



Rules: abide or abandon?

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Should we follow the rules or break them?

It is common sense that we must follow the rules. However, there is also such a saying that “rules are set to break”. Only by daring to break the existing rules can we seek innovation and change in our life and work.

Indeed, unreasonable rules must be abandoned to establish new rules that fit realistic situations. However, most rules are properly established; thus, they must be obeyed. In particular, rules in the medical field should be strictly obeyed.

Medical guidelines are the summation of many authoritative medical practitioners after years of clinical practice and practice. Following medical guidelines can improve the efficiency and efficacy of diagnosis and treatment (1). Proper diagnosis and treatment are not only relevant for specific diseases but also important for patients, families, and even society. Doctors should not only focus on the outcome but also consider the side effects, adverse reactions, and lawful rights of patients. As biological sciences develop, innovative research usually encounters ethical issues; thus, medical practitioners must follow the relevant standards to properly address these ethical issues.

It was a cold winter night in the early 1980s, and I was an intern in a local hospital. On my duty shift, there was a car accident in the middle of the night. The patient was in hemorrhagic shock, with massive non-clotting bloody ascites drawn from abdominal paracentesis. The initial diagnosis was “intra-abdominal bleeding, liver, and spleen rupture”. Due to the limited resources of the local hospital at that time, the patient was rushed to the operating room for emergency exploratory laparotomy after only checking his blood type. When we opened his abdomen, we found that there was little leaking blood in the abdominal cavity, and

the liver and spleen were intact. The bleeding actually came from the retroperitoneum. Further exploration eventually revealed that the right kidney rupture as the bleeding source. Therefore, we had to wait at the operating table for support from a urological surgeon. Due to the poor surgical view from an inappropriate incision and insufficient muscle relaxation, right nephrectomy was an extremely challenging operation to perform. Moreover, the right kidney was severely damaged as the renal hilum was lacerated. After the operation, as the intern, I was routinely responsible for placing a ureteral catheter. Once the catheter was placed, cola-colored urine was expelled. I was immediately overwhelmed by regrets; if I had placed the ureteral catheter before surgery, then the kidney injury would have been correctly diagnosed, thereby saving valuable time for the appropriate surgical incision to have been made and the urologist to arrive sooner. The next day, after hearing me recount the story, the chief of our department said: “the experience that we drew upon from many years and failed cases was that we should routinely perform blood, urine, and stool tests after hospital admissions”. After decades, his words are still engraved deeply in my mind.

Virtue is far more precious than dexterity. The fundamental requirement of medical workers and the core of medical humanist education are awe of life (2). Doctors must not jeopardize the health or lives of patients to test new therapies. Justifying untested methods as “revolutionary” and arbitrarily deciding the patient’s treatment plan according to one’s own experiences, preferences, or even interests is cruel, and could result in a disaster if the decision disobeys scientific principles. The bottom line of the medical industry is to follow the rules; thus, sacrificing patients’ wellbeing to simply challenge the

rules is strongly discouraged.

Examples of adverse consequences caused by violating rules abound in real life. In the early days, many hospitals did not set up sub-specialties in their departments, and “general surgery” often covered gastrointestinal, hepatobiliary, pancreatic, vascular, thyroid, breast surgery, and other specialties. At one time, a doctor who specialized in vascular surgery and performed a gastrectomy for one of his relatives. He assumed that the method and thread for vascular anastomosis was the best and applied these methods for gastrointestinal anastomosis. However, he did not realize that the submucosal layer of the stomach contained abundant blood vessels. To stop the bleeding, submucosal blood vessels should be ligated followed by continuous locking sutures. Additionally, the vascular thread was too smooth to ligate tightly. As a result, the patient experienced active bleeding from the gastrointestinal anastomosis after the operation and had to undergo another operation to stop the bleeding. Severe medical incidents as a result of rule violations still persist in the modern era. One hospital failed to follow management protocols for nosocomial infection causing 69 patients to be infected with hepatitis C (3).

While it is necessary to instate reliable rules, ensuring that people follow the rules is more critical. We should not only formulate scientific diagnosis and treatment guidelines but also foster the compliance of medical staff. Not everyone is capable of challenging medical guidelines. Some people may eschew guidelines to justify their mishandled medical behaviors; in fact, these individuals often do not have the qualifications or abilities to challenge these guidelines at all. If every medical worker abides by the rules, then the standards of the medical industry will improve.

Rules are established for certain purposes. As time passes, some rules may no longer be suitable and thus should be amended. Of course, these revisions should not be arbitrarily made, and instead should only be modified after careful consideration of recent discoveries and evidence. The revision of the criteria for liver cancer transplantation exemplifies this condition.

The “Milan criteria” was the earliest rule for liver transplantation to treat liver cancer (4). However, in clinical practice, although a considerable number of patients had a good postoperative survival rate (5), they were rejected for liver transplantation by this strict standard and thus lost their opportunity for a radical cure. Liver transplantation faces the following dilemma: “wasting” a donor liver on a patient whose liver cancer may relapse or rejecting a liver versus a cancer patient who may be cured by a donated liver.

Either direction would be a loss. Therefore, scholars began studying liver transplantation based on the Milan criteria in mainland China. China has a large population of patients with liver cancer, mostly due to hepatitis B cirrhosis. Many patients are already in the middle or late stages of liver cancer at the time of diagnosis, so conventional liver resection is hindered by a low complete resection rate and a high recurrence rate. Liver transplantation may be these patients’ only hope. In this context, Chinese scholars proposed the “Shanghai criteria” and “Hangzhou criteria” based on evidence from a substantial amount of clinical data and research (6,7). These new standards safely expanded the Milan criteria and allowed more liver cancer patients to receive liver transplants at a long-term survival rate similar to that of patients who meet the Milan criteria.

If pre-existing rules are unsuitable, then we should modify the rules to some degree. The intention of breaking the rules is to go beyond the existing boundaries of thinking and to bring forth new concepts to establish better rules. Being able to follow the rules is the premise of revising rules, and the new rules will also face future challenges.

The human body is fragile, so treatment, especially of the invasive kind, should be moderated and not cause additional harm. The scalpel is light but carries the weight of life. As a doctor, and especially as a surgeon, our daily routine is restless and thus it is difficult to maintain a harmonious balance. Above all, better outcomes for patients can be ensured by abiding by the rules.

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