

Dr. Mabry:

The Last word

I appreciate Dr. Trunkey reviewing and responding to my counterpoint article. It is a bit challenging to decide which of his commentaries to address in this final part of the debate because his opinions are much more focused, reasoned, and tempered in his response than in his original article. Rather than the broad brush used in his main article, he now paints a slightly different picture with a smaller brush and finer strokes.

However, Dr. Trunkey consistently holds to his two primary concerns: the erosion of ethics/values and the lack of commitment on the part of physicians. I am pleased that he clarifies his concerns on these two issues by further noting that these vices afflict only a minority of physicians. In his response, Dr. Trunkey also brings out several areas to which he feels that the American College of Surgeons (ACS) should be investing more time and effort.

Rather than bore the reader with my thoughts on what we each think we said, I would prefer to devote this commentary to the essence of what I think the ACS should and should not do to address some of the important issues that we each have identified.

The ACS has many challenges to face over the next several decades, and resources are limited and precious. The College obviously cannot right each wrong. Therefore, to best represent patients and the Fellows who care for them, it is essential that the College pick and choose wisely which problems it will tackle. I hold that the College should put its primary emphasis on the issues that most adversely affect the majority of patients and surgeons, and not on issues that may involve a few bad apples. What, therefore, is the College doing

about these issues, and, more importantly, should it be doing more?

Ethical surgery

The ethics of surgery happens to be one of the most important and favored issue of the College.* The Board of Regents established the Regents' Committee on Ethics many years ago to address ethical issues that Fellows encounter. The College hosts an annual lecture and devotes ample editorial space to discussing and educating Fellows about ethical questions they may face. The Ethics Colloquium at the 2002 Clinical Congress covered the timely topic of "The Ethics of Entrepreneurialism in Surgery" and included a thorough discussion of some of the deplorable exploits Dr. Trunkey mentions.

The Fellows of the College, through various committees, have spent much time, deliberation, and discussion in arriving at important conclusions about past and current ethical issues. These are summarized for the Fellows and published in the *Bulletin*, in the form of the various statements of the College and College guidelines. Important recent College directives of this type have been: "Guidelines for Collaboration of Industry and Surgical Organizations in Support of Research and Continuing Education," "Statement Regarding Clinical Trials," and "Statement on Ethics in Patient Referrals to Ancillary Services."[†]

Dr. Trunkey hopes to convince us that the ACS should "serve as a watchdog." I don't necessar-

*Regents' Committee on Ethics: ACS Web site: <http://www.facs.org/about/committees/ethics/index.html>.

†Regents' Committee on Ethics: ACS Web site, http://www.facs.org/fellow_info/statements/statement.html.

ily disagree with him, and this concept certainly sounds good in theory, but what does he mean? What else does he want the College to do? We can teach morality, but I don't think we can mandate morality. For example, any or all of the statements mentioned previously, if taken to heart by the infamous "Lupron surgeons," would have averted this ethical public debacle. However, there will always be a few in any group, organization, or profession who don't want to follow the rules of society or ethical guidelines of organizations. It is for this reason that we have prosecutors and prisons. And in the case of the Lupron surgeons it is good that these punitive systems are in place, because those individuals richly deserve some time behind bars.

In his closing line, Dr. Trunkey says, "It is impossible to teach ethics when one does not practice ethics." I am not sure to whom he is referring. If there is any doubt about the commitment or the involvement of the ACS on ethical issues, I encourage the reader to browse through the following section of the ACS Web site (<http://www.facs.org/about/committees/ethics/index.html>) and decide individually. It is a very impressive display in both breadth as well as depth of the high ethical standards Fellows of the College are expected to uphold. As for the Fellows, the ones who I know and have come in contact with could easily qualify as Professors in Ethics, if "ethical practice" were the criteria for teaching this particular course. In my opinion, there is no finer group of women and men out there in this regard.

The critical question, however, is whether the ACS should do more than it currently is doing on ethical issues. To me, the answer is no. We can only do so much, and the thought of our College becoming some type of "watchdog" is where I draw the line. What would we watch, and whom would we choose to bite? And whom would we appoint to determine how to handle all those shades of gray that will inevitably be out there? We are an educational organization, not an arm of law enforcement. New ethical dilemmas will constantly crop up, and rest assured that the College and the Fellows stand ready to discuss and deliberate the proper solutions to those predicaments—as we have done all along.

