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MINEFIELD

> It is a general popular error to imagine the loudest complainers for the public to be the most anxious for its welfare.
>
> Edmund Burke, *Observations on... the Present State of the Nation* (1769)

It was the Universal Declaration of Human Rights of 1948 that let the genie out of the bottle. Thomas Paine, John Stuart Mill and others had, to be sure, given the stopper a tweak much earlier, but the second half of the twentieth century saw a preoccupation with 'rights' that became increasingly strident. When this preoccupation was unaccompanied by a corresponding concern for responsibilities, or for the rights of others, it could even appear unhealthy.

The 'rights' movement exerted a profound influence on the practice of surgery (and, inextricably, anaesthesia) in the second half of the twentieth century. Paradoxically, some of the legislation that the movement spawned would work against the very standards the surgical profession sought to cultivate.

Reporting on a national ethics seminar held in Brisbane in March 1991, M.R. Fearnside, as chairman of the College ethics committee, wrote:

> The days when a surgeon or anaesthetist was able to practise his or her art and science in the secure knowledge that right actions were their own reward, are long gone. There are now fundamental changes to how doctors practise medicine with pressures from new technology and research, community expectations and diminished resources, all contributing to a variety of important issues.
> The College believes that Fellows should address these challenges and join the debate where the issues impact upon their professional lives and conduct.[1]

To Michael Fearnside fell the task of chairing the College's ethics committee at a time when the very term 'ethics' took on a new dimension.

If we look back to the early 1950s, when the College was a quarter-century into its existence, we can note that entry into surgery was becoming fairly strictly regulated, that attendance at surgical meetings as an exercise in 'keeping up' was encouraged, but that the monitoring of performance was still very much an anecdotal business.

Now, anecdote is not to be discounted altogether – an individual

Ross Holland (Dean 1984-86) described the prospects and problems of mortality studies in his Gwen Wilson lecture in 2000.

case can be most instructive – but the gathering and analysis of mass data has even more to offer. In this the pioneers were the anaesthetists, at first with studies of anaesthetic mortality in individual hospitals, then in communities. Ross Holland's 2000 Gwen Wilson memorial lecture described the first such community study in Australia. His account (given from the inside, for he was the first secretary) is instructive of the value and the pitfalls of such an undertaking. The New South Wales project arose out of a study of maternal mortality which had found many deaths to be anaesthesia-related; it arose out of casual discussion of an anaesthetic death in the tearoom of an operating theatre; and it arose because the director-general of public health, Dr C. Cummins, understood the importance of involving 'all of what are now called "stakeholders"' in such an enterprise. Cummins himself became chairman of the committee which undertook the study, Holland (then, in 1960, a young anaesthetist – but later Dean of the Faculty) its secretary. Both the College and the Faculty were included among the nominating bodies.

In 1941 Jewett in Massachusetts had laid down the essentials for such a study:

- a reliable mechanism for the capture of data;
- a guarantee of confidentiality;
- an expert group to evaluate the data scientifically; and
- a vehicle for the publication of results and recommendations.

In New South Wales confidentiality of data was achieved by the then minister having the state Cabinet endorse his recommendation 'that the Committee's proceedings be afforded the status of Cabinet documents – a mechanism which survived for 20 years without question until an event... which almost destroyed the Committee'.

As early as October 1962 the committee produced an interim report, published in the *Medical Journal of Australia*. Handicapped by lack of reported cases (at that time a death outside the theatre was not reported as anaesthetic related), the committee was able to have a '24-hour rule' enacted which gathered in two or three times as many cases as before. The next report in 1970 dealt with 745 cases, of which 286 had proved on investigation to be anaesthesia-related. And at this point enterprising barristers sought to burrow into the committee's data.

Efforts to set up similar committees in the other states had encountered a variety of difficulties: in South Australia, with confidentiality, in Victoria with a reliance on voluntary notification so that 'early responses... often consisted of "war stories" with the anaesthetist cast as hero'.

By 1975 the original New South Wales committee had received 3000 notifications and achieved a response rate of 92%. Of the 1394 which had been classified, anaesthesia had been identified as a contributor in 441. There had, meanwhile, been interest on the part of the surgical members of the committee in the possibility of studying

surgical mortality in a similar fashion. A pilot study was authorised in May 1972, and two operations soon stood out as having an undesirably high mortality rate: abdomino-perineal resection for rectal cancer, and operations for internal fixation of femoral neck fractures. But political manoeuvring prevented the establishment of a definitive Surgical Mortality Committee for 20 years – and during this time the work of the existing anaesthetic committee was put in jeopardy by a bureaucratic muddle.

