14 Ethics and law in surgical practice

- ADUL TS PEOPLE 18 AND ABOVE
- CHILDREN AND YOUNG PEOPLE
- CONCLUSION
- CONFIDENTIALITY BALANCED AGAINST THE RISK OF SERIO
- CONFIDENTIALITY BALANCED AGAINST THE RISK OF SERIOUS
- DECISIONS IN THE BEST INTERESTS OF INCAPACITATED P
- DECISIONS IN THE BEST INTERESTS OF INCAPACITATED PATIENTS
- DISCLOSURE PRIOR TO CONSENT
- DO NOT ATTEMPT RESUSCITATION
- DOCTRINE OF DOUBLE EFFECT
- DUTY OF CANDOUR
- FURTHER PRACTICAL APPLICATIONS OF CLINICAL LAW IN
- HARM
- INCAPACITY
- Introduction
- Learning objectives
- REFERENCES
- RESEARCH
- RESPECT FOR AUTONOMY
- SHARING INFORMATION WITH THE POLICE
- STANDARDS OF EXCELLENCE
- SURGICAL PRACTICE
- THE ROLE OF THE COURT

- TRANSPLANTATION

ADUL TS PEOPLE 18 AND ABOVE

ADUL TS: PEOPLE 18 AND ABOVE

Capacity in adults is presumed, but this may be challenged on the basis of a reasonable belief that they are incapacitated. Incapacity in England and Wales is established (in those aged 16 years and over) by a two-stage test. First, the func tional test for incapacity is employed: is the person unable to make the relevant decision? If the y are able to make the deci sion, the presumption of capacity endures. If they are unable to make the decision, then the second (diagnostic) stage must be employed: is there an impairment or disturbance of the mind or the brain? If so, the tw o stages in combination result out and the entire structure of this area of law is set out in the Mental Capacity Act (MCA) 2005 Code of Practice. This is essential reading, and m ust be available to clinicians in all UK National Health Service (NHS) hospitals. Capacity is not synonymous with (Gillick) competence, but that is a topic for further reading. Capacity and incapacity are the significant binary measure by which the capability of young people and adults is judged, but be aware of the notion of the vulnera - ble patient, who may possess capacity but risks falling victim to predatory actors. Capacity may be erased by psychiatric illness, but even in circumstances where patients have been legally detained for compulsory psychiatric care it by no means follows that such patients are unable to provide consent for surgical care. Their capacity should be presumed and consent should be sought. Only if it is established that such patients also (in addition to or as a consequence of their mental illness) lack capacity to provide consent for surgery can therapy then proceed in their best interests. However, if possible postpone treatment until, as a result of their psychiatric care, patients become able either to consent or to refuse. If this timely recovery is not predicted, then legal steps using the authority of the MCA 2005 must be taken to make elective surgery lawful. It would be unlikely that treatment for physical illness could be authorised under the Mental Health Act 1983. As with children, respect should always be shown for as much autonomy as is present.
ADUL TS: PEOPLE 18 AND ABOVE

Capacity in adults is presumed, but this may be challenged on the basis of a reasonable belief that they are incapacitated. Incapacity in England and Wales is established (in those aged 16 years and over) by a two-stage test. First, the func tional test for incapacity is employed: is the person unable to make the relevant decision? If the y are able to make the deci sion, the presumption of capacity endures. If they are unable to make the decision, then the second (diagnostic) stage must be employed: is there an impairment or disturbance of the mind or the brain? If so, the tw o stages in combination result out and the entire structure of this area of law is set out in the Mental Capacity Act (MCA) 2005 Code of Practice. This is essential reading, and m ust be available to clinicians in all UK National Health Service (NHS) hospitals. Capacity is not synonymous with (Gillick) competence, but that is a topic for further reading. Capacity and incapacity are the significant binary measure by which the capability of young people and adults is judged, but be aware of the notion of the

vulnera - ble patient, who may possess capacity but risks falling victim to predatory actors. Capacity may be erased by psychiatric illness, but even in circumstances where patients have been legally detained for compulsory psychiatric care it by no means follows that such patients are unable to provide consent for surgical care. Their capacity should be presumed and consent should be sought. Only if it is established that such patients also (in addition to or as a consequence of their mental illness) lack capacity to provide consent for surgery can therapy then proceed in their best interests. However, if possible postpone treatment until, as a result of their psychiatric care, patients become able either to consent or to refuse. If this timely recovery is not predicted, then legal steps using the authority of the MCA 2005 must be taken to make elective surgery lawful. It would be unlikely that treatment for physical illness could be authorised under the Mental Health Act 1983. As with children, respect should always be shown for as much autonomy as is present.
ADUL TS: PEOPLE 18 AND ABOVE

Capacity in adults is presumed, but this may be challenged on the basis of a reasonable belief that they are incapacitated. Incapacity in England and Wales is established (in those aged 16 years and over) by a two-stage test. First, the func tional test for incapacity is employed: is the person unable to make the relevant decision? If the y are able to make the deci sion, the presumption of capacity endures. If they are unable to make the decision, then the second (diagnostic) stage must be employed: is there an impairment or disturbance of the mind or the brain? If so, the tw o stages in combination result out and the entire structure of this area of law is set out in the Mental Capacity Act (MCA) 2005 Code of Practice. This is essential reading, and m ust be available to clinicians in all UK National Health Service (NHS) hospitals. Capacity is not synonymous with (Gillick) competence, but that is a topic for further reading. Capacity and incapacity are the significant binary measure by which the capability of young people and adults is judged, but be aware of the notion of the vulnera - ble patient, who may possess capacity but risks falling victim to predatory actors. Capacity may be erased by psychiatric illness, but even in circumstances where patients have been legally detained for compulsory psychiatric care it by no means follows that such patients are unable to provide consent for surgical care. Their capacity should be presumed and consent should be sought. Only if it is established that such patients also (in addition to or as a consequence of their mental illness) lack capacity to provide consent for surgery can therapy then proceed in their best interests. However, if possible postpone treatment until, as a result of their psychiatric care, patients become able either to consent or to refuse. If this timely recovery is not predicted, then legal steps using the authority of the MCA 2005 must be taken to make elective surgery lawful. It would be unlikely that treatment for physical illness could be authorised under the Mental Health Act 1983. As with children, respect should always be shown for as much autonomy as is present.

CHILDREN AND YOUNG PEOPLE

CHILDREN AND YOUNG PEOPLE

In England and Wales, a person is a child until their 18th birthday; older children are distinguished from their younger counterparts, since 16- and 17-year-olds are additionally described as ‘young people’. Citizens under 16 years are presumed incompetent, but they may rebut that presumption and establish their competence by demonstrating that they have su ffi cient maturity – intelligence to understand fully what is proposed – to make the relevant decision. Hence ‘Gillick’ competence. In the case of incompetent children (or competent children who choose to rely on a proxy), parents or someone with parental responsibility are ordinarily required to provide consent on their behalf. This said, surgeons should: /uni25CF take care to explain to children what is being surgically proposed, and why; /uni25CF always consult with children about their response; /uni25CF where possible, take the child’s views into account and note that even young children can be competent to consent to treatment provided that they can ‘pass’ the Gillick test for the decision in question; /uni25CF it is almost always appropriate, in addition, to separately discuss the treatment with their parents, although it should be noted that, if a child is Gillick competent to defend their confidential information, it should not be assumed that they wish to share this with their parents. When such Gillick competence is present, under English law , children can provide their own consent to surgical care, although they cannot unconditionally refuse it until they are 18 years old. These provisions illustrate the importance of respecting the autonomy of child patients and remembering that, for the purposes of consent to medical treatment, they may be just as capable as adults. If faced with a surgical emergency in a child of 15 for whom no consent is available for life- or limb-saving treatment, and there really is no time to seek authority from someone with parental responsibility , the child or the court, then proceed with the operation without consent. So far, in the English common law stretching back 800 years, no case has been brought to court complaining of a child’s life being saved using this doctrine of necessity . CHILDREN AND YOUNG PEOPLE

In England and Wales, a person is a child until their 18th birthday; older children are distinguished from their younger counterparts, since 16- and 17-year-olds are additionally described as ‘young people’. Citizens under 16 years are presumed incompetent, but they may rebut that presumption and establish their competence by demonstrating that they have su ffi cient maturity – intelligence to understand fully what is proposed – to make the relevant decision. Hence ‘Gillick’ competence. In the case of incompetent children (or competent children who choose to rely on a proxy), parents or someone with parental responsibility are ordinarily required to provide consent on their behalf. This said, surgeons should: /uni25CF take care to explain to children what is being surgically proposed, and why; /uni25CF always consult with children about their response; /uni25CF where possible, take the child’s views into account and note that even young children can be competent to consent to treatment provided that they can ‘pass’ the Gillick test for the decision in question;

/uni25CF it is almost always appropriate, in addition, to separately discuss the treatment with their parents, although it should be noted that, if a child is Gillick competent to defend their confidential information, it should not be assumed that they wish to share this with their parents. When such Gillick competence is present, under English law , children can provide their own consent to surgical care, although they cannot unconditionally refuse it until they are 18 years old. These provisions illustrate the importance of respecting the autonomy of child patients and remembering that, for the purposes of consent to medical treatment, they may be just as capable as adults. If faced with a surgical emergency in a child of 15 for whom no consent is available for life- or limb-saving treatment, and there really is no time to seek authority from someone with parental responsibility , the child or the court, then proceed with the operation without consent. So far, in the English common law stretching back 800 years, no case has been brought to court complaining of a child’s life being saved using this doctrine of necessity . CHILDREN AND YOUNG PEOPLE

In England and Wales, a person is a child until their 18th birthday; older children are distinguished from their younger counterparts, since 16- and 17-year-olds are additionally described as ‘young people’. Citizens under 16 years are presumed incompetent, but they may rebut that presumption and establish their competence by demonstrating that they have su ffi cient maturity – intelligence to understand fully what is proposed – to make the relevant decision. Hence ‘Gillick’ competence. In the case of incompetent children (or competent children who choose to rely on a proxy), parents or someone with parental responsibility are ordinarily required to provide consent on their behalf. This said, surgeons should: /uni25CF take care to explain to children what is being surgically proposed, and why; /uni25CF always consult with children about their response; /uni25CF where possible, take the child’s views into account and note that even young children can be competent to consent to treatment provided that they can ‘pass’ the Gillick test for the decision in question; /uni25CF it is almost always appropriate, in addition, to separately discuss the treatment with their parents, although it should be noted that, if a child is Gillick competent to defend their confidential information, it should not be assumed that they wish to share this with their parents. When such Gillick competence is present, under English law , children can provide their own consent to surgical care, although they cannot unconditionally refuse it until they are 18 years old. These provisions illustrate the importance of respecting the autonomy of child patients and remembering that, for the purposes of consent to medical treatment, they may be just as capable as adults. If faced with a surgical emergency in a child of 15 for whom no consent is available for life- or limb-saving treatment, and there really is no time to seek authority from someone with parental responsibility , the child or the court, then proceed with the operation without consent. So far, in the English common law stretching back 800 years, no case has been brought to court complaining of a child’s life being saved using this doctrine of necessity .

CONCLUSION

CONCLUSION

Surgeons have combined duties to their patients: to protect life and health and to respect autonomy , both to an acceptable - professional standard. The specific duties of surgeons are shown to follow from these: reasonable practice concerning informed consent; confidentiality; decisions not to provide, or to omit, life-sustaining care; surgical research; and the maintenance of good professional standards. The final duty of surgical care is to exercise all these general and specific responsibilities with fairness and justice, and without arbitrary prejudice. Now , at - least partly either enshrined in statute or echoed in the English common law , these duties closely reflect the guidance of the - GMC. ship: protecting the vulnerable and respecting human dignity; and equality . To the extent that the practice of individual sur geons is a reflection of such sustained conduct, they deserve the civil respect that they often receive. To the e xtent that it is not, they should not practise the honourable profession of surgery . CONCLUSION

Surgeons have combined duties to their patients: to protect life and health and to respect autonomy , both to an acceptable - professional standard. The specific duties of surgeons are shown to follow from these: reasonable practice concerning informed consent; confidentiality; decisions not to provide, or to omit, life-sustaining care; surgical research; and the maintenance of good professional standards. The final duty of surgical care is to exercise all these general and specific responsibilities with fairness and justice, and without arbitrary prejudice. Now , at - least partly either enshrined in statute or echoed in the English common law , these duties closely reflect the guidance of the - GMC. ship: protecting the vulnerable and respecting human dignity; and equality . To the extent that the practice of individual sur geons is a reflection of such sustained conduct, they deserve the civil respect that they often receive. To the e xtent that it is not, they should not practise the honourable profession of surgery . CONCLUSION

Surgeons have combined duties to their patients: to protect life and health and to respect autonomy , both to an acceptable - professional standard. The specific duties of surgeons are shown to follow from these: reasonable practice concerning informed consent; confidentiality; decisions not to provide, or to omit, life-sustaining care; surgical research; and the maintenance of good professional standards. The final duty of surgical care is to exercise all these general and specific responsibilities with fairness and justice, and without arbitrary prejudice. Now , at - least partly either enshrined in statute or echoed in the English common law , these duties closely reflect the guidance of the - GMC. ship: protecting the vulnerable and respecting human dignity; and equality . To the extent that the practice of individual sur geons is a reflection of such sustained conduct, they deserve the civil respect that they often receive. To the e xtent that it is not, they should not practise the honourable profession of surgery .

