Ethics and law in surgical practice

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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.
- The primacy of **confidentiality** in surgical practice

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.**
- patients have the right **to exercise choice over their surgical care.**
- The surgeon, therefore, 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.**

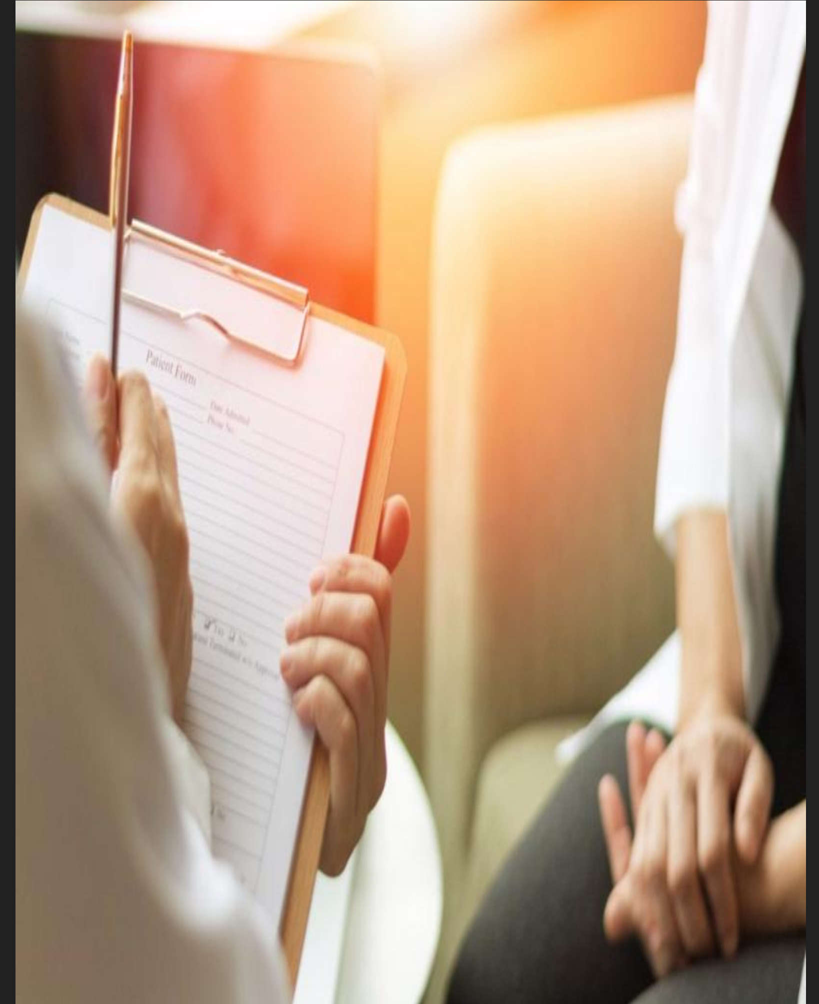
DISCLOSURE PRIOR TO CONSENT

- In surgical practice, **respect for autonomy** *translates into the clinical duty* to obtain **informed consent** before the **commencement of treatment.**
- To establish valid consent to treatment, patients need to be **given appropriate** and **accurate information, include**:
  - the condition and the reasons **why it warrants surgery;**
  - the **type of surgery** proposed and how it might correct the condition;
  - the anticipated **prognosis** and **expected side effects** of the proposed surgery;
  - the **unexpected hazards** of the proposed surgery;
  - **any alternative** and potentially successful treatments other than the proposed surgery;
  - **the consequences** of no treatment at all.

With such information, patients can link their clinical prospects to the management of other aspects of their lives and the lives of others for whom they may be responsible.

Good professional practice dictates

- ✓ a **quiet venue** for discussion should be found;
- ✓ **written material** in the **patient's preferred language** should be provided to supplement *verbal communication*, together with diagrams where appropriate;
- ✓ patients should be **given time** and help to come to their own decision;
- ✓ the person obtaining the consent should ideally be **the surgeon who will carry out the treatment**. It should not be – as is sometimes the case – a junior member of staff who has never conducted such a procedure and thus *may not have enough understanding* to counsel the patient properly



- It is not good enough just to go through the motions **of providing patients with the information** required for considered choice. **Attention must be paid to:**

    ● whether or not the patient has understood what has been stated;

    ● avoiding overly technical language in descriptions and explanations;

    the provision of translators for patients whose speak a different language

    ● asking patients if they have further questions.

- Finally, surgeons now understand that, when they obtain consent to proceed with treatment, **patients are expected to sign a consent** form of some kind.
- they often contain **very little of the information** supposedly communicated to the patient who signed it.
- It is important for surgeons to understand that a signed consent form is ***not proof*** that valid consent has been properly obtained.
- **Even when they have provided their signature**, patients ***can and do deny*** that **appropriate information** has been **communicated** or that the communication **was effective.**
- Surgeons are therefore *well advised* to make **brief notes** of what they have said to patients about their proposed treatments, **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.

