



What do surgeons want to know about clinical law?

What can we learn from the legal enquiries over 14 years from a hospital's clinical law department?

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What do surgeons want to know about law pertaining to their practice? We have found nothing in the literature relating to what members of the surgical community wish to understand better. We present evidence to answer this question.

METHODS

Data on all of the referrals made in relation to surgical patients were collected prospectively from the inception of the department of clinical law at University Hospital Southampton in 2009 until August 2023. Having been given approval by the trust board in 2009,¹ this paper reports a service evaluation of the department using data collected over 14 years.

The hospital provides secondary and tertiary services other than solid organ transplantation, and has 7,500 clinical staff. Of 960,000 outpatient attendances each year, 20% are surgical patients. Referrals were received from within the hospital as well as from other clinicians caring for patients with a surgical pathology in the region. Details of all the referrals to the department were recorded, along with a note of the opinion provided. All data recorded and advice given reside exclusively in the hospital's patient records system (or that of the external referring organisation), ensuring compliance with information governance. Advice thus remains private.

Details of the department's organisation, the formulation of the demography of

clinical law and the basis for authority have been reported previously.² In our original 'demography', 1,251 records collected between 2009 and 2021 were reported, and classified into 9 broad clinical legal domains. We initially intended to use these domains to report these 'surgical' enquiries. However, during our analysis, we found that a simplified taxonomy was achievable. We therefore revised these domains for the purposes of describing the surgical enquiries (whose collection lasted 2 years longer) since with the exception of the professional practice domain, the enquiries were far less diverse and fitted much more easily into simplified recognisable groupings.

RESULTS

Between 2009 and 2023, 1,476 clinical legal enquiries were handled by the department of clinical law. Of these, 154 (10%) related to patients under the care of the 10 surgical specialties or dentistry. When applied to our previously reported taxonomy,¹ we discovered that the majority of these ($n=128$) could be categorised more simply into four categories: professional conduct ($n=49$), competence/capacity ($n=33$), consent ($n=23$) and refusal of treatment ($n=23$). The remaining 26 enquiries related to standard of care ($n=11$), confidentiality ($n=5$), duty of candour ($n=5$), and one enquiry each for withdrawal of care, restraint, conception, coronial matters and tissue.

The enquirer groups were likely skewed as the department of clinical law is hosted in Southampton Children's Hospital, itself incorporated and fully integrated in University Hospital Southampton. Forty-five enquiries were received from the 'children's surgeons' (those dealing with the 6 surgical disciplines for patients aged under 16 years). Among the 'adult' surgical disciplines, 109 enquiries were made. Of these, the most frequent enquirers came from general surgery (including breast, endocrine and hepatobiliary) ($n=34$), trauma and orthopaedic surgery ($n=18$), urology ($n=15$), neurosurgery ($n=10$) and otolaryngology ($n=7$). Cardiac, thoracic, plastic, vascular and dental surgery all generated five or fewer enquiries. There were no enquiries from ophthalmology or gynaecology.

Professional conduct

The enquiries relating to professional conduct were by definition generic and not centrally focused on an individual patient. "Is there a duty to be a 'Good Samaritan'?", unsubstantiated 'professors' and unwise media postings were characteristic examples. In retrospect, we conclude that these represent professional rather than clinical practice and do not deal with them further in this report.

The effect of incapacity

Patients who lack capacity must have their interests protected. Some make provision for incapacity by donating a lasting power of attorney (LPA) to make health and welfare decisions once incapacity emerges. One enquiry related to whether the donee of the LPA could consent for the donor's mastectomy, required owing to cancer. The LPA instrument was entirely aligned with this use and surgery proceeded uneventfully.

More difficult to deal with is fluctuating capacity (in particular, incapacity precipitated by fear). A man needed pleuroctomy/pleurodesis and desperately wanted the procedure as his life was dogged by recurrent pneumothorax. However, he could not face entering the anaesthetic room, and had failed twice (despite premedication) to do so.

Enquiries relating to incapacity were frequent, including questions about the capacity of the patient, where the incapacitated patient's best interests lay and the effect of learning disabilities or difficulties

During these episodes, he was rendered incapacitated and combative. Unusually, it was possible to obtain an anticipatory declaration from the High Court to facilitate reasonable, necessary and proportionate restraint to administer the anaesthetic. Paradoxically, on the day, none of this was required. His fear, seemingly, evaporated.

Assumptions of incapacity are unhelpful. A man presented for herniorrhaphy, smelling of cannabis. On this basis, his discombobulated surgeon concluded incapacity, seeking clinical legal assistance. But the patient could understand, retain, weigh information and communicate his decision to undergo surgery. Capacity was established. Whether he was fit for anaesthesia, irrespective of his capability, remained a matter for the anaesthetist.

