

Limitations of the surgical contract

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Editor's note

Factors affecting the nature of the contract between patient and surgeon, which forms the basis of professional ethics, are examined with particular reference to Sweden. These include: the system by which the surgeon is rewarded for his work; political judgements about the allocation of scarce medical resources; the surgeon's workload as influenced by medical trade union pressure and the need for continuity and for training of new surgical manpower.

The clay tablets of ancient Mesopotamia document the practice of medicine as early as 3000 BC. Of especial significance to surgery is one of the oldest regulatory laws, the code of Hammurabi, promulgated by that Babylonian ruler about 2000 BC. From this code we can clearly distinguish how society, law and justice interfere with the contract between surgeon and patient. While a successful surgical treatment should be generously rewarded, a doctor who has treated a man with a metal knife for a severe wound and has caused the man's death should have his hands cut off. The triangle of patient, surgeon, and society is in the centre of such a critical drama of law and medicine 4000 years ago.

In the Edwin Smith papyrus from the old Egyptian kingdom the doctor is given complete advice on how to behave and the very basic contract between patient and surgeon is beautifully described. Thus a contract has existed for 5000 years based on confidence and a strong personal link between patient and surgeon. This contract, patient-doctor, is also a most important ethical rule, and, in my opinion, the cornerstone of medical ethics.

However, today in modern society threats and hazards limiting this contract certainly exist. We must recognise and be prepared to combat these limitations in order to keep the contract and the confidence between surgeon and patient and indeed confidence in surgery itself.

I will discuss some of the phenomena which can limit the contract.

Money

Money may in many ways be a potential danger to the contract. Our medical service today is based on

two systems different in principle. In one, the patient-surgeon contract is characterised also by a direct economic agreement between the parties, and in the other we have a situation like that in some European countries today, including my own, where the majority of surgeons get their salaries from society, to which the patients have already paid their fees as a substantial amount of tax money. Neither of these systems is free from hazards to the contract. It is not infrequently suggested that the temptation to earn big money, for instance in USA, may lead to unnecessary examinations and surgery or a reluctance to adopt cheaper and simpler methods. Do we really want the surgeon to act as an adviser with responsibility for the patient's financial situation as well as his health?

In the other model, the principally non-profit, but often mixed system, fears are expressed that it may sacrifice the productivity, commitment and personal element that characterise traditional medicine at its best.

Today lack of public money is commonplace, a situation applicable not only to surgery but to medical care as a whole. Expenditure is rising, both in absolute terms and as a percentage of the gross national product, at rates perceived by consumers to be unacceptable. The rise is largely spurred by the cumulative effects of inflation, development of new expensive technologies, increasing wages and fees, and heightened expectations concerning the benefits of medical treatment. The demand for health care by an ageing population, for instance, seems likely to outstrip the resources available to meet total costs. Cutting down is the order of the day in many countries and may, as has already happened, lead to the extreme of closing hospitals. Since surgery is to such a high degree dependent on hospital resources economic restrictions certainly affect the opportunities to practise as a qualified surgeon and thereby seriously limit the contract.

The use made of the diminishing sum of money available is then of the utmost importance. Unfortunately, it seems that surgery suffers from a significant lack of priority, above all in the developed countries. Why is this so?

Primary care

One reason is the wide-spread, sometimes almost

religious belief in the highly beneficial effect of primary care. Complaints regarding the present system of providing medical care include lack of availability where the patients want it, the costs, and the perceived decline from a warm, human personal approach to a more dispassionate and scientific one. With commonplace phrases like these, there is a renaissance for the family doctor. In Great Britain, for instance, the right of every citizen to be provided with primary medical care through his or her own personal general practitioner is often considered to be the greatest benefit that the National Health Service has conferred. But of course, the right to have a GP does not imply that there will necessarily be any real choice of doctor, nor does it guarantee the standard of the primary care that will be offered. Politicians indulge in expectations that primary care will be a possible means for the prevention and cure of diseases often brought about by society itself. As a result of this view-point, money and resources and education are being directed towards and spent in this field of medicine. Furthermore, the politicians believe that they unburden our surgical departments, although in reality we can prove that the more general practitioners we get, the more requests, which is quite natural, for surgical advice and surgery. These requests limit our contract as they can hardly be met without a different priority.

Another reason for the lack of priority may be that overall professional authority has again come under attack. We must be concerned about the rather persistent criticism that seems to be levelled at the medical profession from sociologists, economists, academics in social medicine and certain radical publicists. The profession should not be immune from criticism, but a tendency to denigrate medicine and those who practise it can hardly benefit patients. The potential of medical knowledge for preserving and restoring health has never been greater, and yet the system for applying it has never been so sharply criticised. This paradox is becoming apparent in all developed countries, and it will need to be widely debated before it can be resolved.

Quality

When we thoroughly examine the contract I think we can all agree that the most important pre-requisite condition for the contract is the quality of the surgery we practise.

As I see it the crucial point is that in order to keep the quality there must be a good balance between the number of patients and surgical manpower. Considerable anxiety must be expressed over excessive admission of trainees for specialisation. Of course there are enormous differences between the situations in different parts of the world.

The need for surgery in the developing countries is great and the number of qualified surgeons available is small. Paradoxically the same situation also exists for instance in the USA and Sweden because of the problem of maldistribution. However, in the USA it can be deduced from studies of surgical manpower that perhaps too many surgeons and surgical sub-specialists are being trained and there is evidence predicting that a surgical manpower surplus is already present there. It is anticipated that in 1985 there will be approximately 16 500 United States new medical school graduates with more than 8000 in specialist training. This figure will represent a 35 per cent increase in the number of new specialists at a time when the population is stabilising and the birth rate is below the replacement level.