FURTHER PRACTICAL APPLICATIONS OF CLINICAL LAW IN SURGICAL PRACTICE

- **For consent to be valid**, adult patients must:
  - **have capacity to give it** – be able to understand, remember and deliberate over the information disclosed to them about treatment choices, and to communicate those choices;
  - **not be coerced** into decisions that reflect the preferences of others rather than themselves;
  - **have been given sufficient information** for these choices to be based on an accurate understanding of reasons for and against proceeding with specific treatments.

- Some patients **will not be able to give consent** because of **temporary incapacity.** This may result from their presenting illness or intoxication.
- **The moral** and **legal rules** that govern such situations are clear. The doctrine of medical necessity **enables the surgeon, in an emergency, to save life** and **prevent permanent disability**, operating ***without consent*.**
- 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 current clinical situation.
- **Wherever possible**, 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.

CHILDREN AND YOUNG PEOPLE

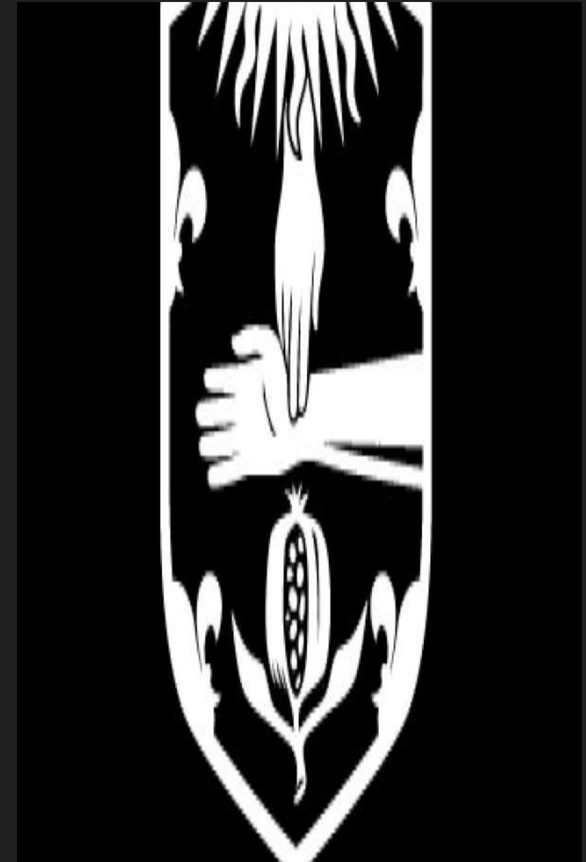
- take care to **explain to children what is being surgically proposed, and why;**
- always consult with children **about their response;**
- where possible, **take the child's views into account** and note that even young children **can be competent to consent** to treatment provided that they can **'pass' the Gillick test** for the decision in question;
- 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.

ADULTS: 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.**
- 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 relative or friend has, very unusually, **been appointed as a deputy by 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 treatment is in the best interests of the patient.

THE ROLE OF THE COURT

- Patient with '**prolonged disorder of consciousness'** he would have profound disability, both ***physical*** and ***cognitive,*** and remain dependent on others to care for him. **The withdraw of his clinically assisted nutrition and hydration (CANH)** should be **automatically referred to the court?**(in UK)
- **If 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 withdrawn **or withheld without needing to make an application to the court.**
- f there is any hint of **lack of agreement** or **conflict** 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.**



DO NOT ATTEMPT RESUSCITATION?

- In England, it **is settled law** that before finally making this ***'DNACPR'*** decision, doctors must discuss it with **patients** or **their relatives.**
- The duty to consult a patient prior to deciding to withhold cardiopulmonary resuscitation ***was subsequently extended*** to a duty to consult those **befriending an incapacitated adult.**

DOCTRINE OF DOUBLE EFFECT

- Surgeons could find themselves involved in the **palliative care** of patients ***whose pain is increasingly difficult to control.***
- There may come a point in the management of such pain when **effective palliation** is possible only at *the risk of shortening a patient's life* because of the **respiratory effects of the palliative drugs.**
- The argument employed to justify such action refers to its **'double effect':** that 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 foreseeably *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 effect* is the **absolute absence of such an intention.**

CONFIDENTIALITY BALANCED AGAINST THE RISK OF SERIOUS HARM

- Respect for autonomy does not entail only **the right of capacious patients to consent to treatment.**
- Their autonomous right extends to control **over their confidential information,** and surgeons must respect their **patients' privacy.**
- means that **surgeons must not discuss** clinical matters with ***relatives, friends, employers*** and other state actors **unless the patient explicitly agrees.**
- **Breaches of confdentiality** are not only **abuses of human dignity**; they undermine the *trust between surgeon and patient.*
- **Patients cannot expect strict adherence to the principle of confdentiality** if it poses a ***serious threat to the health and safety of others.***
- There will be some circumstances in which confdentiality 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 legislation.

reference

- BAILEY & LOVE’S SHORT PRACTICE OF SURGERY 28TH EDITION TEXT BOOK

Thank you