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J Clin Ethics. Author manuscript; available in PMC 2024 October 27.

Published in final edited form as:
J Clin Ethics. 2023 ; 34(1): 98–102. doi:10.1086/723315.

Talking with Patients about Surgical Trainees

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Abstract

Training of resident physicians is essential for the care of future patients. While surgical trainee involvement is necessary, its disclosure to patients can often be omitted or underplayed by surgeons. The informed consent process and the underlying ethical principles make evident that patients should be informed of trainee involvement. In this review we explore the importance of disclosure, current themes in practice, and the optimal discussion for which we should strive.

INTRODUCTION

Physician trainees represent the future of medicine. Throughout their training residents and fellows must acquire the knowledge and skills to provide exemplary care to their future patients. Though physician training serves an essential societal function, the educational need must he balanced with the safety and well-being of current patients. In many cases, trainees elevate care as they progress through their training in a system of graduated responsibility. However, a trainee's inexperience may also result in errors or suboptimal outcomes even with appropriate oversight.[1] The benefits and burdens of physician training are borne by patients in the present to benefit patients in the future. Therefore, participation by trainees should be equitably distributed in the patient populations they serve.

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The goal of a surgical training program is to graduate surgeons who can safely and effectively perform independent procedures. A key factor for surgical trainees in choosing residency and fellowship programs is the amount of hands-on experience they will gain. Each year of training is expected to bring more autonomy, with the trainee performing progressively more complicated portions of a procedure in a process known as graduated responsibility. This process represents the gold standard for training the next generation of surgeons.[2]

While all aspects of medicine involve some form of graduated responsibility, procedural specialties, including surgical subspecialties, put patients in a particularly vulnerable position because much of care is provided while the patient is anesthetized and therefore not directly observing the level of trainee participation. Though the patient agrees in advance to a practical "suspension of autonomy" while under anesthesia, there is an implicit understanding that actions will be taken in their best interests and that they will be kept informed of what is happening both before and after the anesthetic event.[3] As fiduciaries of patients under their care, surgeons thus have an ethical and moral obligation to discuss trainee involvement with patients, which will be discussed further in this article. Additionally, this article will outline the current state of the art and scholarship in methods for optimizing these conversations.

THE IMPORTANCE OF DISCUSSING TRAINEES

A fundamental part of the informed consent process is disclosure of all participants and their roles in the procedure,[4] harkening back to the legal origins of consent as a means of authorizing the "touching" of one's body.[5] Surgery places patients in a particularly powerless position. Under the ethical principles of autonomy and respect for persons, patients have the right to know what will happen to their body and to make key decisions in their care. As will be discussed, surgeons cannot assume that patients understand the extent to which a trainee will be participating in their operation. Proactive discussion and maintaining an open dialogue with patients strengthen trust between surgeon and patient.[6] Conversely, intentional omission of the role of trainees can rapidly deteriorate trust between surgeon and patient. Thus, omission can harm that patient's future interactions with the healthcare system, as well as generate legal and ethical jeopardy for the attending surgeon.

BARRIERS TO DISCLOSURE

Surgeons and patients alike believe hands-on training for residents and fellows to be necessary.[7] However, suigeons still find surgical trainee participation to be a difficult topic to breach with their patients. In our unpublished interviews with surgeons regarding trainee disclosures, many reported describing trainee activities vaguely, if at all. These surgeons justified this based on multiple factors, including time constraints and concern for provoking undue anxiety. Similar sentiments have been identified by other researchers as well.[8] Surgeons we interviewed in highly competitive markets also expressed worry that being forthcoming about trainee participation may result in loss of patients to their less transparent competitors. These concerns are not unfounded—survey data have shown decreased patient willingness to consent when more details about resident involvement are shared.[9] The lack

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of disclosure is self-perpetuating when surgeons do not demonstrate to their trainees the importance of and techniques for proper patient disclosure. Further, there is little available guidance for practicing surgeons to frame the discussion with patients in an informed, ethical, and reassuring manner.

RESPONSIBILITY FOR DISCLOSURE

For the patient to make an informed decision about proceeding with a proposed operation, they must be presented with complete and accurate information. While generally the discussion on trainee involvement does not include offering a choice between surgery with a trainee and surgery without a trainee, this information is still germane to a patient's decision-making process.[10] Thus, the discussion of trainees can be thought of more as an "informed disclosure" than a consent. This conversation can happen as part of discussing a patient's particular procedure or more generally as part of information on care delivered at a teaching institution.

In forthcoming work, we investigate whom surgical program directors viewed as the responsible party for disclosing trainee involvement. While most viewed it as the responsibility of the attending surgeon, there were outliers who suggested that the trainee or even the consent document holds this responsibility. A previous study of ophthalmology programs found that half of programs with a policy on trainee disclosure assigned this responsibility to the trainee.[11]

The burden of acquiring consent should not be placed on the trainee.[12] First, the trainee often does not know which parts of the procedure they will be performing prior to surgery, as this is decided by the surgeon, often on the day of surgery. Second, disclosure of trainee involvement should ideally occur prior to the day of surgery to prevent undue stress and anxiety for the patient.[13] However, the resident is often not present at preoperative encounters where this discussion may occur. Finally, the surgeon is the person with whom the patient has an established, trusting relationship and thus is the person in the most appropriate position to make this disclosure. Indeed, an attending surgeon's endorsement of the trainee and their surgical skills is important to patients and is associated with trust in that trainee.[14]

As many have previously written, signing of the consent document is a necessary but insufficient step to ensure proper informed consent;[15] rather, it is the surgeon-patient discussion and decision-making that is the heart of consent. The document, however, could potentially have utility as a road map to guide surgeons through disclosures that the hospital expects to take place.

