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# Should a Thoracic Surgeon Transfer a Complicated Case to a Competing Medical Center Against the Hospital's Order?

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## INTRODUCTION

Robert M. Sade, MD

The Patient Protection and Affordable Care Act was signed into law several years ago, but the future of the emerging health care system remains unclear. The law is not popular and the political outlook for many of its key components is in doubt. Certain aspects of health care can be predicted with considerable confidence, however: an increasing role for bureaucracies and decreasing power of physicians. These trends pose dilemmas for surgeons, particularly when a conflict of loyalties is created when hospital administrators demand that physicians place the interests of the medical center before the interests of patients.

The question of how to respond to such conflicts of loyalties was debated at the 61$^{st}$ Annual Meeting of the Southern Thoracic Surgical Association. The session focused on the case of a surgeon faced with a complex clinical situation that would require operative management, either in her own hospital, as demanded by an administrator, or in a competing hospital after referral to a surgeon more experienced in handling such cases.

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## A Case of Divided Loyalties

Dr. Elizabeth Black, a young cardiothoracic surgeon in a 400 bed community hospital, receives a call from the emergency department regarding a patient with a confirmed diagnosis of perforated esophagus, which occurred more than 24 hours ago. The patient is stable, but has early sepsis and multiple co-morbidities, including alcohol abuse.

The hospital where the surgeon works has 2 groups of cardiothoracic surgeons in competition with one another, all of whom do cardiac surgery and most of whom also do some general thoracic surgery. None of the surgeons has special expertise with esophageal surgery — they generally refer elective esophageal cases to a large university hospital 50 miles away, which has an international reputation in the management of esophageal disease.

Dr. Black feels it would be in the patient's best interest to be transferred to the university hospital instead of caring for him locally. When arrangements for transfer are begun, the hospital administrator informs the surgeon that she must accept the patient and care for him. The hospital is in the same market catchment area as the university and does not wish to lose patients to its competitor, especially a patient who has already been seen in its emergency department.

Dr. Black feels uncomfortable in accepting this patient, and does not feel confident in her ability to optimize his chances of survival. Nonetheless, financial arrangements and competition with the other group of surgeons make it very difficult to refuse the hospital's demand – she is board-certified and through her education and training, she knows the correct care of the patient, and has done similar cases as a resident.

The patient's social situation (no apparent family members) and current medical condition do not allow him to make an informed decision about his locus of care. In case of a bad outcome, legal repercussion are highly unlikely. Dr. Black asks two of her out-of-state surgical colleagues to advise her on what she should do.

# PRO

Kathleen Fenton, MD

Dr. Black should transfer the patient to a more experienced center. Whether or not to carry out such a transfer is a complex issue. The ethical analysis presupposes an understanding of the medical issues: what are the patient's chances of a good outcome in each hospital, with each surgical team? Once this is defined, we can discuss the patient's rights, the physician's rights and obligations, and the various ways these can be analyzed from an ethical standpoint.

## The Patient

This is a high-risk patient: he has a perforated esophagus, and he has had it for more than 24 hours. The mortality risk of an esophageal perforation that is more than 24 hours old is in the range of 19-27%.[1] If we assume that the perforation was spontaneous (no procedure was mentioned in the history), his chance of dying rises to greater than one in three. Once

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we factor in his sepsis, alcoholism and other co-morbidities, we may estimate that his risk is close to 50%. That assessment is based on studies using data from the biggest and most experienced centers; the outcomes are likely to be worse in less experienced centers.

