WHAT IS THE PRESENT MEDICO-LEGAL STATUS OF THE ABDOMINAL SURGEON?

BY

WILLIAM WARREN POTTER, M.D.,

Buffalo, N. Y.,

Chairman Section of Obstetrics and Diseases of Women, American Medical Association, 1890; Fellow of the American Association of Obstetricians and Gynecologists.

THE line of thought outlined in this paper, no matter how expressed, is intended to be suggestive rather than dogmatic, inquiring rather than assertive, as indicated by its title. The recent rapid advancement of the surgery of the abdomen has inevitably led to its separation from the general surgical field into a distinct specialty; it finds itself in a new environment, without traditions or statutes for its guidance, and hence with only a comparatively recent experience on which to found its legal or surgical status. For these and other reasons we may not speak in this place except suggestively or inquiringly.

That abdominal surgery now holds a place distinct and apart from other branches of the surgical art need scarcely be argued here. That it must of necessity be considered a specialty appears reasonable when we contemplate the nature of the organs dealt with, and the variety in the character of the operations upon these organs. The great point to be insisted upon is that the lines that separate it from the other divisions of surgery are so well marked that, no matter how well a man may be equipped in these, unless he has had abdominal experience he has no right to enter its domain except under urgent necessity, where delay will lose life or endanger it less than the inexperience which proposes to operate. It is surprising that men without such experience, either practical or theoretical, will insist on attempting the work of

[1] Read by invitation in the Section of Medical Jurisprudence at the forty-first annual meeting of the American Medical Association, May, 1890.

reformed abdominal surgery, than which there can be nothing more delicately refined, or exacting in all its details. The inexperienced surgeon will hardly risk tenotomy for a deformed limb, or trephining for focal epilepsy; yet the most illiterate or inexperienced practitioner, but lately become a doctor, considers it his right to rush headlong into an abdomen with his bistoury, maul its contents with his soiled hands, bury the remains with a deceptive death certificate, and complete the farce, which is also a tragedy, by an after-pose before the community as a man who has accomplished something remarkable. This is the kind of work that has carried discredit into the domain of what is perhaps the most delicate branch of all surgery, needing for its success or justification a discriminating knowledge and experience not equalled in any set of surgical procedures.

THE PROPRIETY AND NECESSITY OF THE OPERATION MUST BE EXPLAINED.

The removal of, or the interference with, organs that have to do with the perpetuation of human life is in itself a serious business; while the responsibility of conservative procedures that shall, in some cases, preserve these where they would otherwise be lost must be looked upon as entailing great responsibility, and as requiring a nice degree of discrimination not to be attained except through great experience, special training, and much study.

Now, while the generative organs only are fundamentally dealt with in gynecology, the work of the abdominal surgeon has a far wider range. Abdominal surgery must deal with all or most of the organs having to do with the nutritive functions of the body—intestines, liver, kidneys, stomach, spleen, and pancreas. While interference or complications with some of these is more or less rare, still they enter into an estimation of the question as possible factors, and are not to be lost sight of in formulating the claims of this branch of surgery to a specialty. In dealing with these several organs for traumatic or pathologically diseased conditions, it must always be remembered that they are hidden from the eye of the patient, their functions not generally understood by the laity, and the necessity of interfering with this or that dis-

eased condition is, therefore, not properly understood. Herein arises the urgent reason for a more or less careful explanation of the propriety or necessity of an operation. This will in many cases eliminate the after-possibility of recrimination on the part of the patient, and save the surgeon a deal of trouble and the opprobrium of misrepresentation. In doubtful cases professional evidence of the surgeon's advice and opinion is to be urgently counselled.

Closely allied to the foregoing is the question of the consent of a patient or friends to an operation. A patient has the undoubted right to refuse operative treatment, however urgent or imperative the need. A patient's consent to the removal of the second ovary, or any after-conclusion that the surgeon may deem wise in the interest of the patient, that might arise during the steps of the operation and must then be acted upon, had better be obtained beforehand. A woman's ovaries or uterus are no more to be removed without her own approval or the consent of her husband, speaking generally, than should the self-same husband be castrated without his own consent. Moreover, since the friends of a patient are more likely to cavil than even the patient, it were well to explain all to them likewise.