Difficulties in securing hospital records had compromised the value and promptness of forensic autopsies, and a rewording of the Coroners Act was therefore proposed which would enable the coroner or his agent to demand *'any* document... relating to the medical care or treatment of' a deceased person. The health bureaucrat to whom the draft was referred was, in fact, a member of the NSW committee, but he had not so far attended any meetings and did not appreciate the threat posed by the new clause. The amended Act allowed access to the committee's documents to any policeman who could claim to be acting on behalf of the coroner. Confidentiality was a thing of the past.

In 1980, therefore, the committee was forced into recess. It took three years of lobbying before the state government was persuaded to restore protection 'to all materials related to peer review'.[2] The crisis caused worry enough at the time but had two beneficial results: the amended legislation gave protection to a wider medical community than had the original 'ministerial umbrella', and the report which there was time to produce during the three-year recess was published – by invitation – in the *British Journal of Anaesthesia*. The whole project had been quite instructive.

Several lessons can be drawn from the New South Wales anaesthetic mortality study. It shows how demanding in time and effort an exercise in quality control can be. It shows the hazards represented by lurking barristers, by politicians with their own agendas and by bureaucrats detached from the real world.

It showed, too, how the media will feast on bad news. 'Some media characteristically misquoted, sensationalised or otherwise did their best to create a better story than the facts could support,'[2] Holland noted.

Thanks to media coverage the public has, over half a century, become more informed – which is not synonymous with better informed – and it is against this background, of a public regarding itself as informed, that the practice of surgery has had to be carried on. Whereas in the 1950s patients tended to present with a problem and a touching faith in the surgeon's ability to solve it (or at most with a page from last month's *Reader's Digest* tucked into a pocket), by the 1990s they presented not uncommonly with a list of demands. By the end of the decade these were supplemented by items off that most indiscriminate communication medium, the Internet.

Dame Silvia Cartwright is now governor-general of New Zealand. In 1987-88 she chaired an enquiry into the 'unfortunate experiment' in the management of cervical cancer at National Women's Hospital in Auckland.

Unquestioning trust in medical judgment fell victim to this explosion of information; members of the public became their own experts. The situation came to resemble Herodotus' account of Babylonian society:

> They have no doctors, but bring their invalids out into the street, where anyone who comes along offers the sufferer advice on his complaint, either from personal experience or observation of a similar complaint in others. Anyone will stop by the sick man's side and suggest remedies which he has himself proved successful in whatever the trouble may be, or which he has known to succeed with other people.[3]

Certain other events combined with this sometimes spurious feeling of understanding to produce the process called 'informed consent'.

In New Zealand an enquiry into the management of cervical cancer at National Women's Hospital found that women had been lured into an 'unfortunate experiment' in which premalignant lesions were simply watched to determine their natural history, rather than being radically extirpated as had hitherto been the custom.[4] These women – and 'consumers' in general – were entitled to be informed and then, only if convinced of the merits of a particular approach, treated only in the fashion to which they had consented, the commission held.

The particular circumstances of the 'unfortunate experiment' obscured the fact that, in general, it is an 'informed request' which better describes the agreement between surgeon and patient. In general a patient (even when redefined as a 'consumer' or 'client') approaches the surgeon with a three-pronged query: 'I have this problem; what is wrong?; what can you do to help me?' It has to be allowed that the ideal – of communication and informed choice – has been somewhat skewed because the special conditions at National Women's Hospital (under-treatment in the guise of research) influenced the general situation.

Michael Gorton has been the College's legal adviser in a period of massive change in the law as it affects surgical practice.

That said, the importance of adequate communication prior to the undertaking of a surgical procedure cannot be emphasised enough. The question becomes: what is adequate? What would come close to satisfying one patient may be enough to terrify another; a recital of hazards, for example. What will strike a patient as convincing enough at the time may seem on reflection to have been cursory, especially in the event of complications. It has even been suggested, not entirely in jest, that a patient should be required to answer a series of questions after a briefing, to provide an indication of understanding.

The College wrestled with the subject of informed consent through much of the 1990s. In the College *Bulletin* in March 1993 the honorary solicitor, Michael Gorton, wrote, 'Suffice to say that the nature and extent of a doctor's obligation remains complex and unclear.' In Australia at that time the National Health and Medical Research Council was engaged in developing a comprehensive booklet on the topic. In a submission to NHMRC the College hoped that wide consultation with practitioners would precede the final draft, and that

the Guidelines to be published would be advisory only.

