Medicolegal issues in surgery

The fundamental elements of medical law, duty of care including informed consent and causation, are discussed, with specific emphasis on how these relate to surgeons and surgical practice.

Duty of care

Duty of care for surgeons is an objective test (the Bolam test), a test of reasonableness [Bolam v Friern Hospital Management Committee 1957]. The acts or omissions of the surgeon must be supported by a 'reasonable and responsible' group of surgeons; this can be a small group, and it does not need to be a majority view. If only 5–10% of surgeons support the decision there would be no breach. All aspects of clinical care including diagnosis, consent and treatment are subject to the Bolam test. The Bolam test permits clinical judgement. Clinical judgement is ambiguous – some mistakes could be made despite good clinical judgement, in other cases clinical judgement may be unacceptably poor. Surgical acts or admissions must have a logical basis. Surgical decisions must be 'responsible, reasonable, respectable and logical'.

All surgeons must keep up to date. If a well-publicized randomized controlled trial has demonstrated superiority of one treatment over another, surgeons should rapidly adopt the superior technique. Guidance from the National Institute of Health and Care Excellence (NICE) should usually be followed.

Emergency care at the roadside can be to a lower standard than care in hospital (Todd, 2014a). Where a doctor is working under 'battle conditions' or where an emergency overwhelms resources the standard of care will be adjusted to those special circumstances. Inexperienced doctors cannot perform to a lower standard than more experienced colleagues, in part because their duty of care is to seek help from more experienced colleagues (Todd, 2014a).

Assess your practice – is your practice similar to that of your peers? Are you in disagreement with colleagues in respect of your practice? Would it be easy to get one of your colleagues to support your practice? If the answers are yes then you are probably doing the right thing. If any answer is no you should consider that area of your practice carefully.

Causation

Causation is established if there is a causal link between a breach of duty of care and harm to the patient. The primary pathology, not negligence, is the commonest cause of a poor outcome. The causation test is all or nothing. The primary test is the 'but for' test: whether, but for the breach of duty, the harm would have occurred or not, on a balance of probabilities. If the probability of the breach causing the harm is 51% or better, causation is established; if not causation fails. If there was a chance of a better outcome but the chance is <51%, causation fails.

If there is one cause of the final harm and it is not possible to quantify the effect of the different causes, causation can be established if one of the causes materially contributed to the final harm. For example, a patient underwent endoscopic removal of common bile duct stones, there was haemorrhage which was negligently managed but there was also non-negligent pancreatitis [Bailey v Ministry of Defence 2008]. The combination of the two causes resulted in cardiac arrest and hypoxic brain damage. Each materially contributed to hypoxic brain damage establishing causation.

If a material risk of surgery is not explained to a patient and that risk eventuates, causation can succeed on the basis of public policy and patient autonomy [Chester v Afshar 2004].

A patient was to undergo spinal surgery by one surgeon, and her care was transferred to another surgeon at the last minute. Postoperatively she had cauda equina syndrome. The Court found that if she had known in advance of the surgery that her care had been transferred to the second surgeon she would have asked to stay with the first surgeon and cauda equina syndrome would not have occurred. In these target-driven days surgeons are often asked to take on waiting list cases. The new surgeon must see the patient well in advance of surgery, explain the change of circumstance and get specific consent for the change in surgeon.

The chain of causation can be broken by a new intervening event (novus actus interveniens). A man suffered injury to the low back caused by a breach of duty of care and his earning capacity was reduced by 50%. He subsequently developed a wholly unrelated spinal condition which completely prevented his ability to work. The new spinal condition broke the chain of causation, i.e. after the second event he would not have been able to work anyway. He therefore succeeded only in respect of the losses between the first injury and the second event.

Legal causation is a factual, casual connection between a breach of duty of care and injury to a patient. The basic test is the but for test but under specific circumstances causation can be established in other ways in the interest of justice (Todd, 2014b).

Informed consent

Informed consent is a specific duty of care. Consent should be taken by the surgeon undertaking the operation or somebody who is capable of carrying out the operation (General Medical Council, 2008). Consent must be given in writing. The risks, benefits and alternatives to surgery need to be explained sufficiently far ahead of the operation that the patient has time to reflect upon those issues, the so-called 'cooling off' period. Material risks of surgery explained on the day of surgery do not amount to informed consent.

Adults have capacity to consent to surgical procedures unless it is known that they lack capacity. Patients have an absolute right to accept or refuse surgery; the decision to

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refuse treatment does not have to be sensible, rational or well considered.

Incapacity may be temporary, for example an unconscious patient requiring emergency surgery or where there is an unexpected finding intraoperatively. Surgeons act in the best interests of the patient. Surgery is limited to what is required in that emergency operation. If there are options that can wait and be discussed after reversal of the anaesthetic then that should be done. If in the course of orthopaedic surgery there was the option of amputating a limb or attempting some form of limb-saving procedure and there was no harm in delaying that decision, the patient should be woken up and discussions had with the patient about the options. There may be permanent incapacity to consent to a surgical procedure and views are taken in the best interests of the patient. Under the Family Law Reform Act 1969, children achieve capacity to consent at the age of 16 years. Children under the age of 16 years can have sufficient knowledge to give consent (Gillick competence) [Gillick v West Norfolk and Wisbeck Area Health Authority 1985]. Before that point authority to consent lies with the parents.

Patients must understand the nature of the treatment, its risks, benefits and any alternatives. Surgeons must explain all relevant matters in terms that the patient can understand. Medical jargon should not be used. The duty is to ensure that the patient has understood the relevant information. I recommend that all surgeons read the judgment in Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland)[2015] (or, as a substitute, my letter; Todd, 2016) which is a detailed Judgment from the Supreme Court in respect of the legal requirements for consent.

Conclusions

It is imperative that surgeons understand their legal requirements in respect of the consenting process. It is the surgeon's duty to explain why surgery has been recommended, what alternatives there are to the proposed operation and what the material risks and benefits of surgery are. The discussion should be in terms the patient can understand and the surgeon should ensure that the patient has understood the discussion. The purpose is to allow the patient to make an autonomous decision as to whether he/she wishes to have this surgery at this time. The wise surgeon will record all of this. **BJHM**

Bailey v Ministry of Defence [2008] EWCA Civ 883
Bolam v Friern Hospital Management Committee [1957] 1 WLR 583
Chester v Afshar [2004] UKHL 41

KEY POINTS

- Duty of care is the reasonable and responsible doctor (Bolam) test. There is no breach if you can show that other doctors, acting reasonably, would have acted in the same way.
- Causation is established if the breach caused harm on a balance of probabilities (51% or more) or if the breach materially contributed to the poor outcome.
- Consent is subject to explicit rules which must be understood, used and recorded.

General Medical Council. Consent: Patients and doctors making decisions together. 2008. (accessed 15 May 2018) https://www.gmc-uk.org/-/media/documents/consent---english-0617_pdf-48903482.pdf
Gillick v West Norfolk and Wisbeck Area Health Authority [1985] 3 All ER 402 HL
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