Case Conference

William is a senior surgeon, well respected by his colleagues, both in the small rural hospital where he works and in the nearest large urban teaching hospital. He has moved out to the rural setting only in the last five years. For him it is a move prior to retirement.

Unfortunately he has begun to notice of late that his performance in surgery has started to fall short of his normal high standards. What weighs on his mind is the fact that two patients upon whom he has recently operated have died from mistakes in surgery that he thinks he should never have made.

He is still one of the most capable surgeons in the local setting and in the larger urban base hospital. In his rural practice he has two junior colleagues, one of whom is seeking to sit his final qualifying exam in the Australasian College of Surgeons. The other junior colleague has recently arrived as a political refugee from Africa and looks to be very promising. At the moment neither of them are capable of taking on the full diversity of the case load that he handles, but William is confident that within another year or so they will be more than capable of doing it. He feels that his own conscience is telling him that he ought to retire, but nobody has complained and the management in particular have tried to play down his concerns and suggested that he is over sensitive to his own faults.

There is however a further complication. The local RHA has decided that it must rationalise surgical services in the area. At the moment because he so well respected and considered to providing a very efficient and cost effective service the unit in the rural hospital where he works is not scheduled for closure. However the unit's future will be reconsidered if and when he should retire. In effect it means that if he should retire early as his conscience tells him, patients locally will miss a service that seems to be offering them treatment that is at least as good as they would get were the operations to be performed by the junior surgeons and or the local teaching hospital specialist. This means that patients as a whole have something to lose even though he feels that he is endangering some of their lives.

What should he do in this case?

Commentary One

Dennis Pezaro
Chair,
New Zealand Medical Association

Some assumptions must be made about this case for comment to be relevant.

1. The rural hospital is likely to be within a reasonable travelling time from the large urban teaching hospital. It is assumed that patients considered unsuitable for surgery in the local hospital could be treated at the base hospital.

2. One of his junior colleagues obviously does not have specialist recognition as a surgeon. If the recently appointed surgeon from Africa also lacks a certificate of higher surgical training then there would be a concern that when the senior surgeon is on leave or even away for a brief period the rural hospital would not be adequately staffed. If the recently arrived surgeon does have a certificate of higher surgical training and specialist recognition then the situation is acceptable provided that the two senior surgeons arrange adequate supervision for the surgeon in training.

The issue to me is that the senior surgeon has recognised that two patients have died as a result of surgical technique and this raises the question whether the happenings could be explained by chance or simple error or whether competence is failing.

Management input in this situation is entirely unreliable, lacking in understanding of medical ethics and operating on grossly different agendas. Management may even be looking to protect their own employment with such superficial support.

RHA input is also poorly advised and working to a non clinical agenda.

Clearly, in my view, William should be encouraged to discuss his concerns with the appropriate competence committee of the Royal Australasian College of Surgeons and to discuss his options with them. As a rural general practitioner I do not have sufficient working knowledge of how the College handles these matters but I would have thought that there are many intermediate options between continuing as at present and retiring precipitately.

Assuming that the hospital is staffed by two fully qualified surgeons together with the senior trainee, it should be possible for William to work with the more junior surgeons to handle the bulk of the case load whereas the few more complex cases could be sent to the base hospital.

I believe it important that William's expertise be retained as much as possible, even for his own self-esteem, but patient safety issues become apparent. Management and purchaser requirements must be considered of secondary importance.

Commentary Two

Professor Pat Molloy
Senior Medical Advisor
Healthcare Otago

William has problems!!

Once again a surgeon notices his skills are declining (a regrettable accompaniment to increasing age) and he has to consider his options bearing in mind the admonition "Primum non nocere".

He could stop operating and resign thereby salvaging his conscience. He could reduce his repertoire of operations to simpler procedures. Unless he has deteriorated badly (which is often not realised), he can still maintain limited expertise in a safe environment.

He can keep training his potential successors, including assisting and teaching the cases from which he has withdrawn. That nobody has complained, or their management are adopting a "there there" approach does not excuse William from taking a definitive action regarding his own performance.

In this country action may be driven by provisions of "Medical Manslaughter" or in future by the competence requirements of the Medical Practitioners Act shortly to go before Parliament. Recourse to a respected peer or peers may determine William's approach to the resolution of his problem.

William should make sure there is no physical or mental disability eg, early Alzheimer disease, by having a properly conducted medical examination. Consulting with his colleagues at the teaching hospital may highlight deficiencies or reassure William that the two deaths were a statistical aberration. No surgeon young or old has a zero mortality or zero complications (such a surgeon does no operations).

William's work, in both the urban and rural settings should be carefully audited in case there are other problems such as high infection rates and other major complications above the norm. Once the quality of his practice is established William can then be reassured he is meeting quality standards and not just upset by the two deaths. Such events often precipitate serious conscience searching by surgeons and may lead to injudicious decisions about premature retirement. This may deprive a community, urban or rural, of the years of experience and training of such a senior surgeon.

Stopping operating in the interests of patient safety will precipitate closure of the unit as determined by the local RHA and remove training opportunities for the two trainees who may find it difficult to get into another training program at their relatively senior level of training. This may have a greater impact on the political refugee from Africa, who may well have employment limitations on his visa, than on the local surgeon who may be more easily able to transfer to another programme.

The local public will also be seriously disadvantaged by the removal of surgical services, (as many rural hospitals are) with all the inconvenience of travelling to larger institutions, the waiting list problems, and exposure to strangers.

In small communities nearly everyone knows everyone else, and can be a great support system to families troubled by major surgery, a comfort denied them if away from home.

That William is providing an efficient and cost effective service should be an indication to continue the service after his retirement, especially if he has two potential successors trained to William's own standard to continue the service.

In summary, William should consider reducing his work load to simpler cases, intensifying the training of his juniors and maintain the service at the rural hospital. He probably should retire from the teaching hospital.

As long as he is not aware of physical or mental disability (eg early Alzheimer disease) there is no real reason for him to stop altogether.

Continued New Zealand Presence in the IAB

The new board of directors of the International Association of Bioethics was elected by the membership of the association earlier this year. The board consists of twenty one members drawn from seventeen different nations. In August the board elected its new officers. The new president of the Association (succeeding Professor Peter Singer) is Professor Dan Wikler of the University of Wisconsin at Madison, Professor Alastair Campbell, Director of the Bioethics Research Centre is the new Vice-President of the Association (succeeding Professor Dan Wikler), Professor Ruth Chadwick of the University of Central Lancashire continues as secretary; and the new treasurer is Dr Helga Kuhse of the Centre for Human Bioethics at Monash University.

The newly elected board will be meeting in Rome at November 1995 in order to plan the next international congress, which is to be held in San Francisco towards the end of 1996. The election of Alastair Campbell to the position of Vice-President will ensure that Bioethics in New Zealand retains an international profile and is a clear indication of the high reputation in which the Bioethics Research Centre is held throughout the world. As part of his new duties as Vice-President Alastair will be attending the founding conference of the South East Asia Association of Bioethics which is to be held in Beijing in November. A Report on this congress and the new regional association will be published in the first edition of the Otago Bioethics Report in 1996.

All those interested in Bioethics in its international aspects are encouraged to become members of the International Association of Bioethics. The Association has a whole series of networks linking people of particular interest within the field. For details of how to join contact the administrative officer of the Association, Kay Boyle at the Centre for Human Bioethics, Monash University,
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