## The Hospital

So the patient has a high mortality risk, but is the risk the same no matter where he has surgery, and no matter who operates on him? A strong relationship between *hospital* volume and outcomes for esophageal resection has been documented for many years.[2] Similarly, a recent article in the New England Journal of Medicine showed that centralization of care resulted in better outcomes for esophagectomy patients,[3] and in the Netherlands outcomes improved with increasing volume up to a minimum volume of 40-60 cases per year.[4] While it is true that results for esophageal resection are better when the patient is operated by a thoracic surgeon (as opposed to a general surgeon), it must be emphasized that the surgeon alone does not determine the outcome. A recent paper looked at this very issue and concluded: “Specialty training in thoracic surgery has an independent association with lower mortality after esophageal resection. But specialty training appears to be less important than hospital and surgeon volume.”[5] In order to obtain the best outcomes, care of patients with complex esophageal disease should be centralized.[6]

## The Ethical Argument

The medical literature thus clearly demonstrates that the patient presented is at high risk of death, and that his chances of survival are better when operated in a high-volume center. Does that obligate the surgeon to transfer her patient? If the surgeon is trained to do the operation and the hospital claims to meet the “standard” conditions necessary to care for the patient, is that not “good enough” to allow the hospital administrators to demand that the patient stay there?

In the first place, we can look at this issue using a traditional approach to biomedical ethics, based on the principles of autonomy, beneficence, nonmaleficence and justice.[6] The surgeon wants to do good (beneficence) for her patient, not harm him. We have already looked at the medical data: the best option for the patient is for him to be transferred to where he can get the best care. Because of his condition, the patient is not able to exercise his right of autonomy, and he does not seem to have a family member or surrogate to do it for him. Who should advocate on his behalf? Dr. Black is his physician, so she has a fiduciary responsibility to act in his best interest. Finally, regarding the principle of justice, each patient must be treated as an equal. The fact that a lawsuit is unlikely following this case is irrelevant and should be disregarded; this patient should be treated no differently than one would treat a patient whose sons and daughters were all doctors and lawyers! According to the principlist approach, the patient should be transferred.

Of course, there are many approaches to bioethics, and this case can be analyzed using other systems. For example, the hospital may feel that it is in the best interest of the community to develop a program of esophageal surgery, and there is no better time to begin than now. Exposing this patient to what may be a higher risk because we think it is for the “greater good” could be an example of reasoning according to utilitarian ethics.[7] In utilitarian

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ethics, the "goodness" of an act depends on its likely or average outcome, and the idea is to maximize the good and minimize the bad, often for a population or subpopulation. Dr. Black's community hospital lacks an esophageal surgery program; establishing one may be seen as beneficial for the community, so why not begin with a patient who is already in its own emergency room? Keeping the patient not for his own sake but in order to benefit future patients may seem appealing but it merits more careful consideration. We have already seen that centralization of care for complex problems results in better outcomes; not surprisingly, it also results in lower costs.[8] This does not mean every patient should be transferred or that surgery can only be done in one place; for lower risk patients, the benefit to transfer may be outweighed by the inconvenience (and related likelihood of noncompliance with follow up care) of treatment farther away. In the case presented, however, utilitarian ethical analysis suggests that the patient be transferred, not only for his own benefit but also on broader grounds: it is contrary to the hospital's and the community's best interest to try to develop a program of complex esophageal surgery, because outcomes will be poor, costs will be high, and reputations will suffer.

Finally, like any young surgeon, Dr. Black no doubt wants her career to develop; she wants to be the best surgeon that she can be, and she wants to fulfill her obligations to both her patient and her employer. To be a good technician, a surgeon should operate as much as she can and do the most technically difficult cases, but this alone will not make her a good surgeon. Although technical competence is the most obvious facet of surgery, being a good surgeon is not the same thing as being a good technician — a surgeon is more than a technician. In addition, a good surgeon must be a good physician, and she must be a good person. This means a good surgeon takes into account all the variables and offers the best possible care to each patient under the actual circumstances. Doing the "right thing" is what makes her a good surgeon; this is virtue ethics.[9]

Keeping the patient is good for whom, then? Not for the patient: his chances of doing well are better at the more experienced center. Not for the surgeon: putting the hospital's wishes ahead of her patient's interest is a violation of her responsibility to her patient. In addition, in the (not unlikely) event of an adverse outcome, it could be damaging to her fledgling career. Not for society: outcomes are better and resource utilization is less with centralization of care. And, while keeping the patient may seem to be good for the hospital in the short term, it will not be good for the hospital in the long run, either, because it is likely that such a policy would contribute to a high mortality rate and an unfavorable reputation for the hospital.