CONFIDENTIALITY BALANCED AGAINST THE RISK OF SERIO

CONFIDENTIALITY BALANCED AGAINST THE RISK OF SERIOUS

- CONFIDENTIALITY BALANCED AGAINST THE RISK OF SERIOUS
-

CONFIDENTIALITY BALANCED AGAINST THE RISK OF SERIOUS

CONFIDENTIALITY BALANCED AGAINST THE RISK OF SERIOUS

-

DECISIONS IN THE BEST INTERESTS OF INCAPACITATED P

DECISIONS IN THE BEST INTERESTS OF INCAPACITATED PATIENTS

We are all well aware that adults with capacity must make their own treatment decisions. There is no justification or need to determine the best interests of such patients since they can (by definition) decide these matters for themselves. Accordingly , their ‘best interests’ are never explored. Naturally , clinicians will on occasion disagree with a capacitous patient’s decision, and they are at liberty to try and persuade the patient to change his or her mind, but the patient with capacity has the last word. This is starkly exemplified by the adult with capacity who chooses to refuse the blood that would otherwise have saved his life. Or the capacitous woman who refuses the caesarean section that alone would allow her child to be born alive. But for those who lack capacity to make decisions relating to their treatment, clinicians have become accustomed to act ing in the patient’s best interests . Meetings devoted to this subject are a ubiquitous daily occurrence in hospitals across the country . Again, we are all well aware of the general princi ple standing behind ‘best interests’; the incapacitated patient’s welfare must be viewed in its widest terms, not simply in the sense of medical but also social and psychological interests. The patient’s pr eviously expressed wishes, values, feelings and beliefs must be taken into account. This will involve consider ation of the proposed medical treatment, the prospects of suc cess and the likely outcome. That is all very well; how should we achieve this? A case decided in 2017 provided us with clear, specific guidance concerning Mrs P , who was 72 years old when she su ff ered the intracranial bleed that left her in a minimally con 4 scious state. It was agreed that there was no prospect of her regaining the capacity to make decisions relating to her health, and it was speculated that her potential life expectancy was in the region of 3–5 years. Nonetheless, she was otherwise rela tively healthy and the hospital wished to insert a gastrostomy for hydration and nourishment. She would not tolerate a naso gastric tube, the presence (and frequent replacement) of which distressed her . Mrs P’s daughters disagreed with this proposal, explaining that their mother had previously expressed a wish mental function was severely a ff ected. Because of this disagreement, the court was approached, the hospital seeking a declaration that the proposed treatment was lawful. T he judgement was centred on the notion that, when considering best interests, those making the decisions must try and put themselves in the place of the individual patient and ask what her attitude to the proposed treatment is likely to be. And they must consult those who befriend or look after the patient, in particular to obtain a view on what her attitude to the treatment might be. Factors that should be taken into account would include the views of those who had a close - relationship with the patient when she had capacity , and the impact of the

patient’s fate on those who were closest to her. The court nevertheless made it crystal clear that what the patient would have done in the circumstances (if her capacity had been preserved) would not automatically be reg arded as to be in her best interests. While courts (and clinical decision mak - ers) will strive to recognise and comply with what the patient is likely to have wanted, acting in her best interests remains the paramount objective. DECISIONS IN THE BEST INTERESTS OF INCAPACITATED PATIENTS

We are all well aware that adults with capacity must make their own treatment decisions. There is no justification or need to determine the best interests of such patients since they can (by definition) decide these matters for themselves. Accordingly , their ‘best interests’ are never explored. Naturally , clinicians will on occasion disagree with a capacitous patient’s decision, and they are at liberty to try and persuade the patient to change his or her mind, but the patient with capacity has the last word. This is starkly exemplified by the adult with capacity who chooses to refuse the blood that would otherwise have saved his life. Or the capacitous woman who refuses the caesarean section that alone would allow her child to be born alive. But for those who lack capacity to make decisions relating to their treatment, clinicians have become accustomed to act ing in the patient’s best interests . Meetings devoted to this subject are a ubiquitous daily occurrence in hospitals across the country . Again, we are all well aware of the general princi ple standing behind ‘best interests’; the incapacitated patient’s welfare must be viewed in its widest terms, not simply in the sense of medical but also social and psychological interests. The patient’s pr eviously expressed wishes, values, feelings and beliefs must be taken into account. This will involve consider ation of the proposed medical treatment, the prospects of suc cess and the likely outcome. That is all very well; how should we achieve this? A case decided in 2017 provided us with clear, specific guidance concerning Mrs P , who was 72 years old when she su ff ered the intracranial bleed that left her in a minimally con 4 scious state. It was agreed that there was no prospect of her regaining the capacity to make decisions relating to her health, and it was speculated that her potential life expectancy was in the region of 3–5 years. Nonetheless, she was otherwise rela tively healthy and the hospital wished to insert a gastrostomy for hydration and nourishment. She would not tolerate a naso gastric tube, the presence (and frequent replacement) of which distressed her . Mrs P’s daughters disagreed with this proposal, explaining that their mother had previously expressed a wish mental function was severely a ff ected. Because of this disagreement, the court was approached, the hospital seeking a declaration that the proposed treatment was lawful. T he judgement was centred on the notion that, when considering best interests, those making the decisions must try and put themselves in the place of the individual patient and ask what her attitude to the proposed treatment is likely to be. And they must consult those who befriend or look after the patient, in particular to obtain a view on what her attitude to the treatment might be. Factors that should be taken into account would include the views of those who had a close - relationship with the patient when she had capacity , and the impact of the patient’s fate on those who were closest to her. The court nevertheless made it crystal clear that what the patient would have done in the circumstances (if her capacity had been preserved) would not automatically be reg arded as to be in her best interests. While courts (and clinical decision mak - ers) will strive to recognise and comply with what the patient is likely to have wanted, acting in her best interests remains the paramount objective.

DECISIONS IN THE BEST INTERESTS OF INCAPACITATED PATIENTS

DECISIONS IN THE BEST INTERESTS OF INCAPACITATED PATIENTS

We are all well aware that adults with capacity must make their own treatment decisions. There is no justification or need to determine the best interests of such patients since they can (by definition) decide these matters for themselves. Accordingly , their ‘best interests’ are never explored. Naturally , clinicians will on occasion disagree with a capacitous patient’s decision, and they are at liberty to try and persuade the patient to change his or her mind, but the patient with capacity has the last word. This is starkly exemplified by the adult with capacity who chooses to refuse the blood that would otherwise have saved his life. Or the capacitous woman who refuses the caesarean section that alone would allow her child to be born alive. But for those who lack capacity to make decisions relating to their treatment, clinicians have become accustomed to act ing in the patient’s best interests . Meetings devoted to this subject are a ubiquitous daily occurrence in hospitals across the country . Again, we are all well aware of the general princi ple standing behind ‘best interests’; the incapacitated patient’s welfare must be viewed in its widest terms, not simply in the sense of medical but also social and psychological interests. The patient’s pr eviously expressed wishes, values, feelings and beliefs must be taken into account. This will involve consider ation of the proposed medical treatment, the prospects of suc cess and the likely outcome. That is all very well; how should we achieve this? A case decided in 2017 provided us with clear, specific guidance concerning Mrs P , who was 72 years old when she su ff ered the intracranial bleed that left her in a minimally con 4 scious state. It was agreed that there was no prospect of her regaining the capacity to make decisions relating to her health, and it was speculated that her potential life expectancy was in the region of 3–5 years. Nonetheless, she was otherwise rela tively healthy and the hospital wished to insert a gastrostomy for hydration and nourishment. She would not tolerate a naso gastric tube, the presence (and frequent replacement) of which distressed her . Mrs P’s daughters disagreed with this proposal, explaining that their mother had previously expressed a wish mental function was severely a ff ected. Because of this disagreement, the court was approached, the hospital seeking a declaration that the proposed treatment was lawful. T he judgement was centred on the notion that, when considering best interests, those making the decisions must try and put themselves in the place of the individual patient and ask what her attitude to the proposed treatment is likely to be. And they must consult those who befriend or look after the patient, in particular to obtain a view on what her attitude to the treatment might be. Factors that should be taken into account would include the views of those who had a close - relationship with the patient when she had capacity , and the impact of the

patient’s fate on those who were closest to her. The court nevertheless made it crystal clear that what the patient would have done in the circumstances (if her capacity had been preserved) would not automatically be reg arded as to be in her best interests. While courts (and clinical decision mak - ers) will strive to recognise and comply with what the patient is likely to have wanted, acting in her best interests remains the paramount objective.

DISCLOSURE PRIOR TO CONSENT

DISCLOSURE PRIOR TO CONSENT

In surgical practice, respect for autonomy translates into the clinical duty to obtain informed consent before the commence ment of treatment. It is easy to underestimate the gap in understanding between 2 a surgeon and his or her patient. How many patients would recognise that unilateral eye surgery might lead to contralat eral blindness? The risks and side e ff ects of many operations are not intuitive, and the surgeon is not in a position to guess how the patient's plans for employment, leisure and family life may be inadvertently a ff ected by a foreseeable complication. A b udding Olympic gymnast might choose to forego surgery on a quiescent posterior triangle lesion if he or she knew the poten tial consequences of division of the accessory nerve. That is why patients need to be informed, beforehand, so they can choose whether or not to take the risk. To establish valid consent to treatment, patients need to be given appr opriate and accurate information. In England and Wales, the Department of Health's (DH) Reference Guide to Consent for Examination or Treatment (second edition) should be consulted, together with the General Medical Council's (GMC) most recent guidance Decision Making and Consent (GMC 2020). Such information, disclosed during a formal and tangible discussion, must include: /uni25CF the condition and the reasons why it warrants surgery; /uni25CF the type of surgery proposed and how it might correct the condition; /uni25CF the anticipated prognosis and expected side e ff ects of the proposed surgery; /uni25CF the unexpected hazards of the proposed surgery; /uni25CF any alternative and potentially successful treatments other than the proposed surgery; /uni25CF the consequences of no treatment at all. With such information, patients can link their clinical pros pects to the management of other aspects of their lives and the lives of others for whom they may be responsible. Good professional practice dictates that obtaining informed consent should occur in circumstances that ar e designed to maximise the chances of patients understanding what is said about their condition and the proposed treatment, as well as giving them an opportunity to ask questions and express anxieties. Where possible: /uni25CF a quiet venue for discussion should be found; /uni25CF written material in the patient's preferred language should be provided to supplement verbal communication, together with diagrams where appropriate; /uni25CF patients should be given time and help to come to their own decision; /uni25CF the person obtaining the consent should ideally be the sur geon who will carry out the treatment. It should not be – as is sometimes the case – a junior member of sta ff who has never conducted such a procedure and thus may not have enough understanding to counsel the patient properly . obtaining informed consent for surgery . It is not good enough just to go through the motions of providing patients with the infor mation required for considered choice. Attention must be paid to: /uni25CF whether or not the patient has understood what has been - stated; /uni25CF avoiding overly technical language in descriptions and ex - planations; /uni25CF the provision of translators for patients whose first lan - - guage is not English; /uni25CF asking patients if they have further questions. When there is any

doubt about their understanding, patients should be asked questions by their surgeon about what has supposedly been communicated to see if they can explain the information in question for themselves. - Surgeons ha ve a legal as well as a moral obligation to obtain consent for treatment based on appropriate disclosure. Failure to do so could result in one of two civil proceedings, assum - ing the absence of criminal intent. First, in law , intentionally to touch another person without their consent is a battery , remembering that we are usually touched by strangers as a consequence of accidental contact. Surgeons have an obli - gation to give the conscious and capacitous patient su ffi cient information 'in broad terms' about the surgical treatment being proposed and why . If the patient ag rees to proceed, no other treatment should ordinarily be administered without fur - ther explicit consent. The second legal action that might be brought against a surgeon for not obtaining appropriate consent to treatment is in the tort (civil wrong) of negligence. Patients may hav e been given enough information about what is surgically proposed to agree to be touched in the ways suggested. However, sur - geons may still be in breach of their professional duty if they do not provide su ffi cient information about the risks that patients will encounter through such treatment. Although standards of ho w much information should be provided about risks vary between nations, as a matter of good practice surgeons should - inform patients of the hazards that any reasonable person in the position of the patient would wish to know . In UK law , this level and style of disclosure has been most recently reviewed in 2 the case of Montgomery v Lanarkshire Health Board. Finally , surgeons now understand that, when they obtain consent to proceed with treatment, patients are expected to sign a consent form of some kind. The detail of such forms can di ff er, but they often contain very little of the information supposedly communicated to the patient who signed it. Partly for this reason, the process of formally obtaining consent can become overly focused on obtaining the signature of patients rather than ensuring that appropriate disclosure has been pro - vided and understood. It is important for surgeons to understand that a signed consent form is not proof that valid consent has been properly - obtained. It is simply a piece of evidence that disclosure may have been attempted. Even w hen they have provided their sig - nature, patients can and do deny that appropriate information has been communicated or that the communication was e ff ec - tive. Surgeons are therefore well advised to make brief notes ments, especially information about significant risks. These notes should be placed in the patient's clinical record, perhaps by referring to the disclosure in the letter to the family doctor, copied to the patient. In addition, inf ormation sheets describ ing the generic risks, benefits, complications and alternatives associated with the proposed procedure can be provided. It seems that, soon, a record of dialogue will replace the consent form; see GMC (2020), para. 55. DISCLOSURE PRIOR TO CONSENT

In surgical practice, respect for autonomy translates into the clinical duty to obtain informed consent before the commence ment of treatment. It is easy to underestimate the gap in understanding between 2 a surgeon and his or her patient. How many patients would recognise that unilateral eye surgery might lead to contralat eral blindness? The risks and side e ff ects of many operations are not intuitive, and the surgeon is not in a position to guess how the patient's plans for employment, leisure and family life may be inadvertently a ff ected by a foreseeable complication. A b udding Olympic gymnast might choose to forego surgery on a quiescent posterior triangle lesion if he or she knew the poten tial consequences of division of the accessory nerve. That is why patients need to be informed, beforehand, so they can choose whether or not to take the risk. To establish valid consent to treatment, patients need to be given appr opriate and accurate information. In England and Wales, the Department of Health's (DH) Reference Guide to

