General surgeons and clinical ethics: a survey

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Objective: To determine the preoccupation of general surgeons concerning ethics.

Design: A survey by questionnaire.

Participants: One thousand members of the Canadian Association of General Surgeons were surveyed through a questionnaire, which inquired about the influence of ethics in their clinical practices. The questionnaire contained 12 questions. There was no recall for those who did not respond.

Main outcome measures: Responses to questions concerning the sex of the respondents, location of practice, number of years in practice, the presence of hospital support, surgeons' interest in ethical issues, use of autonomy, beneficence, nonmaleficence and justice in solving ethical dilemmas and level of education in clinical ethics.

Results: Men made up 95% of the respondents; 64% of respondents had been in practice more than 16 years; 58% came from a community or regional hospital; only 10% had no interest in clinical ethics; only 3% stated that they experienced no ethical problems in their practices; and 52% had no formal education in ethics.

Conclusions: There was general sensitivity for clinical ethics but an evident lack of formal education and of the presence of ethics committees and ethics consultants in many hospitals.

Objectif : Déterminer la préoccupation des chirurgiens généraux en ce qui a trait à l'éthique.

Conception : Sondage par questionnaire.

Participants : Mille membres de l'Association canadienne des chirurgiens généraux ont été sondés au moyen d'un questionnaire portant sur l'influence de l'éthique dans leur pratique clinique. Le questionnaire comportait 12 questions. Il n'y a eu aucun rappel auprès de ceux qui n'ont pas répondu.

Principales mesures de résultats : Réponses aux questions concernant le sexe des répondants, le lieu d'exercice de la profession, le nombre d'années de pratique, la présence de soutien hospitalier, l'intérêt que les chirurgiens portent aux questions d'éthique, l'utilisation de l'autonomie, la bienveillance, la non-malveillance et la justice dans la solution de dilemmes éthiques et le niveau d'éducation en éthique clinique.

Résultats : Il y avait 95 % d'hommes parmi les répondants et 64 % des répondants exerçaient depuis plus de 16 ans; 58 % provenaient d'un hôpital communautaire ou régional et 10 % seulement ne s'intéressaient aucunement à l'éthique clinique. Seulement 3 % ont déclaré n'avoir aucun problème éthique dans leur pratique et 52 % n'avaient reçu aucune formation structurée en éthique.

Conclusions : On a constaté une sensibilisation générale à l'éthique clinique mais un manque évident de formation structurée et de comités d'éthique et d'experts-conseils en éthique dans beaucoup d'hôpitaux.

Since the time of Hippocrates, ethics has been intrinsically connected to the practice of medicine. At the end of the 19th century and the beginning of the 20th century, great efforts were made within the American medical profession to renew professional ethics. Until the late 1950s, medical ethics was not a subject of public discussion and was of modest interest to the medical profession.

Societal and political changes in the early 1960s in the United States, combined with rapid advances in medical knowledge and in technology have contributed to the emergence of a new ethical questioning in medicine. It soon became evident ethically and juridically that physicians had to consider patients as autonomous individuals, able to participate in medical decision-making concerning themselves and their families.[1] With the publication of Van Rensselaer Potter,[2] a research oncologist, that proposed a new science of survival (bioethics), ethical considerations of medicine and

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science took on a societal and ecologic dimension. For Potter, bioethics would identify and promote an optimum changing environment and an optimum human adaptation in that environment.

In the mid-1970s, many philosophers and some theologians in the United States were employed by universities to research and teach bioethics and medical ethics in medical schools. In the 1980s, some philosophers moved from the university to the hospital and started to participate in discussions about clinical ethical issues, through ethics committees, or become appointed as ethics consultants. Clinical ethics emerged as a multidisciplinary discipline in which physicians and other health care providers could participate. Clinical ethics comprises the identification, analysis and resolution of moral problems arising in the context of caring for the patient.[3]

Where do we stand now? How much this movement has affected the practice of surgery in Canada?

The present study was designed to determine the preoccupations of general surgeons concerning ethics. What is the role of clinical ethics and its principles in the decision-making? What are the resources available to support surgeons when facing difficult ethical situations? Finally, we sought information on the level of education of general surgeons in the field of clinical ethics.