The concern at that time had arisen out of a case in which an operation on an already virtually blind eye led to sympathetic ophthalmia in the other eye, an admittedly uncommon hazard but one of which the patient had not been warned. Because of its overwhelming impact, the Court held that it should have been mentioned as a risk. Writing in the same issue, a legally qualified Fellow, John Stephens, contemplated the implications of the decision:

> It must be noted that the case under consideration involved a 1:14,000 risk, but on the facts that was held to be relevant. Cosmetic surgeons beware! The lower Courts will simply refer to this High Court decision, and no appeal will exist. It means that one must warn of the risk of DVT, respiratory problems, anaesthetic risks, etc. The list is endless.[5]

The patient's needs are simple enough in theory: to have the intent, nature and hazards of a proposed line of treatment presented clearly, crisply but not in too cavalier a fashion. Applying this simple theory to everyone's satisfaction may, of course, be less straightforward.

And experience has shown surgeons what their own needs are – not simply to impart information but (against the day when its adequacy may be challenged) to record having done so, in detail enough to satisfy a hostile questioner.

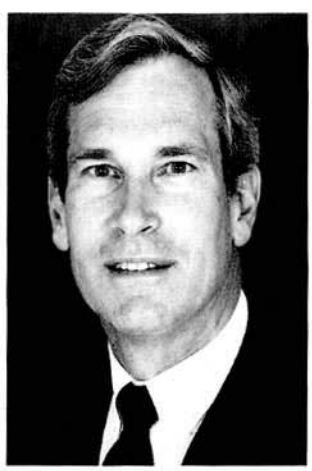
Surgeons tended by now to consider themselves under siege. In New Zealand, at least, they soon felt themselves discriminated against, and that by the application of the law on medical manslaughter. The College became involved while R.D. Blair was chairman of the New Zealand committee, and he for his part was drawn into a five-year crusade.

The problem arose with over-zealous interpretation of Section 155 of the 1961 Crimes Act, which held that:

> everyone who undertakes... to administer surgical or medical treatment... is under a legal duty to have and use reasonable knowledge, skill and care... and is criminally liable for the consequences of omitting without lawful excuse to discharge that duty.

In 1982 an anaesthetist, newly arrived in the country, was convicted and fined $2500 after an anaesthetic death attributable to unfamiliarity with the apparatus. Another anaesthetist was convicted in 1989 but discharged without penalty, as was a radiologist two years later. In each case 'simple' negligence or carelessness was involved and not the 'gross' negligence specified in Australian, English or Canadian law. The 1989 case was appealed as far as the Privy Council, which decided that it should not interfere with a 'policy' decision of the New Zealand courts.

The New Zealand committees of the Colleges of Surgeons and Anaesthetists, the Council of Medical Colleges, the Medical Council



Ross Blair is a former chairman of the New Zealand committee, who found himself at the centre of a campaign to moderate the law on medical manslaughter in New Zealand.

and the Medical Association joined forces to seek amendment of Section 155. They did not get far at first: the Crimes Consultation Committee, reviewing a 1989 Crimes Bill, recommended no change, but at the end of 1993 there were hints of an easing of the offensive section. (There was also a general election, with all the legislative paralysis that this implies.)

Not until November 1997 did the New Zealand parliament pass a Crimes Amendment Act which limited the risk of a manslaughter charge to conduct which represented a 'major departure' from a reasonable standard of care. This equated well enough with the 'gross' negligence of Australian law or the 'reckless' behaviour of an English case. The legislation removed one threat which had lain heavily upon surgeons and anaesthetists. This is important because (although legislators and lawyers may tend to overlook the fact) it is harder to perform well in an operating theatre if one is haunted by thoughts of possible doom, than if one is free to concentrate on performing an operation well.

It might be thought that reviewing outcomes while meeting the requirements of the law and the demands of society, can represent sufficient attention to achieving and maintaining a 'squeaky-clean' image as a profession. It is not so, however.

Ethical issues have crowded in on surgeons in recent years. Indeed 'ethics' has taken on a new meaning. It used to imply caring for the patient while behaving decently towards colleagues. This is what the founders understood by the term when they wrote the first clause in the College's Memorandum of Association: 'to cultivate and maintain the highest principles of surgical practice and ethics'.

Several of the issues described earlier in this chapter have become part of the spectrum of ethics – notably consent, of course, and not simply consent to treatment but consent to participate in research. Developments in surgery have contributed to the broadening of the spectrum. Transplantation surgery has raised its share of ethical dilemmas, particularly in the definition of death; so has the ability of neonatologists and surgeons to bring about the survival of infants who would previously have been born dead or have died very shortly after birth.