Consent for Examination or Treatment (second edition) should be consulted, together with the General Medical Council's (GMC) most recent guidance Decision Making and Consent (GMC 2020). Such information, disclosed during a formal and tangible discussion, must include: /uni25CF the condition and the reasons why it warrants surgery; /uni25CF the type of surgery proposed and how it might correct the condition; /uni25CF the anticipated prognosis and expected side e ff ects of the proposed surgery; /uni25CF the unexpected hazards of the proposed surgery; /uni25CF any alternative and potentially successful treatments other than the proposed surgery; /uni25CF the consequences of no treatment at all. With such information, patients can link their clinical pros pects to the management of other aspects of their lives and the lives of others for whom they may be responsible. Good professional practice dictates that obtaining informed consent should occur in circumstances that ar e designed to maximise the chances of patients understanding what is said about their condition and the proposed treatment, as well as giving them an opportunity to ask questions and express anxieties. Where possible: /uni25CF a quiet venue for discussion should be found; /uni25CF written material in the patient's preferred language should be provided to supplement verbal communication, together with diagrams where appropriate; /uni25CF patients should be given time and help to come to their own decision; /uni25CF the person obtaining the consent should ideally be the sur geon who will carry out the treatment. It should not be – as is sometimes the case – a junior member of sta ff who has never conducted such a procedure and thus may not have enough understanding to counsel the patient properly . obtaining informed consent for surgery . It is not good enough just to go through the motions of providing patients with the infor mation required for considered choice. Attention must be paid to: /uni25CF whether or not the patient has understood what has been - stated; /uni25CF avoiding overly technical language in descriptions and ex - planations; /uni25CF the provision of translators for patients whose first lan - - guage is not English; /uni25CF asking patients if they have further questions. When there is any doubt about their understanding, patients should be asked questions by their surgeon about what has supposedly been communicated to see if they can explain the information in question for themselves. - Surgeons ha ve a legal as well as a moral obligation to obtain consent for treatment based on appropriate disclosure. Failure to do so could result in one of two civil proceedings, assum - ing the absence of criminal intent. First, in law , intentionally to touch another person without their consent is a battery , remembering that we are usually touched by strangers as a consequence of accidental contact. Surgeons have an obli - gation to give the conscious and capacitous patient su ffi cient information 'in broad terms' about the surgical treatment being proposed and why . If the patient ag rees to proceed, no other treatment should ordinarily be administered without fur - ther explicit consent. The second legal action that might be brought against a surgeon for not obtaining appropriate consent to treatment is in the tort (civil wrong) of negligence. Patients may hav e been given enough information about what is surgically proposed to agree to be touched in the ways suggested. However, sur - geons may still be in breach of their professional duty if they do not provide su ffi cient information about the risks that patients will encounter through such treatment. Although standards of ho w much information should be provided about risks vary between nations, as a matter of good practice surgeons should - inform patients of the hazards that any reasonable person in the position of the patient would wish to know . In UK law , this level and style of disclosure has been most recently reviewed in 2 the case of Montgomery v Lanarkshire Health Board. Finally , surgeons now understand that, when they obtain consent to proceed with treatment, patients are expected to sign a consent form of some kind. The detail of such forms can di ff er, but they often contain very little of the information supposedly communicated to the patient who signed it. Partly for this reason, the process of

formally obtaining consent can become overly focused on obtaining the signature of patients rather than ensuring that appropriate disclosure has been pro - vided and understood. It is important for surgeons to understand that a signed consent form is not proof that valid consent has been properly - obtained. It is simply a piece of evidence that disclosure may have been attempted. Even w hen they have provided their sig - nature, patients can and do deny that appropriate information has been communicated or that the communication was e ff ec - tive. Surgeons are therefore well advised to make brief notes ments, especially information about significant risks. These notes should be placed in the patient's clinical record, perhaps by referring to the disclosure in the letter to the family doctor, copied to the patient. In addition, inf ormation sheets describ ing the generic risks, benefits, complications and alternatives associated with the proposed procedure can be provided. It seems that, soon, a record of dialogue will replace the consent form; see GMC (2020), para. 55. DISCLOSURE PRIOR TO CONSENT

In surgical practice, respect for autonomy translates into the clinical duty to obtain informed consent before the commence ment of treatment. It is easy to underestimate the gap in understanding between 2 a surgeon and his or her patient. How many patients would recognise that unilateral eye surgery might lead to contralat eral blindness? The risks and side e ff ects of many operations are not intuitive, and the surgeon is not in a position to guess how the patient's plans for employment, leisure and family life may be inadvertently a ff ected by a foreseeable complication. A b udding Olympic gymnast might choose to forego surgery on a quiescent posterior triangle lesion if he or she knew the poten tial consequences of division of the accessory nerve. That is why patients need to be informed, beforehand, so they can choose whether or not to take the risk. To establish valid consent to treatment, patients need to be given appr opriate and accurate information. In England and Wales, the Department of Health's (DH) Reference Guide to Consent for Examination or Treatment (second edition) should be consulted, together with the General Medical Council's (GMC) most recent guidance Decision Making and Consent (GMC 2020). Such information, disclosed during a formal and tangible discussion, must include: /uni25CF the condition and the reasons why it warrants surgery; /uni25CF the type of surgery proposed and how it might correct the condition; /uni25CF the anticipated prognosis and expected side e ff ects of the proposed surgery; /uni25CF the unexpected hazards of the proposed surgery; /uni25CF any alternative and potentially successful treatments other than the proposed surgery; /uni25CF the consequences of no treatment at all. With such information, patients can link their clinical pros pects to the management of other aspects of their lives and the lives of others for whom they may be responsible. Good professional practice dictates that obtaining informed consent should occur in circumstances that ar e designed to maximise the chances of patients understanding what is said about their condition and the proposed treatment, as well as giving them an opportunity to ask questions and express anxieties. Where possible: /uni25CF a quiet venue for discussion should be found; /uni25CF written material in the patient's preferred language should be provided to supplement verbal communication, together with diagrams where appropriate; /uni25CF patients should be given time and help to come to their own decision; /uni25CF the person obtaining the consent should ideally be the sur geon who will carry out the treatment. It should not be – as is sometimes the case – a junior member of sta ff who has never conducted such a procedure and thus may not have enough understanding to counsel the patient properly . obtaining informed consent for surgery . It is not good enough just to go through the motions of providing patients with the infor mation required for considered choice. Attention must be paid to: /uni25CF whether or not the patient has understood what has been - stated; /uni25CF avoiding overly technical language in

descriptions and ex - planations; /uni25CF the provision of translators for patients whose first lan - - guage is not English; /uni25CF asking patients if they have further questions. When there is any doubt about their understanding, patients should be asked questions by their surgeon about what has supposedly been communicated to see if they can explain the information in question for themselves. - Surgeons ha ve a legal as well as a moral obligation to obtain consent for treatment based on appropriate disclosure. Failure to do so could result in one of two civil proceedings, assum - ing the absence of criminal intent. First, in law , intentionally to touch another person without their consent is a battery , remembering that we are usually touched by strangers as a consequence of accidental contact. Surgeons have an obli - gation to give the conscious and capacitous patient su ffi cient information ‘in broad terms’ about the surgical treatment being proposed and why . If the patient ag rees to proceed, no other treatment should ordinarily be administered without fur - ther explicit consent. The second legal action that might be brought against a surgeon for not obtaining appropriate consent to treatment is in the tort (civil wrong) of negligence. Patients may hav e been given enough information about what is surgically proposed to agree to be touched in the ways suggested. However, sur - geons may still be in breach of their professional duty if they do not provide su ffi cient information about the risks that patients will encounter through such treatment. Although standards of ho w much information should be provided about risks vary between nations, as a matter of good practice surgeons should - inform patients of the hazards that any reasonable person in the position of the patient would wish to know . In UK law , this level and style of disclosure has been most recently reviewed in 2 the case of Montgomery v Lanarkshire Health Board. Finally , surgeons now understand that, when they obtain consent to proceed with treatment, patients are expected to sign a consent form of some kind. The detail of such forms can di ff er, but they often contain very little of the information supposedly communicated to the patient who signed it. Partly for this reason, the process of formally obtaining consent can become overly focused on obtaining the signature of patients rather than ensuring that appropriate disclosure has been pro - vided and understood. It is important for surgeons to understand that a signed consent form is not proof that valid consent has been properly - obtained. It is simply a piece of evidence that disclosure may have been attempted. Even w hen they have provided their sig - nature, patients can and do deny that appropriate information has been communicated or that the communication was e ff ec - tive. Surgeons are therefore well advised to make brief notes ments, especially information about significant risks. These notes should be placed in the patient’s clinical record, perhaps by referring to the disclosure in the letter to the family doctor, copied to the patient. In addition, inf ormation sheets describ ing the generic risks, benefits, complications and alternatives associated with the proposed procedure can be provided. It seems that, soon, a record of dialogue will replace the consent form; see GMC (2020), para. 55.

DO NOT ATTEMPT RESUSCITATION

DO NOT ATTEMPT RESUSCITATION?

Furthermore, the decision to discontinue life-sustaining treat ment may go hand in hand with a decision not to attempt cardiopulmonary resuscitation, in the event of cardiorespi ratory arrest. In England, it is settled law that bef ore finally making this ‘DNACPR’ decision, doctors must discuss it with 8 patients or their relatives. The reason for this insistence is that the patient may have personal circumstances, unbeknown to the surgeon, that might yet influence this final (and for the patient, portentous) decision. The only exclusion to this legal rule is where discussion of this matter with the patient may cause them not merely distress, but harm. The duty to consult a patient prior to deciding to withhold cardiopulmonary resus citation was subsequently extended to a duty to consult those befriending an incapacitated adult. DO NOT ATTEMPT RESUSCITATION?

Furthermore, the decision to discontinue life-sustaining treat ment may go hand in hand with a decision not to attempt cardiopulmonary resuscitation, in the event of cardiorespi ratory arrest. In England, it is settled law that bef ore finally making this ‘DNACPR’ decision, doctors must discuss it with 8 patients or their relatives. The reason for this insistence is that the patient may have personal circumstances, unbeknown to the surgeon, that might yet influence this final (and for the patient, portentous) decision. The only exclusion to this legal rule is where discussion of this matter with the patient may cause them not merely distress, but harm. The duty to consult a patient prior to deciding to withhold cardiopulmonary resus citation was subsequently extended to a duty to consult those befriending an incapacitated adult. DO NOT ATTEMPT RESUSCITATION?

Furthermore, the decision to discontinue life-sustaining treat ment may go hand in hand with a decision not to attempt cardiopulmonary resuscitation, in the event of cardiorespi ratory arrest. In England, it is settled law that bef ore finally making this ‘DNACPR’ decision, doctors must discuss it with 8 patients or their relatives. The reason for this insistence is that the patient may have personal circumstances, unbeknown to the surgeon, that might yet influence this final (and for the patient, portentous) decision. The only exclusion to this legal rule is where discussion of this matter with the patient may cause them not merely distress, but harm. The duty to consult a patient prior to deciding to withhold cardiopulmonary resus citation was subsequently extended to a duty to consult those befriending an incapacitated adult.

DOCTRINE OF DOUBLE EFFECT

DOCTRINE OF DOUBLE EFFECT

Surgeons could find themselves involved in the palliative care of patients whose pain is increasingly di ffi cult to control. There may come a point in the management of such pain when e ff ective palliation is possible only at the risk of short ening a patient’s life because of the respiratory e ff ects of the palliative drugs. In such circumstances, surgeons can, with legal justification, administer a dose that might be dangerous (although experts in palliative care are sceptical tha t this is ever necessary with appropriate training). In any case, the argument - both the relief of pain and death might follow from such an action. Intentional killing (active euthanasia) is rejected as criminal malpractice throughout most of the world. A fore - - seeab ly lethal analgesic dose is thus regarded as lawful only when it is solely motivated by palliative intent , and this motivation has been documented. Recent authority from criminal law indicates that, if an analgesic injection is ‘virtually certain’ also to kill the patient, a court might deduce that the person giving the injection had an intention to kill. The key to the defence of double e ff ect is the absolute absence of such an intention. It follows that if you are virtually certain that a palliative act will end the patient’s life, consult widely before embarking upon it. - DOCTRINE OF DOUBLE EFFECT

Surgeons could find themselves involved in the palliative care of patients whose pain is increasingly di ffi cult to control. There may come a point in the management of such pain when e ff ective palliation is possible only at the risk of short ening a patient’s life because of the respiratory e ff ects of the palliative drugs. In such circumstances, surgeons can, with legal justification, administer a dose that might be dangerous (although experts in palliative care are sceptical tha t this is ever necessary with appropriate training). In any case, the argument - both the relief of pain and death might follow from such an action. Intentional killing (active euthanasia) is rejected as criminal malpractice throughout most of the world. A fore - - seeab ly lethal analgesic dose is thus regarded as lawful only when it is solely motivated by palliative intent , and this motivation has been documented. Recent authority from criminal law indicates that, if an analgesic injection is ‘virtually certain’ also to kill the patient, a court might deduce that the person giving the injection had an intention to kill. The key to the defence of double e ff ect is the absolute absence of such an intention. It follows that if you are virtually certain that a palliative act will end the patient’s life, consult widely before embarking upon it. - DOCTRINE OF DOUBLE EFFECT

Surgeons could find themselves involved in the palliative care of patients whose pain is increasingly di ffi cult to control. There may come a point in the management of such pain when e ff ective palliation is possible only at the risk of short ening a patient’s life because of the respiratory e ff ects of the palliative drugs. In such circumstances, surgeons can, with legal justification, administer a dose that might be dangerous (

sceptical tha t this is ever necessary with appropriate training). In any case, the argument - both the relief of pain and death might follow from such an action. Intentional killing (active euthanasia) is rejected as criminal malpractice throughout most of the world. A fore - - seeab ly lethal analgesic dose is thus regarded as lawful only when it is solely motivated by palliative intent , and this motivation has been documented. Recent authority from criminal law indicates that, if an analgesic injection is ‘virtually certain’ also to kill the patient, a court might deduce that the person giving the injection had an intention to kill. The key to the defence of double e ff ect is the absolute absence of such an intention. It follows that if you are virtually certain that a palliative act will end the patient’s life, consult widely before embarking upon it. -

DUTY OF CANDOUR

DUTY OF CANDOUR

Equal consideration should be given to disclosure of informa tion that was generated by the intervention, particularly where ‘something went wrong’ that caused (or had the potential to cause) harm or distress. The duty to disclose these matters is described as the duty of candour. Surgeons are accustomed to disclosing to their patients tha t the proposed operation may go wrong. The disclosures of ‘bleeding and infection’ are ubiquitous across the land, together with the more specific foreseeab le risks, such as dam age to contiguous structures, recurrence of the original diag nosis or inadvertent exacerbation of disease. Failure to disclose these foreseeable complications prior to surgery , particularly if they then maim, paralyse or scar the patient, may lead to a claim that the consent was invalid and that the pa tient, had they known of the risk, either would have never had the oper ation or would have had it performed by somebody else at another time. Since all of these misadventures are plainly caught by the GMC’s threshold of ‘something going wrong’, they would need to be reported to the patient by the candid sur geon if they crystallise during surgery . Merely because the division of a ure ter during hysterectomy appears as a foreseeable complication on a consent form cannot negate the duty to be candid should it occur; it is plainly an example of something going wrong. This class of surgical complication must be starkly dis tinguished from the complica tions of the disease itself, since these are explicitly excluded from the duty of candour. The patient awaiting surgery for her rectal cancer might present with venous thr omboembolism. This is a regrettable compli cation of her disease, but by itself cannot lead to the deduction that something has gone wrong with surgical management. Accordingly , there would be no duty to be candid. By contrast, if the same patient, on arriving thrombus- free for her resection, then had a postopera tive venous thromboembolism and if the unit’s protocol of 28 days of low molecular-w eight heparin was not prescribed, a duty of candour would certainly be owed since something went wrong. In clinical practice fault is not determinative when con sidering whether to be candid over the occurrence of a com plication. Thus clinicians will wish to ensure that the patient is made aware of events to which she may otherwise remain oblivious, since this information may hav e an e ff ect on her subsequent decision making. Accordingly , if something goes wrong that causes a complication, irrespective of whether the ‘thing that went wrong’ is indicative of substandard care, our obligation to be candid about the existence of the complica tion persists. The question of whether fault has occurred, and careful consideration. Clinicians, and those in the hospital who advise them, need to be certain of the facts before being candid to ensure that they do not mislead the patient when - fulfilling their duty of candour. It is likely that candour rela ting to fault and causation, while eventually necessary , may only be possible after an investigation of the event leading to the complication is concluded. DUTY OF CANDOUR