Lack of commitment

Dr. Trunkey uses as a prime example of lack of commitment by surgeons the practice of hospitals paying surgeons to take call. Here is a typical example of how this "problem" evolves in a community. Hospitals A, B, and C are located in the big city of Megalopolis and have on staff surgeons in all of the various surgical specialties and subspecialties. Surgeons in Megalopolis primarily operate at hospitals A and B and, to a lesser extent, in hospital C. Remember that EMTALA now requires every hospital to have a surgeon on call for unassigned patients, if it elects to offer that particular surgical service to the public. Therefore, in Megalopolis the surgeons are torn between taking call at all three hospitals or dropping one or two hospitals from their practice to meet all the demands of unassigned call, group call, and so on. As a result, hospital C finds itself without any orthopaedists, neurosurgeons, and/or general surgeons. Hospital C wants to increase its market share and census by also offering these specialty services at its facility. Purely as a business strategy, hospital C then approaches and agrees to pay surgeons to take call, so that it can offer these services to the public. Make no mistake, the aim of hospitals A, B, and C is to make money, and to do that they all have to offer certain services that have EMTALA-mandated call-coverage requirements. The surgeons taking obligatory call are just caught in the crossfire between the federal government and the hospitals.

To summarize here: a hospital pays a surgeon to perform a service that may or may not involve actual patient contact. The surgeons' revenue is supplemented by hospital revenue. Is this arrangement proper, moral, and just? In this instance, what is the appropriate role of the College? Should the College insert itself between the financial arrangement of the surgeon and hospital by issuing some sort of national edict?

Wait, don't answer yet. First consider this similar but more common and timeworn situation that involves academic surgery and the relationship between hospital(s) and academia. Many institutions have complex revenue-sharing relationships, in which funds from physicians are diverted to other academic depart-

ments, physician revenue is supplemented, or physician costs are offset by the hospital. There are many instances of “directorships” in which a surgeon’s income is supplemented by the hospital for the surgeon performing some administrative duty. Nurses or other personnel are often hired by the hospital but work for the surgeon, and, as a result, the surgeon (or surgical department) gains financially. This type of hospital supplement to an academic surgical department is very common, and may even occur at Dr. Trunkey’s institution. Let’s again summarize here: Hospital pays a surgeon to perform a service that may or may not involve actual patient contact. Revenue of surgeon is supplemented by hospital revenue. Is this proper, moral, and just? What’s the real difference between the two scenarios? In neither instance do I find the surgeon nor the hospital morally bankrupt. I find no lack of commitment on anyone’s part. From my viewpoint, there is no harm, no foul.

The bottom line of this discussion: financial arrangements are made thousands of times per day between surgeons and hospitals. They are made for sound business reasons and persist in today’s environment because they serve a purpose. I have trouble distinguishing between these two scenarios. They both involve payments for services rendered. However, in either instance there are critical questions that we should be asking: has the good of the patient been compromised by this financial arrangement? If so, then most assuredly, the ACS needs to be front and center in the debate, arguing for good patient care. If not, then I believe there are many, many more urgent and pressing issues that the College should be devoting time and effort to solving.

Conclusion

It is critical that the College be involved in issues that affect patients and surgeons. But, it should prioritize and devote its time to those problems that are both common and, as importantly, that it can reasonably be expected to do something about. The College is doing many things for today’s surgeon to ensure that our patients have good surgical care now and in the future. I do agree with Dr. Trunkey that the

College needs to expand its data collection and analysis of these various practice parameters, such as numbers of surgeons taking call, lack of call coverage for surgical subspecialties, and so on. Those data are essential to helping the College become more responsive to new problems as they develop and to gauge important trends in such areas as physician supply, training, and research. The challenges facing today’s surgeon are great. Development of new educational programs, publication of surgical and ethical standards, increased involvement in socioeconomic affairs, and assistance in improving reimbursement for surgeons are all important parts of that effort now being led by ACS Executive Director Thomas R. Russell, MD, FACS, and the Regents, Governors, and Officers of the College.

From my viewpoint, the ethics and commitment of American surgery and the Fellows, while not perfect, stands heads and shoulders above all other professions. They are our pride, not our shame. □