

## Ethical Centralization of High-risk Surgery Requires Racial and Economic Justice

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An ethical strategy for centralization

### **Ethical Centralization of High-risk Surgery Requires Racial and Economic Justice**

Medicine is at its core a moral pursuit driven largely by the duty to do good and avoid harm. This promise is contained in the Hippocratic Oath, which every physician in some form professes. For surgeons, this duty has motivated research into how to provide patients with the highest-quality surgical care so as to assure the best outcomes (do good), and reduce deaths and complications (avoid harm). Multiple studies have demonstrated that hospital and surgeon volumes are positively correlated with operative outcome. Patients who undergo complex surgery at higher-volume hospitals, performed by higher-volume surgeons, have a lower risk of death and fewer complications.<sup>1,2</sup> This association has been consistently demonstrated for many different operations, most notably high-risk, complex cancer surgery.<sup>3</sup>

#### **The Fallacy of Patient Autonomy in Centralization of High-risk Surgery**

Medicine is also driven by the ethical principle of justice, the precept that there is one standard of care for all, and that all humans should be treated equivalently. Considering together the duties to do good, avoid harm, and treat everyone equally, a proposition has been to centralize high-risk, complex surgery. Under this model, patients would have their operations at centralized, high-quality medical centers, performed by high-quality surgeons. One consequence of this drive toward centralization was the “Take the Volume Pledge” campaign wherein three academic medical centers pledged to restrict the performance of ten specified operations to hospitals and by surgeons who exceeded a minimum threshold.<sup>4</sup>

While arguments for centralization may be based on a desire to provide equally high-quality surgical care to everyone, centralization alone does not fulfill the ethical obligation. This model fails morally because it emphasizes the duty to do good and avoid harm at the expense of equal access and the freedom of patients to choose where to have their complex cancer operations. Centralization alone does not achieve justice nor respect patient autonomy. A morally acceptable model would ensure that high-quality surgery is not only centralized, but that it is also equally available to everyone who desires it. Only then could a patient truly make an autonomous decision whether to have surgery at a local low-volume medical center, or travel to a centralized high-volume medical center.

One of the often-cited disincentives to centralization is the distance many patients would need to travel to reach a high-volume medical center.<sup>5</sup> A proposed work-around places the onus on the patient to decide whether to have their operation at a low-volume, and presumably lower-quality hospital closer to their home, or travel to the centralized high-volume, higher-quality hospital, which may be several hours away.<sup>6</sup> While this argument ostensibly upholds the ethical principle of patient autonomy by letting patients make the decision for themselves, studies show that were it not for social and economic barriers, 92% of patients would elect to travel for operations associated with superior safety or oncologic outcomes.<sup>7</sup> These barriers can be rather easily overcome by free transportation, parking, pet care, and lodging for visitors.<sup>7</sup> This suggests that socioeconomic barriers may prevent patients from exercising full autonomy in decision making when it comes to choosing to travel far distances for their cancer care. Patients placed in this catch-22 situation—having to decide between low-quality surgery or economic and social hardship—suffer a loss, rather than actualization, of their autonomy.

### **The Failure of Centralization to Achieve Racial and Economic Justice**

While increased travel burden has been extensively discussed as a barrier to the accessibility of high-quality care for complex surgery, racial barriers have been largely ignored in the centralization debate. This is in spite of the overwhelming data demonstrating racial disparities in surgical outcomes, particularly complex cancer surgery.<sup>8</sup> For instance, Black patients with esophageal cancer (EC) are less likely to be seen by a surgeon, are less likely to be offered cancer-directed surgery, and when offered surgery, have worse outcomes than White patients undergoing similar cancer-directed surgery.<sup>9</sup>

One explanation for these findings is that Black patients with EC are more likely to have their care delivered at low-volume centers, where outcomes are worse, and where inexperienced surgeons may be disinclined to perform complex cancer surgery.<sup>9</sup> This is supported by the finding that Black patients, the uninsured, and those patients with Medicaid are more likely to undergo complex cancer surgery at low-volume hospitals.<sup>10</sup> Barriers such as travel burden, economic disadvantage, and race must be removed so that all patients have access to high-quality cancer care. Perhaps it is revealing that countries such as the Netherlands, in which centralization of cancer care has led to improved outcomes, also provide universal healthcare.<sup>6</sup>

### **Making Centralization Ethical Through Racial and Economic Access**

It is time for medical centers with excellent outcomes for complex cancer surgery and track records in providing comprehensive longitudinal care to thwart the “Volume Pledge” and instead take an “Access Pledge.” As with the “Take the Volume Pledge,” leadership would begin with the heads of large academic medical centers. By making this pledge, medical centers would promise to accommodate

anyone anywhere who wanted to come to their center for complex surgery. This moral imperative to provide access would build on the successful patient recruitment programs already established at centers that provide high-quality longitudinal cancer care. These centers have experience in facilitating patient access to certain procedures—such as those that are revenue generating and those that are part of clinical studies—by establishing a referral base, as well as direct-to-consumer marketing. These same tools can be used to attract Black patients, Medicaid patients, the uninsured, and patients living in remote areas. Applying these programs to all candidates of complex cancer procedures would help eliminate barriers that restrict patients' access to high-quality surgery.

In addition, culturally and racially appropriate navigators would build relationships with patients and help address their well-justified distrust of medical facilities and providers. Black and poor patients report being ignored and treated as unintelligent as common experiences. By providing navigators, medical centers would go a long way toward addressing these patients' concerns as well as their emotional and spiritual needs. Finally, navigators would facilitate the hospital-to-home transition, making sure that patients have adequate housing, nutrition, and in-home assistance to return to.

Each center's success at fulfilling the "Access Pledge" must be measured by short- and long-term metrics. Medical centers would begin with a baseline assessment of the number of Black, uninsured, and Medicaid patients receiving complex cancer operations and longitudinal cancer care at their facilities. The centers would then set annual benchmarks for improved access. Much like the quality metrics reported to Leapfrog and Medicare, these data would be publicly reported. Long-term assessments would need to demonstrate improved cancer survival among Black, Medicaid and uninsured patients, a certain outcome of improved access to high-quality, longitudinal complex cancer care. Such a commitment is a concrete act of racial and social justice and goes a long way in making reparation for past, and perhaps present, racial and social injustices.

Equal-access centralization embodies the ethical pillars of medicine: respecting patients' autonomy, doing good and avoiding harm, and guaranteeing that everyone is treated equally. Autonomy is incomplete if a patient's freedom to choose is stymied by socioeconomic barriers. Justice is not served if Black patients, Medicaid patients, and the uninsured do not have true access to the same quality of surgical care as White patients, Medicare patients, and the privately insured. Now is the time to do the morally right and just thing: guarantee that everyone has equal access to high-quality surgical care.

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