Equal consideration should be given to disclosure of informa tion that was generated by the intervention, particularly where ‘something went wrong’ that caused (or had the potential to cause) harm or distress. The duty to disclose these matters is described as the duty of candour. Surgeons

are accustomed to disclosing to their patients tha t the proposed operation may go wrong. The disclosures of ‘bleeding and infection’ are ubiquitous across the land, together with the more specific foreseeab le risks, such as dam age to contiguous structures, recurrence of the original diag nosis or inadvertent exacerbation of disease. Failure to disclose these foreseeable complications prior to surgery , particularly if they then maim, paralyse or scar the patient, may lead to a claim that the consent was invalid and that the pa tient, had they known of the risk, either would have never had the oper ation or would have had it performed by somebody else at another time. Since all of these misadventures are plainly caught by the GMC’s threshold of ‘something going wrong’, they would need to be reported to the patient by the candid sur geon if they crystallise during surgery . Merely because the division of a ure ter during hysterectomy appears as a foreseeable complication on a consent form cannot negate the duty to be candid should it occur; it is plainly an example of something going wrong. This class of surgical complication must be starkly dis tinguished from the complica tions of the disease itself, since these are explicitly excluded from the duty of candour. The patient awaiting surgery for her rectal cancer might present with venous thr omboembolism. This is a regrettable compli cation of her disease, but by itself cannot lead to the deduction that something has gone wrong with surgical management. Accordingly , there would be no duty to be candid. By contrast, if the same patient, on arriving thrombus- free for her resection, then had a postopera tive venous thromboembolism and if the unit’s protocol of 28 days of low molecular-w eight heparin was not prescribed, a duty of candour would certainly be owed since something went wrong. In clinical practice fault is not determinative when con sidering whether to be candid over the occurrence of a com plication. Thus clinicians will wish to ensure that the patient is made aware of events to which she may otherwise remain oblivious, since this information may hav e an e ff ect on her subsequent decision making. Accordingly , if something goes wrong that causes a complication, irrespective of whether the ‘thing that went wrong’ is indicative of substandard care, our obligation to be candid about the existence of the complica tion persists. The question of whether fault has occurred, and careful consideration. Clinicians, and those in the hospital who advise them, need to be certain of the facts before being candid to ensure that they do not mislead the patient when - fulfilling their duty of candour. It is likely that candour rela ting to fault and causation, while eventually necessary , may only be possible after an investigation of the event leading to the complication is concluded. DUTY OF CANDOUR

Equal consideration should be given to disclosure of informa tion that was generated by the intervention, particularly where ‘something went wrong’ that caused (or had the potential to cause) harm or distress. The duty to disclose these matters is described as the duty of candour. Surgeons are accustomed to disclosing to their patients tha t the proposed operation may go wrong. The disclosures of ‘bleeding and infection’ are ubiquitous across the land, together with the more specific foreseeab le risks, such as dam age to contiguous structures, recurrence of the original diag nosis or inadvertent exacerbation of disease. Failure to disclose these foreseeable complications prior to surgery , particularly if they then maim, paralyse or scar the patient, may lead to a claim that the consent was invalid and that the pa tient, had they known of the risk, either would have never had the oper ation or would have had it performed by somebody else at another time. Since all of these misadventures are plainly caught by the GMC’s threshold of ‘something going wrong’, they would need to be reported to the patient by the candid sur geon if they crystallise during surgery . Merely because the division of a ure ter during hysterectomy appears as a foreseeable complication on a consent form cannot negate the duty to be candid should it occur;

it is plainly an example of something going wrong. This class of surgical complication must be starkly dis tinguished from the complica tions of the disease itself, since these are explicitly excluded from the duty of candour. The patient awaiting surgery for her rectal cancer might present with venous thr omboembolism. This is a regrettable compli cation of her disease, but by itself cannot lead to the deduction that something has gone wrong with surgical management. Accordingly , there would be no duty to be candid. By contrast, if the same patient, on arriving thrombus- free for her resection, then had a postopera tive venous thromboembolism and if the unit’s protocol of 28 days of low molecular-w eight heparin was not prescribed, a duty of candour would certainly be owed since something went wrong. In clinical practice fault is not determinative when con sidering whether to be candid over the occurrence of a com plication. Thus clinicians will wish to ensure that the patient is made aware of events to which she may otherwise remain oblivious, since this information may hav e an e ff ect on her subsequent decision making. Accordingly , if something goes wrong that causes a complication, irrespective of whether the ‘thing that went wrong’ is indicative of substandard care, our obligation to be candid about the existence of the complica tion persists. The question of whether fault has occurred, and careful consideration. Clinicians, and those in the hospital who advise them, need to be certain of the facts before being candid to ensure that they do not mislead the patient when - fulfilling their duty of candour. It is likely that candour rela ting to fault and causation, while eventually necessary , may only be possible after an investigation of the event leading to the complication is concluded.

FURTHER PRACTICAL APPLICATIONS OF CLINICAL LAW IN

FURTHER PRACTICAL APPLICATIONS OF CLINICAL LAW IN

- FURTHER PRACTICAL APPLICATIONS OF CLINICAL LAW IN
- FURTHER PRACTICAL APPLICATIONS OF CLINICAL LAW IN
-

HARM

HARM

Respect for autonomy does not entail only the right of capac - itous patients to consent to treatment. Their autonomous - right extends to control over their confidential information, and surgeons must respect their patients' privacy , not commu - nicating infor mation revealed in the course of treatment to anyone else without consent. Generally speaking, such respect means that surgeons must not discuss clinical matters with relatives, friends, employer s and other state actors unless the patient explicitly agrees. To do otherwise is regarded by all the regulatory bodies of medicine and surgery as a grave o ff ence, incurring harsh penalties. Breaches of confidentiality are not only abuses of human dignity; they undermine the trust between surgeon and patient on which successful surgery and the professional reputations of surgeons depend. The delicacy - of this situation was amply demonstrated in a recent case. A woman (ABC) had a father (XX) who killed her mother, - 9 leading to his detention in a psychiatric facility . His clinicians tested him for Huntington's disease, which proved positive. He had capacity , and agreed to the testing only on the basis that his results were not shared with his family . In the meantime, ABC fell pregnant. Her father's doc - tors knew about the pregnancy and wanted to disclose XX's diagnosis to his daughter; from the time of his diagnosis there would have been a window of 2 months during which termi - nation of her pregnancy was feasible. XX r efused to disclose, - aware that such knowledge might have an impact on his two daughters' reproductive decision making. ABC discovered her fa ther's diagnosis during a clinical visit when her baby was 4 months old. Shortly afterwards, she decided that her father's diagnosis should not be disclosed to her sister, now in the early stages of her own pregnancy . Four year s later, ABC tested positive for Huntington's. Feel - ing that it had been unfair to bring a child into the world in - these tragic circumstances, she claimed that the doctors should have breached her father's confidentiality and told her of his diagnosis while she had a chance to choose whether she w ould undergo termination. In making this claim, she asserted that she was owed a duty of care by the doctors who also had a duty to respect her father's confidentiality . '…duty /uni00A0 to balance the claimant's interest in being informed of her risk of a genetic disorder against her father's interest in having the confidentiality of that diagnosis preserved'. The court noted that if on that basis the clinicians properly con sidered and balanced the conflicting interests, but decided not to disclose, they would have fulfilled their obligation, provided their conclusion not to disclose the inf ormation was reason able. The judge concluded that it was just, fair and reason able to impose a legal duty to balance ABC's interest in being informed against XX's interest in maintaining his confidenti ality relating to both his diagnosis (and the public interest in maintaining medical confidentiality generally). The decision in ABC reveals that, important as respect for confidentiality is, it is not an absolute right. Sur geons are allowed to communicate private information to other profes sionals who are part of the healthcar e team, provided that the information has a direct bearing on treatment. Here, it is argued that patients have given their 'implied' consent to such communication when the y explicitly consent to a treatment plan. Whether implied consent can in any circumstances be valid is a matter for public debate, as government applies these words to tissue donation and access to

electronic health records. Academic lawyers are sceptical that it is a species of consent at all, since there is no guarantee of the now-treasured disclosure prior to agreement. Such examples of ‘implied’ consent are better viewed as mere acquiescence on the behalf of patients, ignorant of and not objecting to decisions made about them, in the absence of personal consultation. Patients cannot expect strict adherence to the principle of confidentiality if it poses a serious threat to the health and safety of others. There will be some circumstances in which confidentiality either must or may be breached in the public interest. For example, it must be breached as a result of court orders or in relation to the requirements of public health leg islation. HARM

Respect for autonomy does not entail only the right of capac - itous patients to consent to treatment. Their autonomous - right extends to control over their confidential information, and surgeons must respect their patients’ privacy , not commu - nicating infor mation revealed in the course of treatment to anyone else without consent. Generally speaking, such respect means that surgeons must not discuss clinical matters with relatives, friends, employer s and other state actors unless the patient explicitly agrees. To do otherwise is regarded by all the regulatory bodies of medicine and surgery as a grave o ff ence, incurring harsh penalties. Breaches of confidentiality are not only abuses of human dignity; they undermine the trust between surgeon and patient on which successful surgery and the professional reputations of surgeons depend. The delicacy - of this situation was amply demonstrated in a recent case. A woman (ABC) had a father (XX) who killed her mother, - 9 leading to his detention in a psychiatric facility . His clinicians tested him for Huntington’s disease, which proved positive. He had capacity , and agreed to the testing only on the basis that his results were not shared with his family . In the meantime, ABC fell pregnant. Her father’s doc - tors knew about the pregnancy and wanted to disclose XX’s diagnosis to his daughter; from the time of his diagnosis there would have been a window of 2 months during which termi - nation of her pregnancy was feasible. XX r efused to disclose, - aware that such knowledge might have an impact on his two daughters’ reproductive decision making. ABC discovered her fa ther’s diagnosis during a clinical visit when her baby was 4 months old. Shortly afterwards, she decided that her father’s diagnosis should not be disclosed to her sister, now in the early stages of her own pregnancy . Four year s later, ABC tested positive for Huntington’s. Feel - ing that it had been unfair to bring a child into the world in - these tragic circumstances, she claimed that the doctors should have breached her father’s confidentiality and told her of his diagnosis while she had a chance to choose whether she w ould undergo termination. In making this claim, she asserted that she was owed a duty of care by the doctors who also had a duty to respect her father’s confidentiality . ‘…duty /uni00A0 to balance the claimant’s interest in being informed of her risk of a genetic disorder against her father’s interest in having the confidentiality of that diagnosis preserved’. The court noted that if on that basis the clinicians properly con sidered and balanced the conflicting interests, but decided not to disclose, they would have fulfilled their obligation, provided their conclusion not to disclose the inf ormation was reason able. The judge concluded that it was just, fair and reason able to impose a legal duty to balance ABC’s interest in being informed against XX’s interest in maintaining his confidenti ality relating to both his diagnosis (and the public interest in maintaining medical confidentiality generally). The decision in ABC reveals that, important as respect for confidentiality is, it is not an absolute right. Sur geons are allowed to communicate private information to other profes sionals who are part of the healthcar e team, provided that the information has a direct bearing on treatment. Here, it is argued that patients have given their ‘implied’ consent to such communication when the y explicitly consent to a treatment plan. Whether implied consent can in any circumstances be valid

is a matter for public debate, as government applies these words to tissue donation and access to electronic health records. Academic lawyers are sceptical that it is a species of consent at all, since there is no guarantee of the now-treasured disclosure prior to agreement. Such examples of ‘implied’ consent are better viewed as mere acquiescence on the behalf of patients, ignorant of and not objecting to decisions made about them, in the absence of personal consultation. Patients cannot expect strict adherence to the principle of confidentiality if it poses a serious threat to the health and safety of others. There will be some circumstances in which confidentiality either must or may be breached in the public interest. For example, it must be breached as a result of court orders or in relation to the requirements of public health leg islation. HARM

Respect for autonomy does not entail only the right of capac - itous patients to consent to treatment. Their autonomous - right extends to control over their confidential information, and surgeons must respect their patients’ privacy , not commu - nicating infor mation revealed in the course of treatment to anyone else without consent. Generally speaking, such respect means that surgeons must not discuss clinical matters with relatives, friends, employer s and other state actors unless the patient explicitly agrees. To do otherwise is regarded by all the regulatory bodies of medicine and surgery as a grave o ff ence, incurring harsh penalties. Breaches of confidentiality are not only abuses of human dignity; they undermine the trust between surgeon and patient on which successful surgery and the professional reputations of surgeons depend. The delicacy - of this situation was amply demonstrated in a recent case. A woman (ABC) had a father (XX) who killed her mother, - 9 leading to his detention in a psychiatric facility . His clinicians tested him for Huntington’s disease, which proved positive. He had capacity , and agreed to the testing only on the basis that his results were not shared with his family . In the meantime, ABC fell pregnant. Her father’s doc - tors knew about the pregnancy and wanted to disclose XX’s diagnosis to his daughter; from the time of his diagnosis there would have been a window of 2 months during which termi - nation of her pregnancy was feasible. XX r efused to disclose, - aware that such knowledge might have an impact on his two daughters’ reproductive decision making. ABC discovered her fa ther’s diagnosis during a clinical visit when her baby was 4 months old. Shortly afterwards, she decided that her father’s diagnosis should not be disclosed to her sister, now in the early stages of her own pregnancy . Four year s later, ABC tested positive for Huntington’s. Feel - ing that it had been unfair to bring a child into the world in - these tragic circumstances, she claimed that the doctors should have breached her father’s confidentiality and told her of his diagnosis while she had a chance to choose whether she w ould undergo termination. In making this claim, she asserted that she was owed a duty of care by the doctors who also had a duty to respect her father’s confidentiality . ‘…duty /uni00A0 to balance the claimant’s interest in being informed of her risk of a genetic disorder against her father’s interest in having the confidentiality of that diagnosis preserved’. The court noted that if on that basis the clinicians properly con sidered and balanced the conflicting interests, but decided not to disclose, they would have fulfilled their obligation, provided their conclusion not to disclose the inf ormation was reason able. The judge concluded that it was just, fair and reason able to impose a legal duty to balance ABC’s interest in being informed against XX’s interest in maintaining his confidenti ality relating to both his diagnosis (and the public interest in maintaining medical confidentiality generally). The decision in ABC reveals that, important as respect for confidentiality is, it is not an absolute right. Sur geons are allowed to communicate private information to other profes sionals who are part of the healthcar e team, provided that the information has a direct bearing on treatment. Here, it is argued that patients have given their ‘implied’ consent to such communication when the y

explicitly consent to a treatment plan. Whether implied consent can in any circumstances be valid is a matter for public debate, as government applies these words to tissue donation and access to electronic health records. Academic lawyers are sceptical that it is a species of consent at all, since there is no guarantee of the now-treasured disclosure prior to agreement. Such examples of ‘implied’ consent are better viewed as mere acquiescence on the behalf of patients, ignorant of and not objecting to decisions made about them, in the absence of personal consultation. Patients cannot expect strict adherence to the principle of confidentiality if it poses a serious threat to the health and safety of others. There will be some circumstances in which confidentiality either must or may be breached in the public interest. For example, it must be breached as a result of court orders or in relation to the requirements of public health leg islation.