Method

A simple questionnaire was sent to 1000 members of the Canadian Association of General Surgeons (CAGS) with a return-address envelope. No effort was made to recall the nonrespondents.The questionnaire was not pretested on a pilot group but was revised for its pertinence. It was translated for the French-speaking members. The completed, anonymous questionnaire was returned directly and confidentially to the investigators. All the answers were entered into a database for analysis. All answers were treated confidentially.

The questionnaire included 12 questions, easy to answer in 10 minutes. Three questions related to demographic information (location of practice, number of years of practice and sex of the respondent). Other questions dealt with the presence of hospital support, such as a consultant in ethics or the existence of a bioethics committee in the surgeon's community. Three questions asked about interest in ethical issues, the ability to recognize ethical dilemmas and the surgeons' perceptions of the most important ethical issues in their own practice. One question concerned the use of the 4 principles defined by Beauchamp and Childress[4] (autonomy, beneficence, nonmaleficence and justice) for the resolution of ethical dilemmas. Two questions asked the surgeons' opinions concerning the need for education in the domain of ethics.

Results

Four hundred and forty-two questionnaires were returned, a response rate of approximately 50% of CAGS members. The survey results are summarized as follows.

Sex and length of practice

Of the respondents, 95% were men, 22% had been in practice for less than 10 years, 14% from 10 to 15 years and 64% for more than 16 years.

Location of practice

Concerning the location of practice, 58% of the answers came from a community hospital or regional hospital, 38% from a university hospital and 4% from some other site of practice.

General surgeons' interest in ethics

With respect to an interest in ethical issues, 10% of the respondents claimed they were not interested at all, 20% were highly interested and 70% were moderately interested.

Frequency of ethical issues in respondents' practices

The frequency of ethical issues in the practice of the respondents varied from very frequent for 34% of the respondents, occasionally for 61% and no ethical problems for 3%. The other 2% did not answer.

The most important ethical issues

When asked to identify from a list, the most important ethical issues in their practice, 52% of the general surgeons who responded listed the rationing of resources, 50% informed consent, 31% the problem of confidentiality, 30% the autonomy of patients, 30% justice, 29% beneficence to patients and 23% truth telling.

Personal background in bioethics

When questioned about their personal background in ethics, 52% of responding general surgeons answered that they had no formal education in ethics; 46% had some theoretic knowledge and 2% gave no answer.

Use of the 4 principles

When asked about the use of the 4 principles[4] to help resolve ethical conflicts, 57% of the respondents felt the principles were useful, 18% felt the principles were not useful and 25%

did not know enough about the definition of the principles to give a proper answer.

Support within the community

In response to a question about the existence of support that general surgeons could find in their community to help them with ethical problems, 57% confirmed the existence of a bioethics committee, 26% mentioned the presence of a consultant in ethics and 30% confirmed the total absence of any resource to help them handle ethical issues with their patients.

Finally, 76% of the respondents felt that the CAGS should be involved in promoting education in the field of ethics, but 18% felt the CAGS should not be involved. The respondents were embarrassed with the jargon of ethics and stated their need for formal training in this area. Many respondents indicated a real preoccupation with problems such as euthanasia, aggressive surgical therapy and rationing of resources.

Discussion

As a result of the rise of moral and cultural pluralism and the erosion of the physician's authority in the context of a technologic explosion, it has become increasingly difficult to practise surgery, especially because patients and family now expect so much of modern surgery. New social ideology and the more advanced general education of patients have challenged the paternalistic doctor–patient relationship. On the other hand, doctors who in the past took full responsibility for their patients' health now have to share some responsibilities with others. The surgeon must adapt to this new reality and continue to practise surgery competently with compassion and humanity. Ethics has always been a preoccupation for the medical profession. In the past, medical ethics was subordinated to religious belief or considered as a form of etiquette. The huge technologic advances made since World War II and the major scientific advances in surgery have disturbed the traditional professional references. In the 1960s and early 1970s, questioning about the interrelationship between morality and biologic science and their impact on human beings and society led to the development of bioethics.[2] In the last 20 years, we have also seen the development of a corpus of knowledge and the production of a prolific literature concerning clinical ethics, which relate to the individual receiving care.[5]

Biomedical ethics or bioethics has been largely influenced by theologians, philosophers and lawyers. They have introduced a new perspective in the discussion about moral considerations affecting the patient (clinical ethics), research in medicine (research ethics) and legal and policy arenas (public ethics).[6]

Clinical ethics aims to improve the quality of patient care by identifying, analysing and contributing in a multidisciplinary approach to the resolution of ethical problems that arise in the practice of medicine. It seeks the right and good decision and action for a particular patient. It is linked to the work of surgeons and to the practice of surgery.[3,7]

In clinical ethics, much attention is given to discussion and deliberation. There is no pretention to find a universal truth. Clinical ethics is not pure science and serves mainly to promote a critical distance between medicine and the patient, between science and personal beliefs.

