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GUEST EDITORIAL

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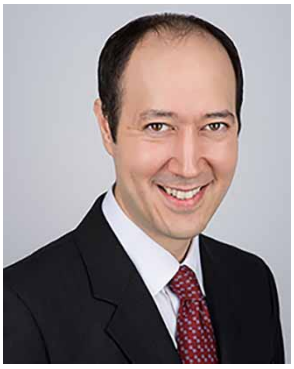
Surgical malpractice - the barrister's perspective



Daniel Sokol, PhD, is a medical ethicist and barrister specialising in clinical negligence. He is the author of '*Tough Choices: Stories from the Front Line of Medical Ethics*'[1].

What strikes fear in the heart of a surgeon? Is it the patient's uncontrollable bleeding in theatre? The nagging doubt that a judgement call was wrong and will lead to catastrophe? The prospect of becoming a patient for major surgery? The incompetent scrub nurse? This editorial explores another common worry: being sued or reported for disciplinary action. In their analysis of spinal malpractice claims in a large NHS Trust, published in this issue of the *Annals*, Quraishi *et al*[2] present a frightening statistic: 80% of surgeons will face a litigation claim by the time they are 45 years old.

The most obvious surgical blunder is the technical error. That can range from a misdiagnosis, such as missing the signs of bile peritonitis, to inadvertently damaging healthy tissue during an operation. The way to minimise such errors is to learn the technical skills through practice, experience and attending courses such as the ones put on by the College, and to avoid operating when exhausted, unwell, or when the operation is far beyond the limit of one's competence. Whitfield[3], in his study of negligence cases in urology, found a doubling in the number of claims from 2011 to 2019 (from 149 cases to 359) and concluded '*at least half of the causes of litigation in urology could and should be avoided*.'

However, technical proficiency is not enough. Even the most dexterous surgeon can get sued if unfamiliar with the requirements of valid consent. Last November, the General Medical Council's new guidance on consent came into effect. All surgeons should read it. In my experience as a clinical negligence barrister, the 6 most common consent-related mistakes for surgeons are failing to:

1. present reasonable alternatives
2. mention all the material risks
3. be accurate when talking of risks and benefits
4. record details of the consent conversation
5. take enough time to obtain consent
6. get consent in good time.

Although it may sound old-fashioned, surgeons should not underestimate the importance of a good 'bedside manner', both before and after the operation. This fosters trust, provides comfort and reassurance to the patient, and reduces the likelihood of a complaint or litigation. However long the 'to do' list, taking the time to explain matters to the patient and, if appropriate, the patient's relatives, is time well spent. As William Osler observed, '*The kindly word, the cheerful greeting, the sympathetic look – these the patient understands*'. I have no doubt that some of my disgruntled clients would not have sued had they felt cared for and listened to.

Finally, surgeons should remember the injunction found at the heart of the Hippocratic Oath: '*in a pure and holy way, I will guard my life and my art*'. The '*pure and holy*' refers to freedom from moral pollution and '*life and art*' relates to a doctor's personal and professional spheres respectively. Thus, a surgeon must be morally upstanding and act with integrity, not only in a clinical context but everywhere and at all times. This includes conduct online and on social media.

As an ethics trainer for doctors undergoing disciplinary procedures, I have seen doctors sanctioned for dishonesty on a CV, creating a false COVID-19 certificate, lying on a form about their profession, physically or verbally abusing a partner, and home insurance fraud. '*But that has nothing to do with my role as a surgeon!*' will be no defence to allegations of misconduct and damage to the reputation of the profession. In determining misconduct, disciplinary tribunals often ask themselves '*was this conduct befitting a doctor?*'

It is telling that the Oath refers to doctors '*guarding*' their life and their art. Guard against what? I suggest against the ever-present temptation to take advantage of one's position, to act unjustly and to cut corners. The sacredness of the doctor-patient relationship, and the Hippocratic commitment to help the sick, should always be at the forefront of the surgeon's mind.

Cutting corners is also a hazard in the medicolegal context. In this issue, Whitfield and van Dellen[4] argue that medical experts who accept to produce 'short reports'

for solicitors on clinical negligence cases, without having sight of all the relevant documents, are acting unethically and making themselves vulnerable to legal action. It is worth remembering that it is usually the medical expert, rather than the lawyer, who determines whether a case is pursued or defended. Hence the importance of clear, informed, and reasoned reports.

The fear of complaint and litigation is a feature of the professions, including my own. There are lawyers who specialise in suing other lawyers. This is no bad thing. The possibility of a complaint should not be a source of fear or lead to defensive practices but should encourage surgeons to be vigilant to whatever may damage their patients' health, their trust, their own reputation and that of the medical profession. This vigilance, which must begin on the first day of medical school and end only upon retirement, is the antidote to the chief causes of surgical error: complacency, arrogance and ignorance.

To learn from the mistakes of others rather than one's own is a mark of wisdom. With the rise of clinical negligence cases, there is good sense in inviting expert witnesses and lawyers to speak to surgeons in hospitals and conferences about recent cases and the lessons to be drawn from them. The risk of being sued, like surgical complications, cannot be eliminated but it can be reduced. A careful read of this special issue is an excellent first step.

References

1. D Sokol. *Tough Choices: Stories from the Front Line of Medical Ethics*. United Kingdom: The Book Guild; 2018.
2. NA Quraishi, A Shetaiwi, D D'Aquino, K Salem. Malpractice litigation and spinal surgery in the National Health Service: a single tertiary-level centre perspective over 12 years. *Ann R Coll Surg Engl* 2021; **103**: 548–552.
3. H Whitfield. Medical negligence in urology: an untapped database. *Ann R Coll Surg Engl* 2021; **103**: 546–547.
4. H Whitfield and A van Dellen. For debate: the short report - legal and ethical implications. *Ann R Coll Surg Engl* 2021; **103**: 544–545.