INCAPACITY

INCAPACITY

Absence of capacity in adults does not vitiate the requirement, where possible, to take into account the patient’s sentiments during clinical decision making. In one case, a judge declared that an elderly man with a septic leg, although incapacitated by his mental illness, had feelings, beliefs and values that weighed so heavily in the consideration of his best interests that they 3 outweighed the clinical desire to save his life by amputation. Although an unusual judgement in this context, it reflects the growing determination to give incapacitated adults an oppor - tunity to influence their fate, as best they can. Elective treatment for less grave complaints can also be pro - vided; in England and Wales this is done under the auspices of the MCA 2005. The associated Code of Practice guides the surgeon in matters of capacity and disclosure, and in dealing with those who have taken steps to influence their treatment, anticipating the time that the y will have lost their capacity . These arrangements may manifest either in documentary form, such as Advance Decisions, or in person, in the form of persons appointed with a Lasting Power of Attorney . It is not possible for relatives of incapacitated adult patients to sign consent forms for surgery on their behalf unless the rel - ative or friend has, very unusually , been appointed as a deputy - b y the Court of Protection. Indeed, to make such requests can be a disservice to relatives, who may feel an unjustified sense of - responsibility if the surgery fails. This said, relatives play a vital role in providing background information about the patient, allowing the clinician to assess and then determine what treat - ment is in the best interests of the patient. It is not lawful to force a capacitous adult to have treatment without their consent. Since the advent of the MCA 2005, the notion of acting based only on the common law ‘doctrine of necessity’ has largely become historical. This is because if an adult lacks capacity , and you are treating in their best interests, the Act authorises necessary and proportionate steps to sav e life and to prevent serious and permanent injury . It is di ffi cult to envisage circumstances where the statute would not be engaged, but the common law doctrine has not been extinguished by the Act, so should give extra reassurance to surgeons acting in emer gencies in the best interests of incapacitated patients. Bear in mind that the presently incapacitated patient may yet regain his or her capacity , so if an intervention can safely be deferred to await cognitive recov ery it should be, provided that deferral is in your patient’s best interests. INCAPACITY

Absence of capacity in adults does not vitiate the requirement, where possible, to take into account the patient’s sentiments during clinical decision making. In one case, a judge declared that an elderly man with a septic leg, although incapacitated by his mental illness, had feelings, beliefs and values that weighed so heavily in the consideration of his best interests that they 3 outweighed the clinical desire to save his life by amputation. Although an unusual judgement in this context, it reflects the growing determination to give incapacitated adults an oppor - tunity to influence their fate, as best they can. Elective treatment for less grave complaints can also be pro - vided; in England and Wales this is done under the auspices of the MCA 2005. The associated Code of Practice guides the surgeon in matters of capacity and disclosure, and in dealing with those who

have taken steps to influence their treatment, anticipating the time that the y will have lost their capacity . These arrangements may manifest either in documentary form, such as Advance Decisions, or in person, in the form of persons appointed with a Lasting Power of Attorney . It is not possible for relatives of incapacitated adult patients to sign consent forms for surgery on their behalf unless the rel - ative or friend has, very unusually , been appointed as a deputy - b y the Court of Protection. Indeed, to make such requests can be a disservice to relatives, who may feel an unjustified sense of - responsibility if the surgery fails. This said, relatives play a vital role in providing background information about the patient, allowing the clinician to assess and then determine what treat - ment is in the best interests of the patient. It is not lawful to force a capacitous adult to have treatment without their consent. Since the advent of the MCA 2005, the notion of acting based only on the common law ‘doctrine of necessity’ has largely become historical. This is because if an adult lacks capacity , and you are treating in their best interests, the Act authorises necessary and proportionate steps to sav e life and to prevent serious and permanent injury . It is di ffi cult to envisage circumstances where the statute would not be engaged, but the common law doctrine has not been extinguished by the Act, so should give extra reassurance to surgeons acting in emer gencies in the best interests of incapacitated patients. Bear in mind that the presently incapacitated patient may yet regain his or her capacity , so if an intervention can safely be deferred to await cognitive recov ery it should be, provided that deferral is in your patient’s best interests. INCAPACITY

Absence of capacity in adults does not vitiate the requirement, where possible, to take into account the patient’s sentiments during clinical decision making. In one case, a judge declared that an elderly man with a septic leg, although incapacitated by his mental illness, had feelings, beliefs and values that weighed so heavily in the consideration of his best interests that they 3 outweighed the clinical desire to save his life by amputation. Although an unusual judgement in this context, it reflects the growing determination to give incapacitated adults an oppor - tunity to influence their fate, as best they can. Elective treatment for less grave complaints can also be pro - vided; in England and Wales this is done under the auspices of the MCA 2005. The associated Code of Practice guides the surgeon in matters of capacity and disclosure, and in dealing with those who have taken steps to influence their treatment, anticipating the time that the y will have lost their capacity . These arrangements may manifest either in documentary form, such as Advance Decisions, or in person, in the form of persons appointed with a Lasting Power of Attorney . It is not possible for relatives of incapacitated adult patients to sign consent forms for surgery on their behalf unless the rel - ative or friend has, very unusually , been appointed as a deputy - b y the Court of Protection. Indeed, to make such requests can be a disservice to relatives, who may feel an unjustified sense of - responsibility if the surgery fails. This said, relatives play a vital role in providing background information about the patient, allowing the clinician to assess and then determine what treat - ment is in the best interests of the patient. It is not lawful to force a capacitous adult to have treatment without their consent. Since the advent of the MCA 2005, the notion of acting based only on the common law ‘doctrine of necessity’ has largely become historical. This is because if an adult lacks capacity , and you are treating in their best interests, the Act authorises necessary and proportionate steps to sav e life and to prevent serious and permanent injury . It is di ffi cult to envisage circumstances where the statute would not be engaged, but the common law doctrine has not been extinguished by the Act, so should give extra reassurance to surgeons acting in emer gencies in the best interests of incapacitated patients. Bear in mind that the presently incapacitated patient may yet regain his or her capacity , so if an

intervention can safely be deferred to await cognitive recov ery it should be, provided that deferral is in your patient’s best interests.

Introduction

INTRODUCTION

This chapter incorporates references to English common and statute law . Nevertheless, these legal and ethical principles have much in common with other jurisdictions across the world. Surgery , ethics and law go hand in hand. In any other arena of public or private life, if someone deliberately cuts another person, draws blood, causes pain, leaves scars and disrupts ever yday activity , then the likely result will be a criminal charge. If the person dies as a result, the charge could be manslaugh ter or even murder. Self-evidently , the di ff erence between the criminal and the surgeon is that their intentions di ff er. While a criminal intentionally (or recklessly) inflicts harm, the surgeon's intention is limited to the treatment of illness. Any harm that ensues is either unintentional or is necessary (such as an inci sion) to facilitate treatment. Patients submit to surgery because they trust their surgeons. What should 'consent' entail in practice and what should sur geons do when patients need help but are unable or unwilling to agree to it? When patients do consent to treatment, sur are pr ovided with a wide discretion. The end result may be cure, but disfigurement, disability and death may also result. How should such surgical 'power' be regulated to reinforce the trust of patients and to ensure that surgeons practise to an acceptable professional standard? Are there circumstances, in the public interest, in which it is acceptable to sacrifice the trust of individual patients through revealing information that was communicated in what patients believed to be conditions of strict privacy? These questions about what constitutes good professional practice concern medical ethics and law relating to consent, confidentiality and the underlying concept of personal auton omy . In addition, these principles need to be applied to surgical activities, including professional ma tters relating to governance, regulation and the process of rev alidation in its di ff erent guises around the world. Surgical training is starting to embrace the 'basic science' of surgical law to o ff er surgeons assistance in the resolution of such ethical dilemmas. This chapter is evidence of that process.

The primacy of con /f_i dentiality in surgical practice • The importance of appropriate regulation in surgical • research The importance of rigorous training and maintenance of • good practice standards

Learning objectives

Learning objectives

To understand: The importance of autonomy in good surgical practice • The necessity for reasonable disclosure prior to seeking • consent for surgery Good practice in making decisions about withdrawal of • life-sustaining treatment Learning objectives

To understand: The importance of autonomy in good surgical practice • The necessity for reasonable disclosure prior to seeking • consent for surgery Good practice in making decisions about withdrawal of • life-sustaining treatment Learning objectives

To understand: The importance of autonomy in good surgical practice • The necessity for reasonable disclosure prior to seeking • consent for surgery Good practice in making decisions about withdrawal of • life-sustaining treatment

REFERENCES

REFERENCES

1 Kings College Hospital v C & V [2015] EWCOP 80 2 Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 11 3 Wheeler RA. Tangible Sentiments. Bulletin RCSE, 2016 January 98 44 4 Salford Royal NHSFT v P & Q [2017] EWCOP 23 5 An NHS Trust & Ors v Y [2018] UKSC 46 6 In re F (Mental Patient: Sterilisation) [1990] 2 AC 1 7 Airedale NHST v Bland [1993] AC 789 8 Regina (Tracey) v Cambridge University Hospital NHS Foundation Trust and another [2014] EWCA Civ 822 9 ABC v St George's Healthcare NHST [2020] EWHC 455 QB 10 W v Egdell [1990] Ch 359 (CA) 11 http://www .uhs.nhs.uk/HealthProfessionals/Clinical law-updates/Clinicallawupdates.aspx Department of Constitutional A ff airs. Mental Capacity Act 2005 Code of - Practice. London: The Stationery O ffi ce, 2007. Department of Health. Confidentiality: NHS Code of Practice. Supple - mentary guidance: public interest disclosures. London: Department of Health, 2010. General Medical Council. Confidentiality: protecting and providing infor - mation . Available from https://www .gmc-uk.org/ethical-guidance/ ethical-guidance-for-doctors/confidentiality General Medical Council. Good medical practice. London: General Med - ical Council, 2006. General Medical Council. 0–18 years: guidance for all doctors. London: General Medical Council, 2007. General Medical Council. Decision making and consent . London: General Medical Council, 2020. Mason JK, Laurie GT . Mason and McCall Smith's law and medical ethics, 11th edn. Oxford: Oxford University Press, 2019. Nair R, Holroyd DJ (eds). Oxford handbook of surgical consent. Oxford: Oxford University Press, 2012. Wheeler RA. Presumed or implied; it's not consent. Clin Risk 2010; 16 : 1–2. Wheeler RA. Clinical law for clinical practice . London: CRC Press, Tay - lor & Francis Group, 2020. Wheeler RA. Gillick or Fraser? A plea for consistency over competence in children. Br Med J 2006; 332 : 807. Woodcock T . Surgical research in the United Kingdom. Ann R Coll Surg Engl 2009; 91 : 188–91. - Woodcock T . Law and medical ethics in organ transplantation surgery . Ann R Coll Surg Engl 2010; 92 : 282–5. REFERENCES

1 Kings College Hospital v C & V [2015] EWCOP 80 2 Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 11 3 Wheeler RA. Tangible Sentiments. Bulletin RCSE, 2016 January 98 44 4 Salford Royal NHSFT v P & Q [2017] EWCOP 23 5 An NHS Trust & Ors v Y [2018] UKSC 46 6 In re F (Mental Patient: Sterilisation) [1990] 2 AC 1 7 Airedale NHST v Bland [1993] AC 789 8 Regina (Tracey) v Cambridge University Hospital NHS Foundation Trust and another [2014] EWCA Civ 822 9 ABC v St George's Healthcare NHST [2020] EWHC 455 QB 10 W v Egdell [1990] Ch 359 (CA) 11 http://www .uhs.nhs.uk/HealthProfessionals/Clinical law-updates/Clinicallawupdates.aspx Department of Constitutional A ff airs. Mental Capacity Act 2005 Code of - Practice. London: The Stationery O ffi ce, 2007. Department of Health. Confidentiality: NHS Code of Practice. Supple - mentary guidance: public interest disclosures. London: Department of Health, 2010. General Medical Council. Confidentiality: protecting and providing infor - mation . Available from https://www .gmc-uk.org/ethical-guidance/ ethical-guidance-for-doctors/confidentiality General Medical Council. Good medical practice. London: General Med - ical Council, 2006. General Medical Council. 0–18 years: guidance for all doctors. London: General

Medical Council, 2007. General Medical Council. Decision making and consent . London: General Medical Council, 2020. Mason JK, Laurie GT . Mason and McCall Smith’s law and medical ethics, 11th edn. Oxford: Oxford University Press, 2019. Nair R, Holroyd DJ (eds). Oxford handbook of surgical consent. Oxford: Oxford University Press, 2012. Wheeler RA. Presumed or implied; it’s not consent. Clin Risk 2010; 16 : 1–2. Wheeler RA. Clinical law for clinical practice . London: CRC Press, Tay - lor & Francis Group, 2020. Wheeler RA. Gillick or Fraser? A plea for consistency over competence in children. Br Med J 2006; 332 : 807. Woodcock T . Surgical research in the United Kingdom. Ann R Coll Surg Engl 2009; 91 : 188–91. - Woodcock T . Law and medical ethics in organ transplantation surgery . Ann R Coll Surg Engl 2010; 92 : 282–5. REFERENCES

1 Kings College Hospital v C & V [2015] EWCOP 80 2 Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 11 3 Wheeler RA. Tangible Sentiments. Bulletin RCSE, 2016 January 98 44 4 Salford Royal NHSFT v P & Q [2017] EWCOP 23 5 An NHS Trust & Ors v Y [2018] UKSC 46 6 In re F (Mental Patient: Sterilisation) [1990] 2 AC 1 7 Airedale NHST v Bland [1993] AC 789 8 Regina (Tracey) v Cambridge University Hospital NHS Foundation Trust and another [2014] EWCA Civ 822 9 ABC v St George’s Healthcare NHST [2020] EWHC 455 QB 10 W v Egdell [1990] Ch 359 (CA) 11 http://www .uhs.nhs.uk/HealthProfessionals/Clinical law-updates/Clinicallawupdates.aspx Department of Constitutional A ff airs. Mental Capacity Act 2005 Code of - Practice. London: The Stationery O ffi ce, 2007. Department of Health. Confidentiality: NHS Code of Practice. Supple - mentary guidance: public interest disclosures. London: Department of Health, 2010. General Medical Council. Confidentiality: protecting and providing infor - mation . Available from https://www .gmc-uk.org/ethical-guidance/ ethical-guidance-for-doctors/confidentiality General Medical Council. Good medical practice. London: General Med - ical Council, 2006. General Medical Council. 0–18 years: guidance for all doctors. London: General Medical Council, 2007. General Medical Council. Decision making and consent . London: General Medical Council, 2020. Mason JK, Laurie GT . Mason and McCall Smith’s law and medical ethics, 11th edn. Oxford: Oxford University Press, 2019. Nair R, Holroyd DJ (eds). Oxford handbook of surgical consent. Oxford: Oxford University Press, 2012. Wheeler RA. Presumed or implied; it’s not consent. Clin Risk 2010; 16 : 1–2. Wheeler RA. Clinical law for clinical practice . London: CRC Press, Tay - lor & Francis Group, 2020. Wheeler RA. Gillick or Fraser? A plea for consistency over competence in children. Br Med J 2006; 332 : 807. Woodcock T . Surgical research in the United Kingdom. Ann R Coll Surg Engl 2009; 91 : 188–91. - Woodcock T . Law and medical ethics in organ transplantation surgery . Ann R Coll Surg Engl 2010; 92 : 282–5.

