ETHICS IN PRACTICE

RESIDENCY TRAINING

R. C. is an orthopaedic resident in a teaching program. At the orthopaedic clinic, he examines an elderly, otherwise healthy patient who requires a total hip replacement. He presents the patient to his covering attending physician, who agrees to supervise the joint replacement surgery. The resident discusses the surgery with the patient. The procedure, risks, goals, benefits, and alternatives are presented. The patient agrees to proceed with the surgery.

The resident performs the surgical procedure with the attending physician's assistance. The surgery lasts forty minutes longer than the attending physician's usual surgical time, and the blood loss is 300 milliliters greater. Postoperative radiographs demonstrate a well positioned press-fit acetabular component and a cemented femoral component in 6 degrees of varus.

Whenever a resident who is at the beginning of a learning curve performs a procedure that could have been done better by someone else with more experience, the learner and the teacher who permits it are not acting for the good of their patient. Since the patient is subjected to a greater risk of harm and discomfort than necessary, they are violating the dictum "do no harm." Furthermore, respect for patient autonomy requires that we avoid treating patients merely as a means to an end, as useful tools for our own purposes. Taken together, these considerations suggest that patients should not be used as learning tools.

Considering the issue from another perspective, however, we have to acknowledge the common desire for good health. Reasonable people understand that, at some point in the future, they or their loved ones are likely to need medical attention. Everyone would want to have trained, skilled physicians available to administer appropriate medical care when it is needed. Because programs of medical education involving patients are a necessary means of achieving the desired medical expertise, training programs that use patients in education must be morally acceptable. Teaching with use of patients is, in fact, essential to the transmission of clinical skills and techniques, and every individual has an ethical responsibility to do his or her fair share to participate in the education of our society's future medical experts. This is essential so that we may each have access to their knowledge and skill when they are needed for ourselves or our loved ones. This insight, however, does not complete the picture of the ethical obligations that are involved in residency training.

Because medicine is committed to the goals of acting for the good of patients and doing them no harm, programs of medical education must be carefully designed and vigilance must constantly be exercised. Through its careful attention to candidate selection, methods of sequential learning, supervised practice, discussion, evaluation, and review, academic medicine does an excellent job of protecting patients' health during the process of resident education. The requirement for such continued vigilance must be recognized as an ethical duty.

Residents learning new techniques or procedures should only perform them under the supervision of an experienced attending surgeon. This policy avoids unnecessary risks to the patient and provides the resident with the training that justifies any increase in risk. Adequate direction and instruction are required to protect the patient and to provide a learning experience for the resident. The supervising surgeon's intervention is required at any point when the resident encounters difficulties. Ready intervention minimizes the risk of complications for the patient and provides crucial education for the resident.

In our case presentation, the slight increases in surgical time and blood loss pose no significant additional risk to the patient. The final position of the components is slightly imperfect but certainly acceptable. The patient should have a well functioning hip replacement with normal component longevity. The resident has had an opportunity to improve in the surgical technique of joint replacement surgery and also an occasion to learn about preoperative decision-making and postoperative care.

These considerations do not, however, exhaust the ethical concerns that have to be taken into ac-

count. Physicians have additional ethical commitments to patients that go beyond avoiding harm. Physicians also are required to respect patients as autonomous beings by allowing them to make their own choices and by taking their perspective into account when making decisions about what would be best. Respect for the autonomy of patients requires more than a charming bedside manner and a polite demeanor; it demands that patients be honored as people by being told the truth about who is being asked to do what for whom. Patients have a right to know who will be performing examinations and invasive procedures and what additional risks, if any, that this may present. If patients ask questions about the experience of those who will be involved in their procedure, they should be given honest answers. If they don't ask, they still need to be given the information that is relevant to making an informed choice that reflects their values and priorities. Those who are clever enough to ask questions do not have more of a right to be treated with respect than do those who are silent. Furthermore, those who are inadequately informed of risks (including resident involvement) cannot give informed consent, and those who are responsible for conveying relevant information are legally liable for failure to do so.

Informing the patient of the learning status of the person who is providing treatment allows the patient the opportunity to fulfill the moral duty of participating in the training of society's future physicians and to enjoy the rightful pride and pleasure of that contribution. The physician's honest communication also promotes the view of patients as heroic partners in the socially important activity of training our future expert doctors.

The orthopaedic surgeon's position on the learning curve and the need to inform patients about it are obvious concerns for residents. The same issues also have to be considered by any surgeon who has not yet mastered a new technique or the use of a new appliance, tool, or material. Peer assessment, as well as self-assessment, should be standard features of readiness. The measure of adequate preparedness cannot simply be personal comfort, which may reflect ego and eagerness rather than skill. The standard for informing patients cannot stop at the need to know; the process must reflect respect for the person being used for skill enhancement. In general, an orthopaedic surgeon should not proceed with a planned therapy that is new for that surgeon without being prepared to explain that fact honestly to the patient. Again, this forthright approach reflects compliance with the legal and ethical standards for informed consent.

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Further Reading

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