

EDITORIAL

The responsibility of clinical practice

A recent article published in *AAOS Now* dealt with burnout as a result of stress in the work place in American orthopaedic surgeons. It prompted me to ponder on the weight of responsibility we carry on a day-to-day basis. Unless you are unrealistically detached, every surgeon has experienced that chilling feeling you get when things have not gone according to plan. A finger remains ivory white after a Dupuytren's contracture release, or the foot suffers a similar fate after tourniquet release, or perhaps the post-operative radiograph looks alarmingly unlike what had been intended by the procedure. These events produce laser-like burns to the brain, etching out indelible monuments like grave stones, until the graveyard is full. These events age us. They burn us out. Our concern and involvement in our patients' well-being is what makes us the professionals that patients expect us to be. While it can be detrimental, paralysing even, to the health caregiver to be too involved in patients' outcomes, it is critical that we remain responsive to and responsible for providing holistic and empathic care throughout the cycle of treatment for any patient.

From the patient's point of view, there is an expectation that once you have embarked on a course of action, you will provide continuous service until completion. Their commitment to, and dependence on, the chosen practitioner is complete. The nature of clinical practice is such that patients more often than not transfer the decision-making role to the treating doctor. After all, 'Doctor knows best'! This is particularly pertinent in the case of surgery. Despite the laborious and hugely flawed process of informed consent, and despite the good intentions of the ethicists to get this right, the process of giving consent for interventions relies heavily on trust and in many ways remains paternalistic. Under current circumstances in South Africa, and many other parts of the world, the complexities of medicine are too great for patients to achieve a meaningful grasp of the issues at stake when the two parties exchange information. Considerable responsibility is thus placed on the doctor to act with integrity and in the best interests of the patient.

We have been taught that whenever a doctor assumes the role of caregiver, that doctor will be responsible for whatever happens, until such time that the patient's care has been transferred to the care of another doctor. The term responsibility as used here implies accountability rather than blame. In earlier years when the fragmentation of medical knowledge had not yet yielded the technical super-specialists of today, the continuity of overall care seldom broke down. Today however, care of patients may fall between two stools, with each doctor dealing with a specific area of expertise in isolation. It may happen that no one in a multidisciplinary team views themselves as the primary caregiver, or being capable of giving advice or treatment in an area not deemed their own. This classically happens with patients in an ICU. Is it the physician or the surgeon? Who do the patient's relatives turn to for advice and information? Who is correct when different opinions are expressed? It's so easy to claim 'beyond my scope of practice' as a 'defence'!

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The practice of medicine and acting as the caregiver can be compared to an athletics relay race. The medical intervention is the race and the surgeon is the runner who carries a baton of responsibility for the patient's care. During the race, somebody and only one body, holds the baton at any given time. The doctor who 'holds the baton' is responsible and answerable for all the decisions, deliberations and communications until such time as the patient is formally referred on or handed over to the care of a different physician. The passing of the baton involves two hands, the passer and the receiver. There is an equally strong responsibility on the receiver. Whoever receives a patient must know from whom and where and why the patient came, and must acknowledge the receipt of the patient, when not referred in person, from the previous caregiver.

This analogy is useful and adequately addresses the 'legal' and ethical requirements of the practitioner; it does not, however, address the loss and disconnection experienced by the patient when being referred on to another practitioner. The relationship of trust established between patient and doctor will easily suffer when, in midstream, the patient is handed over for further treatment, especially of a complication, to another caregiver. Not that this should not happen, as surely it may be in the best interests of the patient, but great care must be taken to ensure that the patient and family, often at a time of greatest need, do not feel they have been 'left in the lurch'. It is frequently this perception of abandonment when a problem occurs that fosters the kind of resentment which culminates in a telephone call to the offices of the Medical Protection Society. Don't walk away, remain concerned and involved.

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Advances in medical practice have compartmentalised us to the extent that it is tempting if not 'legitimising' us to act as technicians. We are not technicians. We have to maintain knowledge in areas of clinical practice not our own. We need to retain a broad base of knowledge so that we can fulfil the role as professionals entrusted to us by our patients. We are professionals who have an understanding of suffering and have been afforded the privilege of providing appropriate support, whatever that may be, to others.

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*Johan Walters
Department of Orthopaedic Surgery
University of Cape Town*