RESEARCH

RESEARCH

As part of their duty to protect life and health to an acceptable professional standard, surgeons have a subsidiary responsibility to strive to improve operative techniques through research to assure themselves and their patients that the care proposed is the best that is currently possible. Y et there is moral tension between the duty to act in the best interests of individual patients and the duty to improve surgical standards through exposing patients to the unknown risks that any form of research inevitably entails. The willingness to expose patients to such risks may be further increased by the professional and academic pressures on many surgeons to maintain a high research profile in their work. For this r eason, surgeons (and physicians, who face the same dilemmas) now accept that their research must be exter nally regulated to ensure that patients give their informed con sent, that any known risks to patients are far outweighed by the potential benefits and that other forms of protection for the patient are in place (e.g. proper indemnity) in case they are unexpectedly harmed. The administration of such r egulation is through research ethics committees, and surgeons should not participate in research that has not been approved by such bodies. Equally , special provisions will apply to research involv ing incompetent patients who cannot provide consent to par ticipate, and research ethics committees will evaluate specific proposals with great care. In practice, it is not always clear as to what constitutes ‘research’ that should be subjected to regulation, as compared with a minor innov ation dictated by the contingencies of a particular clinical situation. Surgeons must always ask them selv es in such circumstances whether or not the innovation in question falls within the boundaries of standard procedures in which they are trained. If so, what may be a new technique for them will count not as research but as an incremental improve ment in personal practice. Nevertheless, major innovations in operative procedure are scrutinised by national regulatory authorities; in the UK by the National Institute for Health and Care Excellence (NICE). This process of scrutiny has been designed to ensur e that the innovation is safe, e ffi cacious and cost-e ff ective. It is regarded (by the NHS) as a mandatory step when introducing a new interventional procedure. Equally , surgeons know that exigencies of operative surgery sometimes demand a novel and hitherto undescribed manoeu vre to get the surgeon (and the patient) out of trouble. Providing your solution is necessary , proportionate to the circumstances, performed in good faith and would pass the scrutiny of your peers as reasonable, it is unlikely that any subsequent criticism of your actions could be sustained. If a proposed innovation passes the criteria for research, it should be approved by a research ethics committee. Such sur gical research should also be subject to a clinical trial designed to ensure that findings about outcomes are systematically com pared with the best a vailable treatment and that favourable gical skill among researchers) that cannot be replicated (see also Chapter 12).

RESEARCH

As part of their duty to protect life and health to an acceptable professional standard, surgeons have a subsidiary responsibility to strive to improve operative techniques through research to assure themselves and their patients that the care proposed is the best that is currently possible. Y

et there is moral tension between the duty to act in the best interests of individual patients and the duty to improve surgical standards through exposing patients to the unknown risks that any form of research inevitably entails. The willingness to expose patients to such risks may be further increased by the professional and academic pressures on many surgeons to maintain a high research profile in their work. For this r eason, surgeons (and physicians, who face the same dilemmas) now accept that their research must be exter nally regulated to ensure that patients give their informed con sent, that any known risks to patients are far outweighed by the potential benefits and that other forms of protection for the patient are in place (e.g. proper indemnity) in case they are unexpectedly harmed. The administration of such r egulation is through research ethics committees, and surgeons should not participate in research that has not been approved by such bodies. Equally , special provisions will apply to research involv ing incompetent patients who cannot provide consent to par ticipate, and research ethics committees will evaluate specific proposals with great care. In practice, it is not always clear as to what constitutes ‘research’ that should be subjected to regulation, as compared with a minor innov ation dictated by the contingencies of a particular clinical situation. Surgeons must always ask them selv es in such circumstances whether or not the innovation in question falls within the boundaries of standard procedures in which they are trained. If so, what may be a new technique for them will count not as research but as an incremental improve ment in personal practice. Nevertheless, major innovations in operative procedure are scrutinised by national regulatory authorities; in the UK by the National Institute for Health and Care Excellence (NICE). This process of scrutiny has been designed to ensur e that the innovation is safe, e ffi cacious and cost-e ff ective. It is regarded (by the NHS) as a mandatory step when introducing a new interventional procedure. Equally , surgeons know that exigencies of operative surgery sometimes demand a novel and hitherto undescribed manoeu vre to get the surgeon (and the patient) out of trouble. Providing your solution is necessary , proportionate to the circumstances, performed in good faith and would pass the scrutiny of your peers as reasonable, it is unlikely that any subsequent criticism of your actions could be sustained. If a proposed innovation passes the criteria for research, it should be approved by a research ethics committee. Such sur gical research should also be subject to a clinical trial designed to ensure that findings about outcomes are systematically com pared with the best a vailable treatment and that favourable gical skill among researchers) that cannot be replicated (see also Chapter 12).
RESEARCH

As part of their duty to protect life and health to an acceptable professional standard, surgeons have a subsidiary responsibility to strive to improve operative techniques through research to assure themselves and their patients that the care proposed is the best that is currently possible. Y et there is moral tension between the duty to act in the best interests of individual patients and the duty to improve surgical standards through exposing patients to the unknown risks that any form of research inevitably entails. The willingness to expose patients to such risks may be further increased by the professional and academic pressures on many surgeons to maintain a high research profile in their work. For this r eason, surgeons (and physicians, who face the same dilemmas) now accept that their research must be exter nally regulated to ensure that patients give their informed con sent, that any known risks to patients are far outweighed by the potential benefits and that other forms of protection for the patient are in place (e.g. proper indemnity) in case they are unexpectedly harmed. The administration of such r egulation is through research ethics committees, and surgeons should not participate in research that has not been approved by such bodies. Equally , special provisions will apply to research involv ing incompetent patients who

cannot provide consent to par ticipate, and research ethics committees will evaluate specific proposals with great care. In practice, it is not always clear as to what constitutes ‘research’ that should be subjected to regulation, as compared with a minor innov ation dictated by the contingencies of a particular clinical situation. Surgeons must always ask them selv es in such circumstances whether or not the innovation in question falls within the boundaries of standard procedures in which they are trained. If so, what may be a new technique for them will count not as research but as an incremental improve ment in personal practice. Nevertheless, major innovations in operative procedure are scrutinised by national regulatory authorities; in the UK by the National Institute for Health and Care Excellence (NICE). This process of scrutiny has been designed to ensur e that the innovation is safe, e ffi cacious and cost-e ff ective. It is regarded (by the NHS) as a mandatory step when introducing a new interventional procedure. Equally , surgeons know that exigencies of operative surgery sometimes demand a novel and hitherto undescribed manoeu vre to get the surgeon (and the patient) out of trouble. Providing your solution is necessary , proportionate to the circumstances, performed in good faith and would pass the scrutiny of your peers as reasonable, it is unlikely that any subsequent criticism of your actions could be sustained. If a proposed innovation passes the criteria for research, it should be approved by a research ethics committee. Such sur gical research should also be subject to a clinical trial designed to ensure that findings about outcomes are systematically com pared with the best a vailable treatment and that favourable gical skill among researchers) that cannot be replicated (see also Chapter 12).

RESPECT FOR AUTONOMY

RESPECT FOR AUTONOMY

Surgeons have a duty of care towards their patients that goes beyond merely protecting life and health. Their additional duty of care is to respect the autonomy of their patients and their - ability to make choices about their treatments, and to evaluate potential outcomes in light of other life plans. Such respect is particularly important for surgeons because, without it, the trust between them and their patients may be compromised, along with the success of the surgical care provided. We are - careful enough in everyday life about whom we allow to touch us and to see us unclothed. It is hardly surprising that many people feel strongly about exercising the same control over a - potentially hazardous activity , such as surgery . For all these reasons, there is a wide moral and legal con - geons sensus that patients have the right to exercise choice over their surgical care. In this context, a right should be interpreted as a claim that can be made on the surgeon. The surgeon, ther efore, accepts the strict duty to respect the patient’s choice, regardless of personal preferences. Thus, to the degree that patients have a right to make choices about proposed surgical treatment, it then follows that they should be allowed to refuse treatments that they do not want, even when surgeons think that they are wrong. The right to make an unwise decision was exemplified in a case where a woman with capacity refused 1 renal replacement therapy . The court reminded doctors that, notwithstanding the fact that other citizens might consider her - decision unreasonable, illogical or even immoral, none of these criticisms of the decision by themselves provide evidence of a lack of capacity . Patients can refuse surgical treatment that will save their lives, either at present or in the future. The lat - ter, through the formulation of advance decisions or lasting powers of attorney , specify the types of life-saving treatments may later become incompetent to refuse them. RESPECT FOR AUTONOMY

Surgeons have a duty of care towards their patients that goes beyond merely protecting life and health. Their additional duty of care is to respect the autonomy of their patients and their - ability to make choices about their treatments, and to evaluate potential outcomes in light of other life plans. Such respect is particularly important for surgeons because, without it, the trust between them and their patients may be compromised, along with the success of the surgical care provided. We are - careful enough in everyday life about whom we allow to touch us and to see us unclothed. It is hardly surprising that many people feel strongly about exercising the same control over a - potentially hazardous activity , such as surgery . For all these reasons, there is a wide moral and legal con - geons sensus that patients have the right to exercise choice over their surgical care. In this context, a right should be interpreted as a claim that can be made on the surgeon. The surgeon, ther efore, accepts the strict duty to respect the patient’s choice, regardless of personal preferences. Thus, to the degree that patients have a right to make choices about proposed surgical treatment, it then follows that they should be allowed to refuse treatments that they do not want, even when surgeons think that they are wrong. The right to make an unwise decision was exemplified in a case where a woman with capacity refused 1 renal replacement therapy . The court reminded doctors that, notwithstanding the fact that other citizens might consider her -

decision unreasonable, illogical or even immoral, none of these criticisms of the decision by themselves provide evidence of a lack of capacity . Patients can refuse surgical treatment that will save their lives, either at present or in the future. The lat - ter, through the formulation of advance decisions or lasting powers of attorney , specify the types of life-saving treatments may later become incompetent to refuse them. RESPECT FOR AUTONOMY

Surgeons have a duty of care towards their patients that goes beyond merely protecting life and health. Their additional duty of care is to respect the autonomy of their patients and their - ability to make choices about their treatments, and to evaluate potential outcomes in light of other life plans. Such respect is particularly important for surgeons because, without it, the trust between them and their patients may be compromised, along with the success of the surgical care provided. We are - careful enough in everyday life about whom we allow to touch us and to see us unclothed. It is hardly surprising that many people feel strongly about exercising the same control over a - potentially hazardous activity , such as surgery . For all these reasons, there is a wide moral and legal con - geons sensus that patients have the right to exercise choice over their surgical care. In this context, a right should be interpreted as a claim that can be made on the surgeon. The surgeon, ther efore, accepts the strict duty to respect the patient’s choice, regardless of personal preferences. Thus, to the degree that patients have a right to make choices about proposed surgical treatment, it then follows that they should be allowed to refuse treatments that they do not want, even when surgeons think that they are wrong. The right to make an unwise decision was exemplified in a case where a woman with capacity refused 1 renal replacement therapy . The court reminded doctors that, notwithstanding the fact that other citizens might consider her - decision unreasonable, illogical or even immoral, none of these criticisms of the decision by themselves provide evidence of a lack of capacity . Patients can refuse surgical treatment that will save their lives, either at present or in the future. The lat - ter, through the formulation of advance decisions or lasting powers of attorney , specify the types of life-saving treatments may later become incompetent to refuse them.