THE PREPARATION OF THE PATIENT; THE OPERATION; THE AFTER-TREATMENT.

Having dealt with the necessity of operation and its explanation from a medico-legal standpoint, the next to be considered in the order of sequence is the special preparation of the patient. It is admitted generally by abdominal surgeons that in order to insure success in abdominal work a special preparation of the patient is necessary; this is, at least, so in all its essentials. An ignorance of the particulars of this preparation, no matter what the operator's skill in other respects, should bar him the right of attempting any abdominal operation. These details need not be entered into here; it is enough merely to refer to the important bearing they have on the mental equipment of the abdominal surgeon.

Having prepared the patient, the next step is the operation itself. Once into the abdomen the work is to be done speedily and carefully, having in view always the best interests of

the patient, not the glorification of the operator—not to operate merely for the sake of doing something, and not to unnecessarily prolong the operation lest the narcosis itself does harm. The anesthetic should be administered by an experienced and trustworthy anesthetizer. It may sometimes be—nay, often is—necessary to carry the operation beyond the lines marked out prior to opening the abdomen, as I have previously hinted. Such being the case, it is especially to be urged that the operator hold this fact always in mind, and have provisional permission to extend the operation as far as in his judgment the best interests of the patient are subserved. Now, while an extension of a proposed operation may certainly be justifiable in the interests of the patient, the extreme of this proposition comes up in the right of a woman to refuse operation even to save her life—as, for example, in puerperal peritonitis. The law may say that suicide is improper when attempted by violence, yet it will not interpose and compel the consent of a patient to an operation to save life. Even if it should or could do so, no surgeon would be willing to operate under circumstances where such a contributing influence to the success of the operation as the cheerful assent of the patient would be lost. But if voluntary suicide is wrong, enforced suicide is much more so. A woman may be urgent in her demands for relief, while her husband perversely refuses his consent to surgical interference. Though the wife may possess the legal right to insist upon an operation, the husband's perverseness is among the most serious obstacles to contend with. Here, if anywhere, the law should interfere and compel the consent of the husband to permit his wife to exercise her own judgment in deciding, under expert advice, upon steps necessary to save her life. A man may with as much reason be justified in preventing assistance to his wife in rescuing her from his burning house, as to interfere with her personal prerogative in deciding any other question in which her life is involved. A similar set of questions are to be considered with reference to minors and guardians, and parents and children.

With the operation completed, the after-treatment next claims consideration. If special training is required to prepare the patient properly as well as to do the operation, it is

equally necessary to enforce a special technique in the after-treatment. It is not sufficient that a trustworthy nurse who has had special training be left in charge; the surgeon himself must not only know what is to be done, but he must also do much of the work with his own hands. Herein consists the danger of grafting new methods on to old ideas. To illustrate: Opium was the fundamental, next to the knife, of all ancient surgery. A surgeon would quite as soon have thought of doing an operation with his finger nails as to have omitted, in the after-management, the use of morphia or an opium suppository. Now, if any one thing has been shown to be on the average dangerous in this branch of surgery, it is the use of opium in any form. That the older men, as a rule, find it difficult to bring themselves to an understanding of this fact, is not strange; but in so far as they are unable to resist the temptation to administer opium, by just that much is their incompetency to manage these cases to be measured.

The like is true of the intra-abdominal application of chemical solutions, which are, under the misnomer "antiseptics," but too generally merely irritants. The idea of Listerism must not be carried chemically into the abdomen, if we would escape complications otherwise to be eliminated. Over-refinement is as dangerous in its way as too little refinement.