Dr. Black's first "gut reaction" was right. She knew she should transfer the patient. She should explain her rationale to the administrators; possibly they will understand and agree, but if not, she should do the right thing and accept the consequences. This idea is concisely summarized in the relevant sections of the STS and AATS codes of ethics.[10][11]

**1.1** When caring for patients, members must hold the patient's welfare paramount.

**1.3** Members should practice medicine within the scope of their training, experience, and license, should not accept lay interference in professional medical matters, should seek appropriate consultation for problems that are

beyond their competence, and should provide appropriate supervision for trainees.

**1.4** Members should use their best efforts to protect patients from harm by recommending and providing care that maximizes anticipated benefits and minimizes potential harms.

**1.8** Members should responsibly steward the use of health care resources under their supervision without compromising patient care and welfare.

On grounds of several ethical approaches and the specific guidelines of our surgical organizations, it seems crystal clear that Dr. Black should transfer the patient to the other hospital, regardless of the preferences or demands of the hospital administration.

## CON

Jennifer Ellis, MD

Dr. Black should not transfer the patient to the more experienced center. This case boils down to 5 issues.

The first question is, "Is it physically possible to do the case?" Does this hospital have an available operating room? Are appropriate anesthesia and ancillary staff present? We can presume that the answer is yes, it is physically possible to do the case, pending consideration of the thoracic surgeon.

The second issue is addressed in the Hippocratic Oath when it mandates, "I will use those ... regimens which will benefit my patients according to my greatest ability and judgement." [12] The physician is required to do at least the standard of care and do the best he or she can. There is no mandate to provide the absolute best care available. In fact there is never a mandate to provide the best care available; rather, the standard is to provide a reasonable level of care. The Hippocratic Oath further states, "by the set rules, lectures, and every other mode of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to students bound by this contract having sworn this Oath to the law of medicine ..."[12] This statement suggests that there is a mandate *not* to provide the absolute best care. The best care would always be provided by a master of the subject and since those in training by definition do not have the same experience and skills, they are not necessarily providing the best care. For the field of medicine to continue generation after generation, it is widely agreed and established that there will be teaching in medicine. At a certain point in teaching, the less experienced practitioner will have to perform the procedure, and while the care needs to be good and the care needs to be safe, it is arguably not necessarily the best. To carry this idea to the extreme, if the absolute best care would have to be provided to all patients at all times then there would not be two facilities in the market overlapping in any treatment fields, and medicine would die after one generation.

The third question is, "Is the available physician competent to perform the surgery?" In the translation from the Latin, the medical school diploma from Jefferson Medical College it states, "Forasmuch as academic degrees were instituted to the intent that persons endowed



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with learning and wisdom should be distinguished from others by honors."[13] To this end we in the practice of medicine have established standards of care to be admitted to the boards. The American Board Thoracic Surgery states that the board certified thoracic surgeon has competency in the treatment of the esophagus. The Board explicitly addresses this issue in its statement "even though emphasis on one or another facet of thoracic surgery (pulmonary, cardiovascular, esophageal, thoracic trauma, etc.) may have characterized a candidate's residency experience, the candidate is nevertheless held accountable for knowledge concerning all phases of the field."[14] Thoracic residency and the endorsement of the program director certify that the board certified physician has the "ability to cope with a wide variety of clinical problems."[14] In our scenario the physician is a board certified thoracic surgeon and knows the correct care of the patient.

The fourth consideration is the contract with the institution. Is there a written contract to provide ALL thoracic services brought into the emergency room, or is contract only implied? In this case, the administrator said the physician MUST care for the patient, implying a written or binding contract. When the group accepted the contract, the physician and her group did not just imply but asserted that they were capable and competent to perform the care and treatment of patients that would be brought to the group under that contract. Difficult cases arrive all the time and it is reasonable for the group to have foreseen such difficult cases. If the case is too difficult for the group, they should have anticipated that contingency and made appropriate accommodations in the contract. To have accepted the benefits of the contract and then try to renege on fulfilling their obligation is at best disingenuous, and at worst fraud. While the physician can ask for an exception, the hospital is under no obligation to accede to his or her wishes, and the physician is obligated to tend to the patient or be in breach of the contract.