SHARING INFORMATION WITH THE POLICE

SHARING INFORMATION WITH THE POLICE

It is not uncommon to receive a request from the police for patient data. Consider the patient admitted after a fall down the stairs; it is suggested that his partner had caused the fall. The partner is in police custody , awaiting a court’s decision on bail the following day . The patient, at the time of the police enquiry , was intubated and ventilated, lacking capacity to decide whether to consent to the disclosure of his clinical details. What should our posi tion be in these circumstances? Sixty years ago Lord Denning made it clear that there is no general obligation for clinicians to disclose confidential information following a request the police. Naturally , a constable can always approach a court in the face of clinical refusal; it would be most unlikely that an NHS trust would refuse to comply with a court order to disclose. The DH suggests that doctors should consider disclosure if, among other considerations, the alleged o ff ence is grave and delayed but for prompt disclosure. Clinicians m ust disclose to the police any information iden - tifying a driver alleged of committing a tra ffi c o ff ence; and - even in the absence of a police request, their suspicions of a person’s involvement in terrorist activities. Less specifically , doctors must disclose to the police the admission of a person - w ounded by knife or gun, so that at least the constabulary is - made aware of an armed assailant in the neighbourhood. Whether the stabbed or shot person allows subsequent disclo - - sure of their identity rather depends on their capacity at the time. Naturally , if the patient consents to disclosure no prob - lem occurs. But some victims of assault may choose to remain silent, perhaps fearing more grievous injur y if they become identified as an informer. - The patient who lacks capacity poses a more di ffi cult prob - lem. If it seems likely that they will soon regain the ability to make their own decision, it would be prudent to await that recovery . If there is evidential material that could be lost during the lapse of time, such as clear scars or bruises or f ootprints, by all means have these images recorded, but await the patient’s capacitous consent before handing them to the police. At the other extreme, if the patient is unlikely to recover capacity after an assault, a grave o ff ence may have transpired, making disclo - sure in the absence of consent more palatable. If there is a simple stark binary choice between either respecting a person’s confidentiality or protecting them from death or serious harm, most clinicians would likely value life and limb over a notion of confidences. Guidance from DH suggests that unlawful killing , rape, treason and child abuse could all cross the ‘serious harm’ threshold. By contrast, theft, fraud and criminal damage would not. The leading case is of Dr Egdell, a psychiatrist instructed by 10 W , who had killed five people with extreme violence. W was - seeking review of his secure hospital order and hoped that Dr Egdell would provide a favourable report of his mental health. On the contrary , Dr Egdell found that W was highly danger - ous, fascinated by high explosives, and that the secure hospital’s sta ff were oblivious to the threat W continued to pose. Faced with the unhelpful report W’s solicitors did not pur - sue the application to the Mental Health Tribunal, but Dr Egdell felt his report should nonetheless go to the Home Sec -

retary and the medical director of the hospital. W disagreed. In subsequent litigation the Court of Appeal held that this dis - closure in the teeth of W’s capacitous opposition was justified and in the public interest. The breac h in confidentiality was made lawful by the real risk of serious harm to others should W be r eleased. - Frustratingly , the paucity of cases provides us with no fur - ther judicial gloss on this clinical dilemma. from SHARING INFORMATION WITH THE POLICE

It is not uncommon to receive a request from the police for patient data. Consider the patient admitted after a fall down the stairs; it is suggested that his partner had caused the fall. The partner is in police custody , awaiting a court’s decision on bail the following day . The patient, at the time of the police enquiry , was intubated and ventilated, lacking capacity to decide whether to consent to the disclosure of his clinical details. What should our posi tion be in these circumstances? Sixty years ago Lord Denning made it clear that there is no general obligation for clinicians to disclose confidential information following a request the police. Naturally , a constable can always approach a court in the face of clinical refusal; it would be most unlikely that an NHS trust would refuse to comply with a court order to disclose. The DH suggests that doctors should consider disclosure if, among other considerations, the alleged o ff ence is grave and delayed but for prompt disclosure. Clinicians m ust disclose to the police any information iden - tifying a driver alleged of committing a tra ffi c o ff ence; and - even in the absence of a police request, their suspicions of a person’s involvement in terrorist activities. Less specifically , doctors must disclose to the police the admission of a person - w ounded by knife or gun, so that at least the constabulary is - made aware of an armed assailant in the neighbourhood. Whether the stabbed or shot person allows subsequent disclo - - sure of their identity rather depends on their capacity at the time. Naturally , if the patient consents to disclosure no prob - lem occurs. But some victims of assault may choose to remain silent, perhaps fearing more grievous injur y if they become identified as an informer. - The patient who lacks capacity poses a more di ffi cult prob - lem. If it seems likely that they will soon regain the ability to make their own decision, it would be prudent to await that recovery . If there is evidential material that could be lost during the lapse of time, such as clear scars or bruises or f ootprints, by all means have these images recorded, but await the patient’s capacitous consent before handing them to the police. At the other extreme, if the patient is unlikely to recover capacity after an assault, a grave o ff ence may have transpired, making disclo - sure in the absence of consent more palatable. If there is a simple stark binary choice between either respecting a person’s confidentiality or protecting them from death or serious harm, most clinicians would likely value life and limb over a notion of confidences. Guidance from DH suggests that unlawful killing , rape, treason and child abuse could all cross the ‘serious harm’ threshold. By contrast, theft, fraud and criminal damage would not. The leading case is of Dr Egdell, a psychiatrist instructed by 10 W , who had killed five people with extreme violence. W was - seeking review of his secure hospital order and hoped that Dr Egdell would provide a favourable report of his mental health. On the contrary , Dr Egdell found that W was highly danger - ous, fascinated by high explosives, and that the secure hospital’s sta ff were oblivious to the threat W continued to pose. Faced with the unhelpful report W’s solicitors did not pur - sue the application to the Mental Health Tribunal, but Dr Egdell felt his report should nonetheless go to the Home Sec - retary and the medical director of the hospital. W disagreed. In subsequent litigation the Court of Appeal held that this dis - closure in the teeth of W’s capacitous opposition was justified and in the public interest. The breac h in confidentiality was made lawful by the real risk of serious harm to others should W be r eleased. - Frustratingly , the paucity of cases provides us with no fur - ther judicial gloss on this clinical dilemma. from SHARING INFORMATION WITH THE POLICE

It is not uncommon to receive a request from the police for patient data. Consider the patient admitted after a fall down the stairs; it is suggested that his partner had caused the fall. The partner is in police custody , awaiting a court’s decision on bail the following day . The patient, at the time of the police enquiry , was intubated and ventilated, lacking capacity to decide whether to consent to the disclosure of his clinical details. What should our posi tion be in these circumstances? Sixty years ago Lord Denning made it clear that there is no general obligation for clinicians to disclose confidential information following a request the police. Naturally , a constable can always approach a court in the face of clinical refusal; it would be most unlikely that an NHS trust would refuse to comply with a court order to disclose. The DH suggests that doctors should consider disclosure if, among other considerations, the alleged o ff ence is grave and delayed but for prompt disclosure. Clinicians m ust disclose to the police any information iden - tifying a driver alleged of committing a tra ffi c o ff ence; and - even in the absence of a police request, their suspicions of a person’s involvement in terrorist activities. Less specifically , doctors must disclose to the police the admission of a person - w ounded by knife or gun, so that at least the constabulary is - made aware of an armed assailant in the neighbourhood. Whether the stabbed or shot person allows subsequent disclo - - sure of their identity rather depends on their capacity at the time. Naturally , if the patient consents to disclosure no prob - lem occurs. But some victims of assault may choose to remain silent, perhaps fearing more grievous injur y if they become identified as an informer. - The patient who lacks capacity poses a more di ffi cult prob - lem. If it seems likely that they will soon regain the ability to make their own decision, it would be prudent to await that recovery . If there is evidential material that could be lost during the lapse of time, such as clear scars or bruises or f ootprints, by all means have these images recorded, but await the patient’s capacitous consent before handing them to the police. At the other extreme, if the patient is unlikely to recover capacity after an assault, a grave o ff ence may have transpired, making disclo - sure in the absence of consent more palatable. If there is a simple stark binary choice between either respecting a person’s confidentiality or protecting them from death or serious harm, most clinicians would likely value life and limb over a notion of confidences. Guidance from DH suggests that unlawful killing , rape, treason and child abuse could all cross the ‘serious harm’ threshold. By contrast, theft, fraud and criminal damage would not. The leading case is of Dr Egdell, a psychiatrist instructed by 10 W , who had killed five people with extreme violence. W was - seeking review of his secure hospital order and hoped that Dr Egdell would provide a favourable report of his mental health. On the contrary , Dr Egdell found that W was highly danger - ous, fascinated by high explosives, and that the secure hospital’s sta ff were oblivious to the threat W continued to pose. Faced with the unhelpful report W’s solicitors did not pur - sue the application to the Mental Health Tribunal, but Dr Egdell felt his report should nonetheless go to the Home Sec - retary and the medical director of the hospital. W disagreed. In subsequent litigation the Court of Appeal held that this dis - closure in the teeth of W’s capacitous opposition was justified and in the public interest. The breac h in confidentiality was made lawful by the real risk of serious harm to others should W be r eleased. - Frustratingly , the paucity of cases provides us with no fur - ther judicial gloss on this clinical dilemma. from

STANDARDS OF EXCELLENCE

STANDARDS OF EXCELLENCE

To optimise success in protecting life and health to an accept - able standard, surgeons must only o ff er specialised treatment in which they have been properly trained. To do so will entail sustained further education throughout a surgeon’s car eer in the wake of new surgical procedures. While training, surgery should be practised only under appropriate supervision by someone who has appropriate levels of skill. Such skill can be demonstrated only through appropriate clinical audit, to which all surgeons should regularly submit their results. When these reveal unacceptable levels of success, no further surgical work of that kind should continue unless further training is under - gone under the supervision of someone whose success rates are satisfactory . To do otherwise would be to place the interest of the surgeon above that of their patient, an imbalance that is - never morally or professionally appropriate. - Sur geons also have a duty to monitor the performance of their colleagues. To know that a fellow surgeon is exposing patients to unacceptable levels of potential harm and to do nothing about it is to incur some responsibility for such harm when it occur s. Surgical teams and the institutions in which they function should have clear protocols for exposing unac - ceptable professional performance and helping colleagues to - understand the danger to which they may expose patients. If - necessary , o ff ending surgeons must be stopped from practis - ing until they can undergo further appropriate training and counselling. Too often, such danger has had to be reported by individuals whose anxieties have not been properly heeded and who have then been professionally pilloried rather than acknowledged for their contribution to pa tient safety . Those - who participate in closing ranks, and ostracism, share the moral responsibility for any resulting harm to patients. If something goes wrong with surgical treatment, the UK health regulators unanimously insist that the patient should be told what has - happened; in many senses, a similar disclosure to that which occurred during the consent process, but now with the benefit of hindsight. Again, this candid disclosure is designed to put the patient in the same position as the surgeon, with respect to 11 information about their health. STANDARDS OF EXCELLENCE

To optimise success in protecting life and health to an accept - able standard, surgeons must only o ff er specialised treatment in which they have been properly trained. To do so will entail sustained further education throughout a surgeon’s car eer in the wake of new surgical procedures. While training, surgery should be practised only under appropriate supervision by someone who has appropriate levels of skill. Such skill can be demonstrated only through appropriate clinical audit, to which all surgeons should regularly submit their results. When these reveal unacceptable levels of success, no further surgical work of that kind should continue unless further training is under - gone under the supervision of someone whose success rates are satisfactory . To do otherwise would be to place the interest of the surgeon above that of their patient, an imbalance that is -

never morally or professionally appropriate. - Sur geons also have a duty to monitor the performance of their colleagues. To know that a fellow surgeon is exposing patients to unacceptable levels of potential harm and to do nothing about it is to incur some responsibility for such harm when it occur s. Surgical teams and the institutions in which they function should have clear protocols for exposing unac - ceptable professional performance and helping colleagues to - understand the danger to which they may expose patients. If - necessary , o ff ending surgeons must be stopped from practis - ing until they can undergo further appropriate training and counselling. Too often, such danger has had to be reported by individuals whose anxieties have not been properly heeded and who have then been professionally pilloried rather than acknowledged for their contribution to pa tient safety . Those - who participate in closing ranks, and ostracism, share the moral responsibility for any resulting harm to patients. If something goes wrong with surgical treatment, the UK health regulators unanimously insist that the patient should be told what has - happened; in many senses, a similar disclosure to that which occurred during the consent process, but now with the benefit of hindsight. Again, this candid disclosure is designed to put the patient in the same position as the surgeon, with respect to 11 information about their health. STANDARDS OF EXCELLENCE

To optimise success in protecting life and health to an accept - able standard, surgeons must only o ff er specialised treatment in which they have been properly trained. To do so will entail sustained further education throughout a surgeon’s car eer in the wake of new surgical procedures. While training, surgery should be practised only under appropriate supervision by someone who has appropriate levels of skill. Such skill can be demonstrated only through appropriate clinical audit, to which all surgeons should regularly submit their results. When these reveal unacceptable levels of success, no further surgical work of that kind should continue unless further training is under - gone under the supervision of someone whose success rates are satisfactory . To do otherwise would be to place the interest of the surgeon above that of their patient, an imbalance that is - never morally or professionally appropriate. - Sur geons also have a duty to monitor the performance of their colleagues. To know that a fellow surgeon is exposing patients to unacceptable levels of potential harm and to do nothing about it is to incur some responsibility for such harm when it occur s. Surgical teams and the institutions in which they function should have clear protocols for exposing unac - ceptable professional performance and helping colleagues to - understand the danger to which they may expose patients. If - necessary , o ff ending surgeons must be stopped from practis - ing until they can undergo further appropriate training and counselling. Too often, such danger has had to be reported by individuals whose anxieties have not been properly heeded and who have then been professionally pilloried rather than acknowledged for their contribution to pa tient safety . Those - who participate in closing ranks, and ostracism, share the moral responsibility for any resulting harm to patients. If something goes wrong with surgical treatment, the UK health regulators unanimously insist that the patient should be told what has - happened; in many senses, a similar disclosure to that which occurred during the consent process, but now with the benefit of hindsight. Again, this candid disclosure is designed to put the patient in the same position as the surgeon, with respect to 11 information about their health.