So, after the operation, it is to be insisted upon that unless the surgeon is accorded absolute control of the patient, even to the point of making the family physician merely an agent in accomplishing what, in his judgment, is required from an operative standpoint for the patient's welfare, no responsibility as to results can be assumed. Indeed, it is best to have such understanding previous to an operation; and if there is demurring, operation should be refused. When a surgeon is chosen to do an abdominal operation of any kind whatever, it should be done with a full confidence in his ability to manage the case from its inception to its completion, and interference with his wishes or directions should not for a moment be thought of or tolerated. If the results then are not satisfactory, from bad behavior on the part of the patient, the friends, or the attending physician, the operator is not responsible.

An ethical question may arise in this relation in case, after

the operation, the patient desires to discharge the attending physician and retain the services of the surgeon who has been called to do the operation. This would place the surgeon in the position of being accused of sacrificing the patient to the "code" if he should refuse to attend, and at the same time subjects him to the criticism of professional thievery if he continues in charge of the case. Since these refinements would scarcely serve one in a court of law, this point should be thoroughly explained to the patient previous to the operation, and the understanding reached that the surgeon for the time being accepts charge of the case simply as the pilot who steers the vessel through dangerous waters, to resign as soon as she has reached and safely passed the danger line. On the other hand, operations for incompetent men who refuse after-assistance, although incompetent to take intelligent care of the patients themselves, should be avoided; as should likewise operations in which a man, with no experience whatever, seeks the assistance of a competent operator in order to have the name of operating. In these cases, if the patient recovers the "assistant" gets no credit; if the patient dies he gets all the blame.

HOSPITAL TREATMENT.

The hospital treatment of abdominal cases needs some elucidation. As a rule a general hospital is not an ideal place in which to open the abdomen, yet it is usually equipped with many conveniences that facilitate the work for the surgeon, and so he operates there often on that account. Private hospitals are less objectionable, and many such are without reproach in this regard. The technique of that management which is to-day conceded to be the best is little understood, speaking generally, by the physician in whose charge these cases have been previously; hence the great tendency to seek the shelter of either the public or private hospitals. Such being the case, it is well to take cognizance here of the fact that unjust strictures often arise from ignorant criticism of the management of individual cases in hospital, and a feeling occasionally is excited both against the hospital and the surgeons connected with it. This was lately illustrated in the trial of a prominent operator in the State of New York upon an indictment for manslaughter. A woman

who had been operated upon at the defendant's private hospital desired to go home on the fourth or fifth day; her friends co-operated with her in the desire and actually did so remove her. She died of septic peritonitis soon afterward, hence the indictment and trial. It may be proper to add that a prominent newspaper, hitherto of reputable standing, lent its influence to accomplish the ruin of this surgeon, thus compromising the good name of legitimate journalism. The surgeon happily was vindicated by the court and jury, but the lesson to be drawn from the case is that under no circumstances should a patient be removed from the place where the operation was done until convalescence or cure is established.

THE TRANSPORTATION OF CRITICAL CASES.

This brings me to remark that the removal of patients who are suffering from peritonitis, ruptured tubal pregnancy, gunshot or stab wounds of the abdomen, and other critical conditions or injuries, may well receive the attention of the abdominal surgeon; for they often require transportation to more convenient and healthful environs before operation. If this be not done with care and with due regard to the particular disease or injury involved, it may exert an abiding influence for harm upon a subsequent operation. Our entire ambulance system may, therefore, be regarded with a jealous eye by the abdominal surgeon, and when possible he should superintend in person the removal of cases that he proposes to operate upon.

There are many other important questions that have an intimate relationship to the medico-legal status of the abdominal surgeon—*e.g.*, the operation for irregular practitioners, operating at a distance from home and leaving incompetent persons in charge, etc.—of which I cannot now speak.

THE AFTER-CARE OF SPECIMENS.

