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

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Introduction

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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 Sixty-first 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.

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 several comorbidities, including alcohol abuse.

The hospital where the surgeon works has two 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 believes 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 had 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 repercussions are highly unlikely. Dr Black asks two of her out-of-state surgical colleagues to advise her on what she should do.

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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 195 to 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 we factor in his sepsis, alcoholism, and other comorbidities, 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 to 60 cases per year [4]. While it is true that results for esophageal resection are better when the patient is operated on 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]. 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 on 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 after 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 consider 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 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 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]. That 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.