These issues were discussed at the Ethics seminar held in 1991 and its deliberations published in the *RACS Bulletin* over several issues. In 1993 the College position was consolidated into a 'Code of Ethics' and published as a booklet. This was favourably received. R.R.A. Syme, a grandson of the founding president, wrote:

> The authors of the RACS Code of Ethics (September 1993) should be congratulated on a splendid document, whose language and principles shine brightly compared to [*sic*] the rather more pedestrian Code of Ethics of the AMA (July 1992).

He went on,

> The preamble... states that 'It is imperative that the surgical ethic preserve the patient's dignity, individuality and autonomy'. The association of these three rights in this sentence emphasises that they should be considered as inter-related rights. Thus, if the patient is denied autonomy the patient may lose his dignity, and by denial of dignity he loses his individuality. Nowhere is this more evident than in the care of the dying.[6]

And here, of course, is the core of the euthanasia debate. In this context it is probably best simply to point out the paradox that the most succinct statement of the ideal in the care of the dying was made, quite unintentionally, in a satirical couplet of A.H. Clough.[7]

The final guideline in the published Code stated, 'The surgeon will respect the rule of Law, but recognises a responsibility to seek to alter those Laws or regulations which do not work in the best interests of the patient.' Ross Blair and his fellow campaigners may have been heartened by this observation as they battled to bring humanity into Section 155 of the New Zealand Crimes Act.

But nothing is ever simple – indeed, if Malcolm Fraser, a former Australian prime minister is to be believed, 'life wasn't meant to be easy'. In response to Rodney Syme's paper another Fellow, Ian Bissett, working in Nepal, cited the example of

> Krishna... a 21 year old man who has three children, no work and no education. He comes to me as a surgeon to request a below-knee amputation so that he can present as a beggar in the streets of Kathmandu... with an obvious physical deformity, he will certainly receive enough to keep himself and his family alive... His decision is perfectly rational, and expresses his own autonomy... Should we as surgeons carry out this man's wish? If we refuse to do so under our new ethics, are we acting unethically, exposing the patient to the risk of having his leg removed for a high fee by an untrained surgeon with concomitant complications?[8]

This is, if you like, the down-side of patient autonomy, and in New Zealand it was enshrined in law by the passage of the Health and Disability Commissioner Act 1994. The commissioner drew up a Code of Health and Disability Services Consumers' Rights, some of which proved to be mutually exclusive. Thus Right 4 stated: You have the right to be treated with care and skill, and to receive services that reflect your needs; while Right 7 stated: It is up to you to decide. In one case at least, the commissioner ruled that Right 7 took priority over Right 4, and that a patient (or consumer!) had the right to be badly treated if he so wished and could indeed demand what a practitioner knew to be bad treatment. This is anathema to any practitioner who has been brought up to believe that a doctor should never knowingly do harm to a patient, yet it is a natural enough consequence of an exclusively 'rights-based' Code.

Senator Peter Baume FRACP, in a report grandly entitled 'A cutting edge', was considered to have missed a good opportunity to offer a better approach to the problem of workforce numbers.

The various problems that have been catalogued so far in this chapter can be attributed to influences outside the profession. It caused the College little concern, therefore, when a physician, a professor indeed, a senator named Peter Baume, was commissioned to conduct an enquiry into specialist services. As the then president David Theile wrote,

> Our ultimate aim is to set and maintain high standards of surgical care; and we are interested in the truth. Accordingly we have no fear of investigation and assessment.

But when Baume's report came out it caused anger and consternation.[9] It appears, Theile wrote,

> to contrive towards pre-conceived propositions; it does not start with an assessment of services as was its brief; and it largely dismisses quality... Baume does make some points and recommendations with which we would agree, but such are his inconsistencies that in other parts of the report he contradicts these same points and recommendations.

In his presidential newsletter of March 1995 Theile was able to report to the Fellows of his College that:

> The College has made a detailed recommendation by recommendation response to the Baume Report... The general style of the response was to be critical of the Inquiry and its Report. All criticisms were illustrated precisely by specific examples.
> The response to the specific recommendations dissected the facts of the matter and responded in an often critical manner.
> We have, however, responded positively about the need for greater analysis of workforce numbers and needs. We have also signified our wish to work with governments to find solutions for deficiencies in the surgical workforce... The purpose of these meetings [with Ministers and senior administrators] has been to ensure that our views of the Baume Report are quite clear, and that our areas of cooperation are not lost among the multiple criticisms of the Report that we have made (and by which we stand).

David Theile, as president, commented on the Baume report: We have signified our wish to work with governments to find solutions to deficiencies in the surgical workforce.