As a last consideration in this group of thoughts, therefore, I desire to bring to the notice of the Section the necessity of carefully guarding the specimens removed. It is a well-known fact that after a growth has been preserved in alcohol it becomes distorted, decreases in size, and that the original lesion for which it was removed is often unrecognizable. If

a specimen of this sort should fall into the hands of an ignorant patient, one capable of being wrought upon by a malevolent medical or surgical "brother"—Heaven save the name! —untold mischief may result. There is yet a feeling rife in the bosoms of some operators that they alone must hold majestic sway of the world's operations, and that any one who also attempts to do the work in which they are engaged must be put down at all hazards. They are members of our medical societies, they are usually subscribers to the "code," are generally prominent in the affairs of church, and are yet little better than professional blackmailers. They scruple at nothing to cast disrepute and discredit upon other men's work, stooping even to get hold of specimens to misrepresent them. The spirit that applied to Atlee the title of "the greatest rascal in Philadelphia" still stalks abroad, and that which prophesied the penitentiary and a shaven head for another of Philadelphia's famous operators is still to be recognized and to be scotched. I deem it of the first importance that specimens should not pass into the hands of patients, and that they should be either kept strictly away from the laity, or, if that is impossible, destroyed.

CONCLUSIONS.

The factors, then, that enter into the inquiry, "What is the medico-legal status of the abdominal surgeon?" and that largely determine that status, may be grouped and summarized as follows:

1. *The Operator's Ability.*—What has been his apprenticeship, what his surgical aptitude, his experience, his fertility of resource—in short, speaking surgically, his abdominal instinct?

2. *The Propriety of the Operation.*—Has this been established beyond reasonable doubt, and have its necessity and dangers been fully explained to the patient and his or her friends; or, in case of minors, to guardians or parents?

3. *The Consent of the Patient.*—Has this been obtained in a legal and binding manner, and have the near friends also consented; and in case of minors have the parents or guardians legally consented, and is there indubitable proof of this?

4. *The Preparation of the Patient.*—Has this been adequately done in accordance with the modern rules of abdominal surgery?

5. *The Anesthetic.*—What form of this was used, and was the anesthetizer experienced in the administration of anesthetics; were the proper precautions taken to determine the relative safety to the patient of the anesthetic chosen?

6. *The Operation.*—Has it been performed with that skill that the present light of the science would demand?

7. *The After-Treatment.*—Was this in all its details scrupulously and zealously carried out under the eye of the operator? Was a skilled nurse employed, who faithfully attended to her duties? Did the attending physician yield absolute control to the operator?

8. *The Environment.*—Was the operation done in hospital, public or private, or at the home of the patient?

9. *The Transportation of the Patient.*—Was the patient removed prior or subsequent to the operation? If so, under what circumstances? Was it with the advice and consent of the surgeon and under his superintendence?

On a trial for manslaughter resultant from a disastrous abdominal operation, some or all of these questions would form proper subjects for inquiry by the court, and therefore appear germane to the purposes of this discussion. Doubtless others will be dealt with by the authors who jointly appear in this debate. I will therefore conclude what I have to say in a few brief sentences bearing on the rights of patients and operators:

A patient has the right to refuse operative treatment, however urgent or imperative the need.

After operation the patient has the right to refuse further attendance or treatment from a physician or surgeon who may have been in charge, either as operator or otherwise.

The patient, if sane, has the right to be removed at any time she may elect. Her actions or movements, her acceptance or non-acceptance of a course of treatment by her physician, are matters of her own option, over which he can exercise no legal control. She can go counter to or in accord with his advice, as she may will. He cannot exercise over her person any authority beyond that to which she consents.

For any act of duress the physician could be held legally liable.

In the matter of the husband, his legal control over the wife would not prevent her from submitting to surgical or other treatment at the hands of a physician of her own choice, but with her consent the husband would have the right to direct or control her movements in the face of any protest of the physician.

The same principles in a modified form apply in cases where there are guardians.

From the foregoing it will be seen that the physician is absolutely helpless in all cases that he cannot reach and control by moral suasion. This places the abdominal surgeon at a peculiarly trying disadvantage, for he is in the rather anomalous position of incurring grave legal responsibilities in cases where he has few legal rights or privileges.

284 Franklin Street.
