

DUTY OF CANDOUR

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Equal consideration should be given to disclosure of information 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 that the proposed operation may go wrong. The disclosures of 'bleeding and infection' are ubiquitous across the land, together with the more specific foreseeable risks, such as damage to contiguous structures, recurrence of the original diagnosis 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 patient, had they known of the risk, either would have never had the operation 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 surgeon if they crystallise during surgery. Merely because the division of a ureter 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 distinguished from the complications 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 thromboembolism. This is a regrettable complication 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 postoperative venous thromboembolism and if the unit's protocol of 28 days of low molecular-weight heparin was not prescribed, a duty of candour would certainly be owed since something went wrong. In clinical practice fault is not determinative when considering whether to be candid over the occurrence of a complication. 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 have an effect 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 complication 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 relating 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

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Revision #1

Created 2025-12-31 15:09:01 UTC by Omar Ayman

Updated 2025-12-31 15:09:01 UTC by Omar Ayman