SURGICAL PRACTICE

SURGICAL PRACTICE

Thus far, the moral and legal reasons why the duty of surgeons to respect the autonomy of patients translates into the specific responsibility to obtain informed consent to treatment have been reviewed. For consent to be valid, adult patients must: /uni25CF have capacity to give it – be able to understand, remem - ber and deliberate over the information disclosed to them - about treatment choices, and to communicate those - choices; /uni25CF not be coerced into decisions that reflect the preferences of others rather than themselves; /uni25CF have been given su ffi cient information for these choices to be based on an accurate understanding of reasons for and - against proceeding with specific treatments. Surgical care would grind to a halt if it were always neces - sary to obtain explicit informed consent every time a patient is touched in the context of their care. Fortunately , it is an elementary step merely to ask the patient whether they mind being examined – the usual response will be acce ptance. This - simple transaction illustrates that the legal and ethical ‘rules’ that govern a surgeon are often no more than an expression of good clinical practice; in this case, politeness. Some patients will not be able to give consent because of - temporary incapacity . This may result from their presenting illness or intoxication, or an unanticipated situation may be encountered midway through a general anaesthetic. T he moral and legal rules that govern such situations are clear. The - doctrine of medical necessity enables the surgeon, in an emer - gency , to save life and prevent permanent disability , operating without consent. This has historically been employed daily , where unconscious emergency patients undergo surgery to save ‘life and limb’. No consent has been provided and none is required, providing the treatment is in the patient’s best inter - - ests. However, if the patient has made a legally valid advance decision refusing treatment of the specific kind required, their - decision must be honoured, providing it is applicable to the cur - - rent clinical situation. Wherever possib le, surgery on patients who are temporarily incapacitated should be postponed until their capacity is restored and they are able to give informed consent or refusal for themselves. Surgeons must take care to respect the distinction between procedures that are necessary to prevent death or irremediable harm and those that are done merely out of convenience. - If /uni00A0 the /uni00A0 patient consents only to a dilatation and curettage, do interests’, simply because she is anaesthetised. SURGICAL PRACTICE

Thus far, the moral and legal reasons why the duty of surgeons to respect the autonomy of patients translates into the specific responsibility to obtain informed consent to treatment have been reviewed. For consent to be valid, adult patients must: /uni25CF have capacity to give it – be able to understand, remem - ber and deliberate over the information disclosed to them - about treatment choices, and to communicate those - choices; /uni25CF not be coerced into decisions that reflect the preferences of others rather than themselves; /uni25CF have been given su ffi cient information for these choices to be based on an accurate understanding of reasons for and - against proceeding with specific treatments. Surgical care would grind to a halt if it were always neces - sary to obtain explicit informed consent every time a patient is touched in the context of

their care. Fortunately , it is an elementary step merely to ask the patient whether they mind being examined – the usual response will be acce ptance. This - simple transaction illustrates that the legal and ethical ‘rules’ that govern a surgeon are often no more than an expression of good clinical practice; in this case, politeness. Some patients will not be able to give consent because of - temporary incapacity . This may result from their presenting illness or intoxication, or an unanticipated situation may be encountered midway through a general anaesthetic. T he moral and legal rules that govern such situations are clear. The - doctrine of medical necessity enables the surgeon, in an emer - gency , to save life and prevent permanent disability , operating without consent. This has historically been employed daily , where unconscious emergency patients undergo surgery to save ‘life and limb’. No consent has been provided and none is required, providing the treatment is in the patient’s best inter - - ests. However, if the patient has made a legally valid advance decision refusing treatment of the specific kind required, their - decision must be honoured, providing it is applicable to the cur - - rent clinical situation. Wherever possib le, surgery on patients who are temporarily incapacitated should be postponed until their capacity is restored and they are able to give informed consent or refusal for themselves. Surgeons must take care to respect the distinction between procedures that are necessary to prevent death or irremediable harm and those that are done merely out of convenience. - If /uni00A0 the /uni00A0 patient consents only to a dilatation and curettage, do interests’, simply because she is anaesthetised. SURGICAL PRACTICE

Thus far, the moral and legal reasons why the duty of surgeons to respect the autonomy of patients translates into the specific responsibility to obtain informed consent to treatment have been reviewed. For consent to be valid, adult patients must: /uni25CF have capacity to give it – be able to understand, remem - ber and deliberate over the information disclosed to them - about treatment choices, and to communicate those - choices; /uni25CF not be coerced into decisions that reflect the preferences of others rather than themselves; /uni25CF have been given su ffi cient information for these choices to be based on an accurate understanding of reasons for and - against proceeding with specific treatments. Surgical care would grind to a halt if it were always neces - sary to obtain explicit informed consent every time a patient is touched in the context of their care. Fortunately , it is an elementary step merely to ask the patient whether they mind being examined – the usual response will be acce ptance. This - simple transaction illustrates that the legal and ethical ‘rules’ that govern a surgeon are often no more than an expression of good clinical practice; in this case, politeness. Some patients will not be able to give consent because of - temporary incapacity . This may result from their presenting illness or intoxication, or an unanticipated situation may be encountered midway through a general anaesthetic. T he moral and legal rules that govern such situations are clear. The - doctrine of medical necessity enables the surgeon, in an emer - gency , to save life and prevent permanent disability , operating without consent. This has historically been employed daily , where unconscious emergency patients undergo surgery to save ‘life and limb’. No consent has been provided and none is required, providing the treatment is in the patient’s best inter - - ests. However, if the patient has made a legally valid advance decision refusing treatment of the specific kind required, their - decision must be honoured, providing it is applicable to the cur - - rent clinical situation. Wherever possib le, surgery on patients who are temporarily incapacitated should be postponed until their capacity is restored and they are able to give informed consent or refusal for themselves. Surgeons must take care to respect the distinction between procedures that are necessary to prevent death or irremediable harm and those that are done merely out of convenience. - If /uni00A0 the /uni00A0

patient consents only to a dilatation and curettage, do interests', simply because she is anaesthetised.

THE ROLE OF THE COURT

THE ROLE OF THE COURT

The question has arisen regarding the circumstances in England in which clinical decisions relating to withdrawal of 5 treatment should be automatically referred to the court. Mr Y was an active man in his fifties when he had a cardiac arrest and consequent cerebral hypoxia. He never regained consciousness. He was fed through a gastrostomy , and over the following 3 months his doctors concluded that he had a ‘prolonged disorder of consciousness’ (a term that courts have accepted as encompassing persistent vegetative and minimally conscious states). It was also concluded that, if he were to regain consciousness, he would have profound disability , both - physical and cognitive, and remain dependent on others to care for him. This prognosis was confirmed by a second opin - ion. His wife and children told the clinicians that Mr Y would - not have wished to be kept alive if he had received that progno - sis during the time preceding his loss of capacity . Accordingly , the family and clinicians all agr eed that it would be in Mr Y ’ s best interests to withdraw his clinically assisted nutrition and hydration (CANH). - The question for the court was whether a court order must - always be obtained in such situations, or whether, under cer - tain circumstances, these decisions can be taken without the involvement of a court. Twenty-five years earlier, the courts had considered two very di ff erent clinical questions. In re F the question related to - whether sterilisation to prevent pregnancy (rather than to treat 6 disease) could be performed on an incapacitated woman. In Bland it was proposed that CANH in a young man who had been in a persistent vegetative state for 3 years should be with - 7 - drawn. The House of Lords had made it clear in both cases that, as a matter of good practice, a court declaration should be - obtained (that the proposed treatment was in an incapacitated person’s best interests) prior to the actions being taken. In considering Mr Y ’ s case, the Supreme Court noted that decisions on withdrawing CANH are frequent and ubiquitous, best interests of patients with a wide range of neurodegenera tive conditions, notably stroke and dementia. There could be no principled or logical reason to demand a court review of the tiny subset of patients with a ‘prolonged disorder of con sciousness’ while b lithely accepting the commonplace practice of withdrawal in other patients without recourse to the courts. Similarly , since CANH is seen as medical treatment, there can be no reason why its withdrawal should be seen as ‘first among equals’, ther e being no automatic recourse to declarations for withdrawal of antibiotics, ventilation or organ support. For these and other reasons, the Supreme Court held that, provided the provisions and guidance of the MCA 2005 are followed, and that there is agreement as to what is in the patient’s best interests, then life-sustaining treatment, whether this is CANH or any other form of life support, can be with drawn or withheld without needing to make an application to the court. Plainly , if there is any hint of lack of agreement or con flict of interest from any quarter, clinical or family , when the withdrawal of life-sustaining treatment is being considered, an application to court must be made. Equally , if in these circum stances at the end of the decision-making process the clinicians or family remain uncertain, because the conclusions on best interests are finely balanced, an application must be made. This judgement marked a ‘handing back’ to clinicians of responsibility to make some decisions that for the last 25 years have been e xclusively within the control of our courts. This

redoubles the responsibility that clinicians bear to ensure that the MCA 2005 is understood and applied assiduously . THE ROLE OF THE COURT

The question has arisen regarding the circumstances in England in which clinical decisions relating to withdrawal of 5 treatment should be automatically referred to the court. Mr Y was an active man in his fifties when he had a cardiac arrest and consequent cerebral hypoxia. He never regained consciousness. He was fed through a gastrostomy , and over the following 3 months his doctors concluded that he had a ‘prolonged disorder of consciousness’ (a term that courts have accepted as encompassing persistent vegetative and minimally conscious states). It was also concluded that, if he were to regain consciousness, he would have profound disability , both - physical and cognitive, and remain dependent on others to care for him. This prognosis was confirmed by a second opin - ion. His wife and children told the clinicians that Mr Y would - not have wished to be kept alive if he had received that progno - sis during the time preceding his loss of capacity . Accordingly , the family and clinicians all agr eed that it would be in Mr Y ’ s best interests to withdraw his clinically assisted nutrition and hydration (CANH). - The question for the court was whether a court order must - always be obtained in such situations, or whether, under cer - tain circumstances, these decisions can be taken without the involvement of a court. Twenty-five years earlier, the courts had considered two very di ff erent clinical questions. In re F the question related to - whether sterilisation to prevent pregnancy (rather than to treat 6 disease) could be performed on an incapacitated woman. In Bland it was proposed that CANH in a young man who had been in a persistent vegetative state for 3 years should be with - 7 - drawn. The House of Lords had made it clear in both cases that, as a matter of good practice, a court declaration should be - obtained (that the proposed treatment was in an incapacitated person’s best interests) prior to the actions being taken. In considering Mr Y ’ s case, the Supreme Court noted that decisions on withdrawing CANH are frequent and ubiquitous, best interests of patients with a wide range of neurodegenera tive conditions, notably stroke and dementia. There could be no principled or logical reason to demand a court review of the tiny subset of patients with a ‘prolonged disorder of con sciousness’ while b lithely accepting the commonplace practice of withdrawal in other patients without recourse to the courts. Similarly , since CANH is seen as medical treatment, there can be no reason why its withdrawal should be seen as ‘first among equals’, ther e being no automatic recourse to declarations for withdrawal of antibiotics, ventilation or organ support. For these and other reasons, the Supreme Court held that, provided the provisions and guidance of the MCA 2005 are followed, and that there is agreement as to what is in the patient’s best interests, then life-sustaining treatment, whether this is CANH or any other form of life support, can be with drawn or withheld without needing to make an application to the court. Plainly , if there is any hint of lack of agreement or con flict of interest from any quarter, clinical or family , when the withdrawal of life-sustaining treatment is being considered, an application to court must be made. Equally , if in these circum stances at the end of the decision-making process the clinicians or family remain uncertain, because the conclusions on best interests are finely balanced, an application must be made. This judgement marked a ‘handing back’ to clinicians of responsibility to make some decisions that for the last 25 years have been e xclusively within the control of our courts. This redoubles the responsibility that clinicians bear to ensure that the MCA 2005 is understood and applied assiduously . THE ROLE OF THE COURT

The question has arisen regarding the circumstances in England in which clinical decisions relating to withdrawal of 5 treatment should be automatically referred to the court. Mr Y was an active man

in his fifties when he had a cardiac arrest and consequent cerebral hypoxia. He never regained consciousness. He was fed through a gastrostomy , and over the following 3 months his doctors concluded that he had a ‘prolonged disorder of consciousness’ (a term that courts have accepted as encompassing persistent vegetative and minimally conscious states). It was also concluded that, if he were to regain consciousness, he would have profound disability , both - physical and cognitive, and remain dependent on others to care for him. This prognosis was confirmed by a second opin - ion. His wife and children told the clinicians that Mr Y would - not have wished to be kept alive if he had received that progno - sis during the time preceding his loss of capacity . Accordingly , the family and clinicians all agr eed that it would be in Mr Y ’ s best interests to withdraw his clinically assisted nutrition and hydration (CANH). - The question for the court was whether a court order must - always be obtained in such situations, or whether, under cer - tain circumstances, these decisions can be taken without the involvement of a court. Twenty-five years earlier, the courts had considered two very di ff erent clinical questions. In re F the question related to - whether sterilisation to prevent pregnancy (rather than to treat 6 disease) could be performed on an incapacitated woman. In Bland it was proposed that CANH in a young man who had been in a persistent vegetative state for 3 years should be with - 7 - drawn. The House of Lords had made it clear in both cases that, as a matter of good practice, a court declaration should be - obtained (that the proposed treatment was in an incapacitated person’s best interests) prior to the actions being taken. In considering Mr Y ’ s case, the Supreme Court noted that decisions on withdrawing CANH are frequent and ubiquitous, best interests of patients with a wide range of neurodegenera tive conditions, notably stroke and dementia. There could be no principled or logical reason to demand a court review of the tiny subset of patients with a ‘prolonged disorder of con sciousness’ while b lithely accepting the commonplace practice of withdrawal in other patients without recourse to the courts. Similarly , since CANH is seen as medical treatment, there can be no reason why its withdrawal should be seen as ‘first among equals’, ther e being no automatic recourse to declarations for withdrawal of antibiotics, ventilation or organ support. For these and other reasons, the Supreme Court held that, provided the provisions and guidance of the MCA 2005 are followed, and that there is agreement as to what is in the patient’s best interests, then life-sustaining treatment, whether this is CANH or any other form of life support, can be with drawn or withheld without needing to make an application to the court. Plainly , if there is any hint of lack of agreement or con flict of interest from any quarter, clinical or family , when the withdrawal of life-sustaining treatment is being considered, an application to court must be made. Equally , if in these circum stances at the end of the decision-making process the clinicians or family remain uncertain, because the conclusions on best interests are finely balanced, an application must be made. This judgement marked a ‘handing back’ to clinicians of responsibility to make some decisions that for the last 25 years have been e xclusively within the control of our courts. This redoubles the responsibility that clinicians bear to ensure that the MCA 2005 is understood and applied assiduously .

TRANSPLANTATION

TRANSPLANTATION

The law and ethics of organ transplantation require more space than this chapter allows. In common with other nations, the UK has a statutory framework for transplantation, but even among this small group of nations there is no unanimity of legislation, thus rules for deceased and live donor transplants compensating a living donor and for legitimising a market in organs di ï¬€ er widely . It is strongly recommended that you refer to the rules within your own jurisdiction.
TRANSPLANTATION

The law and ethics of organ transplantation require more space than this chapter allows. In common with other nations, the UK has a statutory framework for transplantation, but even among this small group of nations there is no unanimity of legislation, thus rules for deceased and live donor transplants compensating a living donor and for legitimising a market in organs di ï¬€ er widely . It is strongly recommended that you refer to the rules within your own jurisdiction.
TRANSPLANTATION

The law and ethics of organ transplantation require more space than this chapter allows. In common with other nations, the UK has a statutory framework for transplantation, but even among this small group of nations there is no unanimity of legislation, thus rules for deceased and live donor transplants compensating a living donor and for legitimising a market in organs di ï¬€ er widely . It is strongly recommended that you refer to the rules within your own jurisdiction.