The questionnaire used in this survey tried to capture a picture of the situation of Canadian surgeons confronted by problems relating to clinical ethics in their practice in 1997. The response level of almost 50% indicates that surgeons are highly interested in clinical ethics. Only 10% of the surgeons responding to the questionnaire indicated a total lack of interest.

Unfortunately, our questionnaire did not define well enough the meaning of ethics, bioethics and clinical ethics. We suspect that many general surgeons are more involved in ethical decisions than they realize. For surgeons, a good practice of surgery involves ethics. It involves ethical decisions taken every day at the patient's beside when discussing the implications of a proposed surgical procedure or when obtaining an informed consent. Most respondents have recognized that they are occasionally challenged by conflicts arising in their practice. Ethical dilemmas appear when agreements about the medical facts alone do not settle a disagreement and involve a conflict of values. Those conflicts arise when there are different interpretations about the patient's best interest or when there are conflicts between moral principles and institutional policy or the law, or when there is uncertainty about prognosis, efficacy of a treatment or a patient's capacity to decide about applicability of advance directives and about surrogate decisions.[5]

How does the physician solve these conflicts? How can the physician clarify the situation? Is there a need for a compromise? Surgeons must be prepared to answer these questions while participating in a discussion including the patient, the family and sometimes other health care providers. To participate effectively in those ethical discussions, a minimal knowledge of clinical ethics is necessary. If the surgeon wants to remain the captain of the boat, he or she has to perform as well or better in clinical ethics than the other members of the health care team. It is now inescapable in the practice of surgery.

In the list of ethical concerns provided to the surgeons, 50% of the surgeons identified major concerns for rationing of resources and informed consent. It is not difficult to understand why surgeons are sensitive to the rationing of resources. Many organizational decisions in the health care system taken in the last 5 to 7 years by our political leaders were probably ethically incorrect. Many surgeons are expressing their own discomfort toward the practice of surgery in our current economic and political context. They feel excluded from discussions about the decisions made on the reform of the health care system.

To understand better the numerous ethical aspects of their practices and recognize the hidden ethical implications of decisions made in the health care system, surgeons need to be better educated in the field of ethics.

Only 46% of the respondents had some knowledge of clinical ethics. Clinical ethics should not be seen by surgeons as an esoteric discipline driven solely by philosophers, theologians or lawyers. They should find their place in the development of a new knowledge in clinical ethics.[8] So far the input from surgery in the domain of clinical ethics, its teaching and research has been too limited.[9] Fortunately a new book on surgical ethics has just been published, which should be helpful.[10]

The resources available to the surgeon facing difficult ethical situations are not very abundant. I imagine that many small hospitals and even regional hospitals are missing an ethics committee or have no ethics consultants. In that situation, surgeons need to be better prepared to confront ethical dilemmas in their practice and must have all the tools they need to solve ethical issues. Many surgeons who responded to the questionnaire have confirmed the need for more information in that field through the CAGS. This survey also carried a message for all those involved in the education of future surgeons. We must shoulder our responsibilities to educate the next generation in the field of bioethics and especially in clinical ethics. We, as educators, have to make a special effort to upgrade our own knowledge and ability in clinical ethics or seek the help necessary to provide high-quality teaching in this area. We expect that our residents will not be ethically blind and will contribute to critical thinking about health care.[11]

Conclusions

This survey indicates that general surgeons have a moral sensitivity and interest in clinical ethics. Not surprisingly, most have not been formally introduced to the language of ethics, because little attention has been paid to the teaching of ethics in the past. Today surgeons may feel uncomfortable when they face very complex ethical issues. When theories, principles and arguments become necessary to solve an ethical issue, surgeons may lack the background to handle the problems. Surgeons admit the need for more education in clinical ethics. A comprehensive training in surgery should include not only the intuitive and spontaneous aspect of ethics, which is transmitted through the daily practice of surgery, but also knowledge and methodology in bioethics and clinical ethics. In addition to these tools, a critical mind and questioning what is done by surgeons and by the health care system are needed to help us make better ethical decisions in a very complex world.

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