Ethics of operative scheduling: Fiduciary patient responsibilities and more

James W. Jones, MD, PhD, Laurence B. McCullough, PhD, and Bruce W. Richman, MA

You are a vascular surgeon with an arduous operative schedule in a large private hospital. Your first two cases today took much longer than estimated, and your third case has been changed to “add-on” status. Your remaining patient is an indigent patient with noninfected gangrene of the fifth toe and rest pain; he requires a femoral-popliteal bypass within 24 hours to avoid additional risk. All ORs except the trauma room are currently occupied. Staffing drops off with the shift change in 1 hour, and afterwards incoming trauma patients will probably delay the start of other cases. If your case is declared an emergency, it will be started now; otherwise it must wait until a room opens. No cases are pending in the ER. Tomorrow is your clinic day and your operative schedule is full for the remainder of the week. What should you do?

A. Do the case as an “add-on” after consulting the OR supervisor.
B. Declare emergency status and operate in the trauma room.
C. Cancel your morning clinic and operate tomorrow.
D. Call your friend, the Chief of Staff, and apply pressure to operate now.
E. Ask a colleague to do the case in the morning.

Large surgical services often experience periods when OR capacity is exceeded and the schedule becomes congested. Problems tend to cluster around first starts and the late afternoon, when everyone is pressing to complete the schedule. This patient urgently requires surgical management of serious vascular insufficiency to save his leg. If his gangrenous toe becomes infected, his condition could become life-threatening, with sepsis rapidly advancing through the ischemic tissue and compounding the risk of infection in the surgical graft. Declaring the case an emergency would heighten its priority and ensure rapid access to an operating room, starting before prime staffing time is over. Nevertheless, the definition of a surgical emergency in the AORN standards uniformly accepted by American hospitals is based on an absolute need for surgery within 2 hours to protect life and limb. This patient’s acuity level does not meet this standard; his need is urgent but not emergent.

The surgeon’s primary fiduciary responsibility is to his patient, but that is not his only responsibility. There are secondary ethical obligations as well, and they must be honored. You have a clear obligation to observe and cooperate with the organizational and functional structures of the Operating Room, which are designed to ensure that all patients will receive safe, timely, and complete operative care consistent with their clinical needs. Every hospital has established OR policies to efficiently utilize professional time, space, and equipment, while maintaining reserves in each category to handle the unforeseeable but inevitable emergency presentations. You are expected to be an advocate for your patient, but not to the exclusion of all others, and particularly not at the peril of other patients with even more compelling needs. From an institutional viewpoint, surgery is a team sport, with mutually supportive roles intended to maximize every member’s productivity and effectiveness.

It is well understood that most surgeons would like to complete the day’s operations as early as possible and clear the schedule for the next working day. With an established diagnosis of a potentially life-threatening condition, there is no question of this patient’s legitimate demand upon the surgeon’s attention. Nevertheless, choice B, declaring him a surgical emergency and commandeering the only unengaged operating room, is a deception primarily intended to satisfy the surgeon’s impatience rather than improve the patient’s prognosis, which will be substantially unchanged if he is operated on immediately, tonight, or tomorrow morning. Although the ER has no patients for emergency surgical referral, reclassifying your case as an emergency and taking him to the trauma room places any true emergency arriving while you are operating at possible risk. Though no
such cases may present, and though your primary fiduciary responsibility is to your current patient, professional integrity recognizes a concurrent obligation to support or change carefully crafted OR policies designed to anticipate the most extreme eventualities of patient care. Choice B serves the surgeon’s convenience without substantially improving the patient’s prognosis, markedly imperils newly arriving true emergencies, and must be rejected.

Choice C, canceling the next day’s clinic and operating tomorrow to avoid a late case today, breaks faith with the patients who have arranged their own schedules, weeks or months in advance, to be seen by you. Many will likely be in significant need of your clinical attention and could be placed at added risk by being asked to postpone their evaluation or postoperative care. Clinic cancellation on short notice is an imposition on the good will of patients and support staff alike and is generally seen by referring physicians as a reflection upon one’s professional reliability and integrity. It should be reserved for those rare emergencies when a problem has no other solution. This one does, including proceeding with today’s case later than anticipated or asking another surgeon to operate for you. Choice C should therefore be discarded.

Choice D, calling upon a personal friend in a position of higher authority to override the OR’s contingency policies, imposes an unwelcome conflict of interest upon the Chief of Staff and generates all the other threats to emergency management just described, all to suit your own convenience without significantly improving your patient’s situation. It should be rejected.

Choice A ensures that surgery will be completed within necessary clinical parameters without misrepresenting the patient’s acuity and creating a dangerous backlog should a true emergency present while you are operating in the trauma room. Although your day will be lengthened by waiting to add the legitimately “urgent” operation, your clinical and ethical responsibilities to your patient, the institution’s other patients, and the OR team will all have been met. Choice E, asking a colleague to operate on your patient in the morning, is a viable alternative if the prospect of a late operation after a long day causes you to be concerned about fatigue and the quality of your care.

Surgeons determine the order of cases in the OR. Sometimes, the order is motivated by clinically irrelevant and therefore ethically unjustified considerations, such as the social standing of the patient, the source of payment, avoiding an inconvenient cancellation of a case, and others that are even more flagrantly self-serving. The surgeon in this case surely must be aware, unless his or her capacity for self deception is unbridled, that he or she scheduled an urgent case after two purely elective ones. This decision was entirely voluntary and unnecessarily created a potential ethical conflict that, if this patient’s surgery is unduly delayed, will become an actual and serious ethical conflict. Because of a lack of forethought or deliberate wrongful scheduling, the surgeon has now imposed a preventable hardship on himself or herself, other surgeons, and the OR staff and management. The result is to put this patient, and perhaps other patients, at preventable risk of suboptimal care.

An organizational culture shaped by fiduciary responsibility and its professional virtues is an essential ingredient of a preventive approach to cases such as this. Organizational culture includes the policies and practices of an organization, as well as its values and priorities, particularly as these are made concrete in budgets and hiring and promotion decisions. Organizational culture is shaped by what leaders expect, inspect, reward, punish, and—perhaps most importantly—tolerate.

REFERENCES