In forthcoming research on a large US sample of informed consent documents we found that most, but not all, of the documents from academic institutions included disclosures about trainees. The content of these disclosures, however, varied widely. Commonly, descriptions were simple hut vague statements like "Other doctors, resident doctors, medical trainees or other providers may be involved." A few documents had more complete disclosures, such as the following:

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> I understand that the attending physician may choose assistants, including other health care professionals and residents (physicians who have finished medical school, but are getting more training), to be part of the team performing my procedure. The assistants may suture; harvest grafts; dissect, remove or alter tissue; implant devices; or do other tasks that the attending physician has deemed appropriate. If known, the attending physician has discussed with me whether there will he assistants and whom s/he expects the assistants to be. I understand that during the procedure, the attending physician may need to choose different assistants or have them do different tasks.

This wording is transparent and thorough, but it is also complicated and represents a much higher reading level than recommended by the National Institutes of Health for patient-facing documents.[16]

It is not clear that any of these disclosures will be read or understood by patients without additional commentary by the attending surgeon. Simply put, these disclosures are laudable but not enough to ensure patient comprehension. The attending surgeon is the only team member in the position of providing information that is most likely to be received and understood by the patient and, therefore, should hold the responsibility for this disclosure as they do for the overall care for the patient.

PATIENT VIEW OF RESIDENT INVOLVEMENT

If the surgeon does not discuss trainee involvement, patients are left to formulate their own ideas of what trainee participation means. Driven by anecdotes, social media, television shows, and pop culture, the role of trainees and the extensive oversight inherent in surgical skill development is largely misunderstood by patients, often with trainees assumed to be either passive observers or, worse, recklessly unsupervised (e.g., *Grey's Anatomy*).

In a study we conducted exploring patient perceptions, many thought that trainees would he "assisting" or "helping" rather than "doing" the operation; conversely, others were worried about someone being allowed to "practice" on them.[17] These misconceptions can be rectified. In the same study, after showing patients real surgical footage and debriefing about the active participation of both the attending surgeon and trainee, patients were able to put into their own words a realistic description of trainee involvement. Additionally, even patients who thought that trainees had a more passive role tended to feel comfortable with active trainee involvement after viewing the videos (with the caveat that the video did not depict any circumstances of trainees operating without the attending surgeon actively helping).[18]

WHAT DO PATIENTS WANT TO KNOW ABOUT TRAINEE INVOLVEMENT?

It is sensible that patients would want to know who will do what to them while they are anesthetized, and it is important that surgeons maintain a sympathetic stance to patients' desire for this information. In the aforementioned study, the descriptions of trainee involvement that patients gave after watching surgical footage revealed six information themes that patients found "truthful and reassuring": an explicit statement that a trainee

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would he involved, a description of the trainee's activities (performing parts of the operation), an endorsement that the trainee had some experience in the tasks they would do, a statement that the attending surgeon would be supervising the trainee's work, an expression of teamwork, and reassurance regarding the safety of resident involvement.[19] In a forthcoming follow-up study, we tested these and other themes in a large-scale survey and identified that the most valuable information to patients were statements regarding trainee skill and what impact the trainee would have on the actual surgery. Importantly, this follow-up survey also identified that patients with past negative experiences with trainees wanted to know more information about resident roles overall. This finding fits with our prior research showing a connection between trust in the healthcare system and willingness to have trainees operate independently.[20]

The main conclusions of these studies are that patients do want to know about trainee involvement and that many believe it can be discussed in a comforting way if given sufficient information. The findings also suggest that surgeons should be aware that some patients, particularly those with past negative experiences or difficulty trusting the healthcare system, will want to know more information. For these patients there might be no information sufficient to reassure them on the role of trainees, speaking to the greater and fundamental importance of trust in the surgeon-patient relationship.

HOW SHOULD WE COMMUNICATE THIS INFORMATION TO PATIENTS?

The ideal discussion of surgical trainee involvement with patients meets the above ideals of truthful and reassuring. To date, our work and that of others have yet to identify a disclosure script that universally comforts patients. Although there are key themes, we expect that any discussion will need to be tailored to the individual patient's desire for information. The first step is committing to doing the disclosure and starting this conversation at a time that allows for patient contemplation and questions (i.e., not only in preoperative holding).

A reasonable litmus test for ethical practice is that a surgeon should not put trainees in a patient care role that the surgeon would not be willing to transparently disclose. Additionally, the goal of current research should he to identify ways to make such disclosures comfortable for the surgeon and patient. An open conversation provides the opportunity to dispel harmful myths about the role of trainees and supports future team-based care for that patient. Whatever strategy surgeons adopt to begin the conversation about trainee involvement should be followed by an opportunity for the patient to ask questions based on their baseline understanding and concerns, allowing the remainder of the conversation to be tailored to the individual patient.

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