made in this respect. That good resident training can be provided within this limitation has been demonstrated.

Five months later the Board revised its stand on the application of ghost surgery to residency training programs:

The Board considers it a breach of ethics when any patient who has made an agreement with a surgeon is operated upon by another without knowledge and consent of the patient. However, the Board considers it proper for the responsible surgeon to delegate to his assistant the performance of any part of a given operation, provided the surgeon is an active participant throughout the essential part of the operation. The Board of Regents approves the inclusion of all practice.

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**SUMMARY**

1) The lawfulness of permitting residents to operate on private patients will be determined by two natural rights which those patients possess: (a) the right to be spared all unnecessary surgical risk, and (b) the right to require of the contracting surgeon the total personal service which they reasonably expect.

2) The element of additional risk can be avoided if cases are carefully chosen according to the resident’s recognized surgical ability, and if throughout the operation he remains under the supervision of a qualified surgeon. It should be conceded that surgical residents can be entirely competent operators in selected cases. Hence it is not necessarily inability which is invoked as the reason for denying them surgical rights with regard to private patients.

3) Consent of the private patient, however, to undergo surgery at the hands of anyone other than the contracting surgeon is a prime requisite for the lawfulness of this practice. Since it does not seem likely that this consent would ordinarily be given by the private patient for a resident actually to operate, presumption of that consent in ordinary circumstances does not seem to be justified.

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**CONCLUSION**

On the strength of these premises, my solution of our hypothetical cases would be as follows:

1) The resident surgeon is morally justified in performing the appendectomy. Mr. A has engaged no surgeon of his own, but has authorized the hospital to provide a competent operator. On the assumption that the resident surgeon is prudently judged to be competent, no moral objection can be raised to his operating under proper supervision.

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2) Neither Dr. X nor Dr. Y nor the hospital can be justified in this case. The patient has contracted with Dr. X only, and cannot be presumed to consent to the substitution of the resident as operator, even under Dr. X’s supervision.

While these two cases are more or less clear-cut, there are others which are not so easy of solution because they verge on the borderline. I refer to instances in which residents are allowed to assist at surgery performed on private patients. Certainly there is a considerable area within which no reasonable patient would object to a resident’s lending the operating surgeon a helping hand. Everyone understands at least vaguely that surgery is not a one-man performance and that various assistants have to be on hand to relieve the surgeon of details extraneous to the actual operation. To know that another doctor, in the person of a resident, is standing by to help under the surgeon’s direction would strike me as being more reassuring than disturbing to a reasonable patient, and something to which he would readily consent.

The difficulty here lies in determining satisfactorily the limits within which the resident can truly be said to be assisting at, and not actually performing, the operation. That is a question which the moralist must transmit to the surgeon—and perhaps even to the surgeon himself. The surgeon can offer no more than a rough rule of thumb. One can, as did ACS, talk about “the essential part of an operation” (thereby implying parts which are less than essential), but what precisely does this mean in terms of a tonsillectomy, an appendectomy, a hysterectomy, etc., is not for theologians to define. But we would, I think, concede that if the surgeon himself performs what doctors generally would consider the substantial essence of an operation, he would be morally justified in supervising a competent resident’s execution of other details.

THE EVANSVILLE, INDIANA, GUILD reports that Dr. Thomas A. Dooley of DeRidder-Burnet fame, now engaged in Operation Loos in Indo-China, has been accorded honorary membership in the group. In addition to visiting the Mead Johnson Co. plant in that city before leaving for his mission, he met with the Executive Committee of the Guild and also lectured to Evansville physicians, clergy, and others. In his book this young Navy doctor gives a first-hand account of finding he managed to feed, clothes, and treat three left-overs of an eight-year war. Dr. Dooley “processed” more than 600,000 refugees down river and out to sea on small craft, which were then transferred to U.S. Navy ships to be carried to the free areas of Saigon. Not satisfied with past labors, Dr. Dooley has returned to Saigon, Viet Nam, to give further assistance. The Mead Johnson Co. has provided him with vitamins and other products to use on his Operation Loos.

LINACRE QUARTERLY

Benefactor of Mankind .......

Louis Pasteur

SECOND in the series of biographical sketches of the Catholic men of science honored by The Federation of Catholic Physicians’ Guilds in the permanent display set up for convention use, The LINACRE QUARTERLY introduces Louis Pasteur, one of the greatest figures in bacteriological science. He was born at Dole in France, December 27, 1822, the son of a tanner. Unlike his distinguished companion, Koch, who began as an obscure country doctor, he was early educated in chemistry and achieved distinction in other lines of research before turning his attention to the study of bacteria, in which field his name is resplendent. In 1847 he was graduated from the Ecole Normale, in Paris, and in the following year became professor of medicine at Dijon, shortly resigning this post to become professor of chemistry at Strasbourg. He had already made important discoveries in chemistry and was at this time absorbed in his studies as to the nature, causes, and effects of fermentation, particularly in relation to the “diseases” of beer and wine, a problem which had long engaged the attention of chemists. He was always an indefatigable worker and after long and thorough experimentation, he proved fermentation to be due to the presence and growth of tiny organisms, or ferments, and set himself to find a way by which the formation of these organisms might be prevented.

In 1854 he left Strassburg for Lille; three years later he held the important position of director of the Ecole Normale Superieure. Here he continued his work, discouraged by the opposition of friends who believed that he was carrying on a fruitless quest, and eventually he was rewarded by finding it within his power to give to the world specific knowledge which has proved of incalculable benefit to mankind. One of the first practical results from his study of fermentation was to revolutionize the industry of beer and wine manufacture, making it possible to abandon the old uncertain methods and carry on the work with assurance of definite results.

In 1865 (at that time, professor of chemistry at the Ecole des Beaux Arts) his help was sought in investigating a silkworm disease which was making severe ravages and ruining the silk industry in the south of France. Although he had never seen a silkworm, he attacked the problem, at the insistence of his friend Dumas, and within a few months was able to discover the origin of the disease and suggest means for its cure. He also developed a method of inoculation of cattle to prevent the dreaded