Finally, it is not unreasonable for the hospital to look after its interests. The hospital is in competition with the other institutions in the area, and as long as it provides the appropriate facility and meets the standard of care it is under no obligation to expedite transfers to its competition. The social situation of the patient in this case is a red herring. It implies that if there is less of a chance for legal repercussions, the physician would be more willing to take on difficult cases. The American College of Surgeon's code of conduct states the physician must "serve as effective advocates of our patients needs,"[15] and the appropriate care can be provided at both institutions.

As a minor additional point, there are group considerations. If the other group in direct competition but at the same hospital is more competent in various subspecialties then the physician could refer to the other group without reasonable objection from the hospital administrator.

In conclusion the physician should do the care and treatment she was trained to do. She should provide the standard of care while tending to this patient to the best of her abilities.

## CONCLUDING REMARKS

Robert M. Sade, MD

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Our health care system is moving toward increasing responsibility for administrators in clinical decision making — after all, they are responsible for solvency of the system. This shift is not likely to make physicians happy, so in our scenario, Dr. Fenton seems to be on the side of the angels, while Dr. Ellis is on the side of the bête noir of many physicians, health care administration. On closer inspection, however, the situation is not so clearly defined.

Dr. Black's dilemma would be considerably diminished if the patient retained decision-making capacity. Then, she could present the options of staying in his current situation and having his operation at somewhat higher risk, or being transferred to the competing hospital where the risk would be lower. The patient's preferences and values would then influence, though not determine, the decision. (The question of whether the physician is obligated to offer both options to a competent patient is not necessarily crystal clear, however, as has been argued in these pages.[16][17]) This case removes that possibility, because the patient lacks capacity and, further, has no available proxy or surrogate decision maker. A decision based on substituted judgment (what would the patient want?), therefore, is not possible, so the surgeon must make her decision on grounds of the patient's best medical interest. His best interest seems to be the lower risk procedure, which would entail transfer to the competing hospital. But, again, not so fast.

The paramount obligation of physicians is to serve the best interest of their patients.[18] This is certainly our most important obligation, but it is not the only one. We also have legitimate obligations to hospitals, partners, and personal life, among others. These obligations are secondary to the interests of patients, but should not be entirely disregarded in making health care decisions about patients. All have to be carefully weighed in the balance of decision making.

We frequently talk about the need to be the best physician, the best surgeon, the best medical center, but these terms are aspirational and cannot be taken to be realistic standards — unlike the inhabitants of Lake Wobegon, where "all the children are above average,"[19] some of us will be above and some below average, by definition. We can only be expected to do the best we can in the circumstances. The standard for physician performance is not being the best: it is being competent.[16]

In the process of weighing ethical obligations (we set aside contractual obligations because, despite Ellis's thought-provoking point, a contract is not mentioned in the vignette), the difference in risks is critically important. For example, consider surgeon A who is contemplating transfer of a patient to surgeon B because of B's expertise with operation Z. If expert surgeon B can do operation Z with 5% mortality rate and surgeon B expects a 10% rate, the secondary obligations will weigh more heavily in balancing them against the primary obligation to the patient than if surgeon A's mortality rate is 5% and surgeons B's is 30%, in which case the obligation to the patient gains a great deal in the balance.

In our scenario, Fenton calculates the risk of treating the patient's esophageal perforation at about 50% for the expert surgeon. If Dr. Black estimates the mortality risk in her own hands to be, say, 90%, she is far more justified in insisting on transferring the patient than if she

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estimates the risk to be much closer to the expert's, say, 60%. Of course, neither she nor we can accurately make such an estimate, but the burden of decision-making under uncertainty is a quotidian reality for surgeons.

In the final analysis, in my opinion, the conflicting conclusions of Fenton and Ellis may both be correct. Dr. Black wants to be a good surgeon and to do the right thing in the circumstances. In the current scenario, doing the right thing requires two virtues in particular: honesty in assessing her own capabilities, which are an important component of the careful balancing she must do, and wisdom in assigning weights to her conflicting responsibilities.

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