It is possible to feel that Baume wasted a valuable opportunity, quite apart from the effort to which he put the College. Fortunately, his report seems to have fallen quite rapidly into a black hole of almost astronomical proportions, thus vindicating the view reported to the Council meeting in February 1995:

> [The President] had gained the impression from the Victorian Health Department that, with the exception of the Queensland and Northern Territory Governments, the Health Ministers, through their forum at the Australian Health Ministers Advisory Council (AHMAC), were unlikely to pursue many recommendations in the Report beyond

> attempting to establish accurate workforce numbers. It had been suggested to him by the Head of that department that at the last AHMAC meeting there had been an almost complete desire on the part of Ministers and departmental heads to ignore the Report.[10]

The College's next salutary experience involved not a mere physician, but a surgeon – even if the surgeon concerned was not an Australasian Fellow. It had been recognised for some while that College decisions on training matters, and College selections into training schemes, would sooner or later be challenged. A good deal of powder and shot had to be expended in defending decisions made in good faith (and, in hindsight, with good reason: the litigious have a remarkable capacity for showing themselves in their true colours).

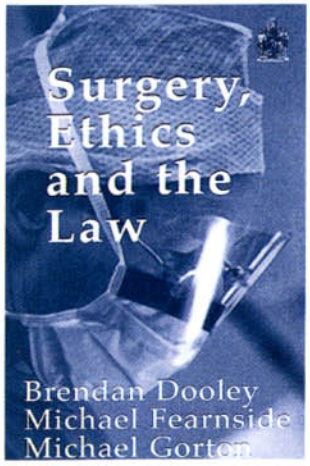
Now, however, an invited College report became a *cause célèbre*. It had been common enough in New Zealand (and to some extent in Australia) for employing authorities to appoint an overseas-trained candidate rather than leave a vacancy, and to be less than particular in verifying the candidate's training and capabilities. An English-trained surgeon was appointed in Dunedin – as a general surgeon – and expected to handle emergency calls across the general surgical spectrum. As he had concentrated on breast surgery before gaining much of a grounding in other aspects of general surgery, he tended to steer clear of everything except breast surgery (in which he soon gained a loyal public following), and his colleagues and employers became rather less than gruntled.

The College was invited by his employers to examine and report on his colo-rectal work. The report was unfavourable and he was dismissed, whereupon he set out to challenge the content and findings of the report.

There were indeed some errors of detail in the account of his work and (vociferously supported by his followers and generously reported by the media) he embarked on a crusade that ultimately extended as far as the Privy Council. Here the errors were acknowledged but the findings sustained. It had taken almost six years – and cost dearly. The experience gained was hardly compensation, though reports trickling through from Britain of further contretemps involving the surgeon in question have given the College some cause for anticipation. In particular, the case demonstrated that medical colleges and the like are within the purview of the Judicature Amendment Act and hence subject to judicial review. Another corner of the minefield had been identified and marked.[11]

But this story of surgical angst does have a happy ending: at the Brisbane meeting in May 1997 the College's honorary solicitor, Michael Gorton, was admitted to honorary Fellowship. The award may well be considered richly justified. Three years later in Melbourne the meeting provided the occasion for the launch of another College publication: the book *Surgery, Ethics and the Law*. Co-authored by Brendan Dooley, a former censor-in-chief, by Michael Fearnside who

chaired the ethics committee as the College began a decade of galloping change, and by Michael Gorton himself, it is a valuable map of the minefield.



The book *Surgery, Ethics and the Law* was launched at the 2000 Melbourne meeting.

NOTES

1. *RACS Bulletin* (1991) 11:3: 19.

2. In this account I have quoted quite often from the text of Professor Ross Holland's lecture, which he has been kind enough to make available to me.

3. Herodotus (trans. A. de Sélincourt) (1954) *The Histories*, Harmondsworth, Penguin, p.121.

4. Dame Silvia Cartwright, who headed the enquiry, then enjoyed a meteoric rise through the ranks of the judiciary and, in 2000, was named as Governor-General of New Zealand, taking up her office in April 2001.

5. Stephens, J (1993) Medical negligence – the duty to inform, *RACS Bulletin* 13:1:49.

6. *RACS Bulletin* (1994) 14:3: 28.

7. Thou shalt not kill, but need'st not strive
Officiously to keep alive.
– *The latest Decalogue* (1862)

8. *RACS Bulletin* (1995) 15:3: 66.

9. It appeared with the grandiose title: *Report of the Inquiry into the Supply of and Requirements of Medical Specialist Services in Australia: A Cutting Edge: Australia's Surgical Workforce 1994.*

10. Proceedings of a meeting of the RACS Council held on February 23 and 24, 1995, p.11.

11. The course of events, and the legal lessons of the case, can be found recorded in *RACS Surgical News*, 1:7: 4-5 (August 2000).