The number of surgical trainees is necessarily limited by several factors, including the provision of training posts, adequacy of teachers and training facilities and the availability of appointment on completion of specialist certification. If the surgeon cannot practise the art and craft of surgery at an adequate standard he will lose his competence, and the levels of surgery will inevitably fall. The patient-surgeon contract will then be seriously threatened.

When I was invited to take part in this symposium I could clearly imagine some reasons why:

- a) The medical systems of many countries today are, if not already similar to ours, quite obviously on their way towards a system from which I think they realise there is no escape: a system where medical planning on a social scale will impinge on physicians' autonomy, not we may hope, always negatively.
- b) Such medical systems, however, as in Sweden for instance, the so-called promised land of socialised medicine, could well be expected to harbour certain limitations of the surgical contract.
- c) By tradition and by necessity we have in Sweden a very strong union organisation of doctors. Could the efforts of the union possibly influence the surgical contract?

The Union

There should be no conflict between professionalism and unionisation. The important message we have to get through to the public is that doctors' unions are being formed to protect the rights of patients as well as those of physicians. It is the influence of what we can call the second opinion, *ie*, not the opinion of patients and doctors but the opinion of medical bureaucrats, which can be a serious limitation to the contract. The strategy of the union is to make known its opposition to governmental and other third party programmes that

may affect patient care, before the point of no return is reached. Let me give one example. In our union we are fully convinced that the chief of a surgical department should in addition to medical responsibility, also assume full administrative responsibility, for personnel, budget, etc. to guarantee the surgical contract. We think this disputed matter is worth fighting for.

Let us take a look at the question of regulated working hours—a matter which concerns the ambitions of both society and the unions of the employed surgeons. In USA there have been strikes for fewer working hours, with demands from residents that the typical weekly 100–120 hours work should be reduced to eighty. I presume that this demand for a work week reduction was directly related to patient care. I have never been convinced by the view that the physicians' idealism is created or the patient-surgeon contract preserved by the ordeal of slaving such long hours. Nor have I ever been convinced that an exhausted physician—or student—is likely to be a better one.

However, regulated and lowered hours of work together with other manifestations of the so-called welfare society may result in complications for surgical practice. Although I have been eagerly fighting within the union of the Swedish Surgical Society for the idea that also surgeons shall have human rights, I must admit that today's rapid development worries me and I will try briefly to illustrate why.

When most of our surgeons entered today's medical system, employed and paid entirely by the community, the outcome of the salary negotiated had been distinctly in their favour. Surgeons are still in a high income group by Swedish standards with higher pay than that of, for instance, the prime minister and they still retain the right to additional private practice. But as is also well known, that income taxes in Sweden are so very heavy that those with high incomes do not always find it worth working too much and too hard and there is no incentive to make extra money. Therefore, in a society where money as an incentive plays a minor role, other values such as leisure time for the family, for sailing and skiing and travelling become more important.

Let's take a look at the real situation today for young men and women, who after six or seven years of basic medical studies start their specialisation in general surgery which will take 4–5 years.

The weekly working hours are limited by law to forty and although the surgeons still work and are paid for about forty-five, the residents are already down to forty hours. When the resident is on duty he gets one hour free for every hour he works except at nights and on Saturdays and Sundays, when he gets two hours for every worked hour. Furthermore, all employed citizens in Sweden have the legal right to paid leave of absence for things like taking care

of children under fifteen, laws which have no equivalent in comparable countries. Altogether, vacation, on duty compensation, and 'social rights' keep the surgeon away from work 14–18 weeks per year.

Since the same rules apply also for the certified surgeons you can easily imagine that we need a great number of surgeons, in reality one half person extra for every appointment, to keep the surgical service running day and night. Inevitably this jeopardises the very important factor of continuity in the doctor-patient relationship and it also has consequences for training programmes.

Training

We know that in 1972 when we had no more than about 300 specialised general surgeons, our residents during 4 years of training performed about 300 operations, not counting minor and diagnostic procedures. We also know that surgeons both specialised and residents, performed operations independently during 4.6 hours per week. We know that 5 years later when we had 750 specialists the number of comparable operations for the residents had diminished to 300 and with an increasing number of surgeons of course the weekly operating hours will diminish further.

There is today an intensive discussion within the Swedish Surgical Society about how to handle the situation and there are colleagues who seriously question if it is at all possible to become and to be a surgeon under existing conditions. I am happy that the title of my paper releases me from furnishing a definite answer to this delicate question, but I cannot simply drop it, since it is a problem of ultimate importance for future surgeons all over the world.

Is the solution then, that we should make an effort to keep our working time high and subsequently diminish the number of surgeons being trained? In other words should surgeons work more than other physicians? I am fully convinced that this is no solution. The typical young resident today with a professional wife, three children, a big house and two cars, a summer house and/or a sailing-boat—he is definitely not interested in less time for his family and more money to pay back in tax. He was recruited because of the fundamental value and attraction of surgery and the possibility within this field of medicine of serving patients in a concrete way. It is this positive aspect of surgery we should seize upon, not meaningless contrast between present and future conditions of life.

Instead we must make all possible efforts to make training and working conditions optimal. No lack of manpower should prevent young surgeons from being effectively guided in the technical training by experienced colleagues. It should be possible to abandon the time-consuming method of trial and

error. More than ever it becomes imperative to develop the teaching and training of surgery with international exchange of experiences.

Society and the contract

In all the complex mechanisms influencing the surgical contract society plays a necessary part. I think it is important that we consider the demands

of a changing society and the fact that we can neither escape our social responsibility nor ignore the working conditions in the society within which we live. However, we must work together as colleagues and friends to protect our patients and our work from society when we are convinced that its ambitions of interference and control direction will not benefit but limit the contract—the contract between patient and surgeon—without which there can be nothing left worth the name of surgery.