A surgeon's responsibility: their life in your hands

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Surgeons literally take the life of their patients in their hands. In this article Joseph Smith describes the trust patients put in their surgeons and how surgeons have to respond to that trust, by only performing operations that they themselves know they are qualified and competent to perform.

Surgery is never routine or minor for the patient undergoing it. There are few, if any, parallels wherein an individual willingly and with full knowledge enters into such a vulnerable state in the hands of another. Often, the patient is not conscious and is removed from any further decisions, despite the potential implications for their health and life. There is an almost sacred covenant of trust between a patient and a surgeon – trust that the surgeon will subjugate any personal agenda and focus solely on the welfare of the patient.

In some situations, for elective surgery, the patient chooses the surgeon, sometimes after painstaking research. In others, a surgeon may be assigned, but it is always the prerogative of a patient to seek or demand a different surgeon. This increases the responsibility on the surgeon. The patient not only has to subject themself to the inherent risk of the operation, but must identify and select the individual in whose hands they literally will place their life.

TEAM EFFORT

Despite the individual responsibility of the surgeon, surgery is a team effort. Studies show that hospitals conducting a particular procedure in high volumes provide better outcomes than those in which the operation is performed less frequently. The reasons are multifactorial, but are due at least in part to the skill and experience of the nurses, anaesthetists and other personnel in the operating theatre and hospital. Nonetheless, the surgeon is truly the ‘captain of the ship’. Further, the patient typically does not meet the
remainder of the operating team before
the day of surgery or have any role in
selecting them.

Patients are handicapped in their ability
to truly assess a surgeon’s skill. Reputation,
recommendations and personality may
be influential, but access to information
that truly helps to inform them about a
surgeon’s ability is limited.

Where, then, is the check point in the
system to restrict a surgeon to performance
of operations in which he or she has
demonstrated technical proficiency? In
the USA, surgical privileges are granted
by individual hospitals. To their credit,
most attempt to gather appropriate data
about training and prior experience before
granting privileges. However, even for the
most scrupulous process, the information is
limited. Further, hospitals sometimes have
additional pressures and motives, as inclusion
of active surgeons on the staff increases
hospital patient volume and revenue.

Surgical outcomes have been shown
to correlate with surgeon and hospital

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the capability, experience
and comfort of a surgeon
with a particular operation’

experience. However, simply tabulating
case numbers is inadequate, because
experience is not the only relevant factor
and even highly skilled surgeons must
start at the beginning. Reputation among
colleagues is important, but not always
transparent. Complication rates and
other outcomes for a particular surgeon
are rarely compiled and come to public
knowledge even less commonly.

NEW TECHNOLOGY
These considerations become even
more acute with the advent of new
and innovative technology and
techniques, such as robotic surgery.
Since the introduction of robotics, many
mid-career surgeons have faced the
challenge of gaining expertise with a
new and unfamiliar surgical technique.
Increasingly, ‘learning curve’ issues have
diminished, as residents in training
have the benefit of supervised, graded
responsibility. Nonetheless, there are
many examples of unfavourable patient
outcomes that have occurred as a
consequence of operations performed by
surgeons who have not acquired enough
experience with a new technology.

Only one person truly knows the capability,
experience and comfort of a surgeon with
a particular operation – the surgeon him-
or herself. All patients deserve a surgeon
who will not undertake an operation for
which he or she recognises they have an
inadequate level of expertise or experience.

Surgeons have multiple influences on
their surgical practice, including personal
pride, peer pressure and financial
incentives. None of these should override
responsibility to the patient. Boards may
grant certificates, residency training
requirements may be completed, and
hospitals may provide operating privileges.
The surgeon, though, is the one who
really knows.

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