Enquiries relating to incapacity were frequent, including questions about the capacity of the patient ($n=8$), where the incapacitated patient's best interests lay ($n=5$) and the effect of learning disabilities or difficulties ($n=3$). This last group was illustrated by a question as to whether a young man with normal intellectual ability combined with severe specific problems with information processing could be anaesthetised for a haircut; he suffered louse infestation in unmanageably long hair, causing him misery. Finding that he lacked capacity in terms of the Mental Capacity Act 2005, it was then decided that this procedure was in his best interests.

The diagnosis of incapacity in some cases caused difficulty. One patient had been found to be incapacitated by one team and then provided ostensibly capacitous consent for surgery to another team ten minutes later. The enquiry focused on how to unravel this knot. Another apparently capacitous patient was restrained under the Mental Capacity Act deprivation of liberty safeguards legislation; this represents a clear contradiction given that the act authorises liberty deprivation only in those who lack capacity. Further enquiry was founded on the notion that a blind man's capacitous consent for surgery must be recorded on

a form 4 (a consent form for incapacitated patients). We have little doubt that these anomalies are repeated nationwide and on a daily basis.

On a more positive note, patients with reduced intellectual ability can be greatly

consent and the manner of the recording of the transaction.

Of the remainder, a 14-year-old mother sought to provide consent for her newborn's surgery. Having delivered the baby, she by definition had parental responsibility for her

Most surgical questions referred to generic matters of who can provide consent, the substance of disclosure prior to consent and the manner of the recording of the transaction

assisted by learning disability specialists. A man who had severely impaired intellectual ability had a keratinised mass of cholesteatoma growing into his mastoid, eroding the bone and resulting in urgent hospitalisation with parameningeal infection. Surgery was required. His wife, similarly impaired, had told him that people die in hospital, without providing further context to this warning, and he reasonably refused surgery. The learning disability team showed him a large model of the ear canal, mastoid and facial nerve including the keratin mass, and explained the plan as well as the unlikelihood of death. Ultimately, despite his disability, he was able to demonstrate capacity (albeit with the considerable assistance provided under the Code of Practice of the Mental Capacity Act) and underwent successful surgery.

Consent

There were 23 enquiries relating to consent. (The total number of consent enquiries for the whole hospital cohort was 152 so the surgical rate was disproportionately low.) Most surgical questions referred to generic matters of who can provide consent, the substance of disclosure prior to

child. It remained to be determined whether she had sufficient maturity and intelligence to understand the relevant disclosure, and come to a decision.

Two enquiries concerned the status of 'retrospective' consent for surgery, which is not an entity in medical practice. Both related to adult patients who had presented in extremis, incapacitated, and who required emergency surgery. In both cases, surgery proceeded with no consent whatsoever, purely on the basis of the necessity to save life or limb, in the best interests of the patient. This is a usual and lawful arrangement. There is no mechanism for consent by proxy (or in retrospect) in adult practice. A different misconception was demonstrated by a question about implied consent for the rectal examination of a capacitous woman, which would not customarily accord with reasonable practice. Ask first, prior to examination.

Of the questions relating to disclosure preceding consent, one concerned the proposed provision of information prior to oncological surgery solely by clinical nurse specialists. The opportunity for discussion with a surgeon was limited at the time the form was signed. This was not

in accordance with the General Medical Council's advice.

Obtaining prenatal consent for postnatal procedures on newborn babies is often a matter of convenience, particularly when families may live hundreds of miles from the tertiary centre and urgent helicopter/ambulance transfer of the newborn may take place before a mother recovering from Caesarean section is fit to travel. The problem is that the unborn child has no legal personality and that the mother will not have parental responsibility (and hence the right to consent) until the baby is born. For these reasons, in theory, prenatal consent for postnatal treatment has no legal basis. We can find no decided judgement so this remains an enigma, untested.

Refusals of treatment

Eleven enquiries were made about patients who needed amputations for distal leg ischaemia. In all cases, the patient was opposing surgery and lacked capacity to decide whether amputation provided overall benefit as they could weigh neither the risks nor the benefits of operative versus conservative management. The surgeons sought advice as to how this should be resolved; applications to the Court of Protection were required. An adult with autism presented with an open fracture of the elbow that required surgery. He was able to understand and weigh the benefits against the risks both of surgery and of conservative treatment but was not able to believe that infection posed a risk as he could see no soil or other contamination involving the wound. While his lack of belief could be construed as negating his capacity, an interview with the learning disability service clarified the matter and he provided valid consent.

Capacitous refusals of treatment were usually on the basis of patients wishing to avoid blood transfusion, mostly owing to their religious beliefs. Adults in this situation are free to run the risk of catastrophic bleeding unsupported by blood transfusion. Nevertheless, surgeons, anaesthetists and intensivists must not pursue a course of

conduct that they believe is contrary to their patient's welfare. Having discussed the benefits and limitations of all adjunctive techniques to avoid blood product transfusion, two patients required guarantees that in no circumstances would blood be administered during the course of elective treatment. They were provided with a referral for a second opinion, to units who might be prepared to conform with their requests.

Incapacitated adult Jehovah's Witnesses in urgent need of blood transfusion were also encountered. An unconscious man exsanguinating after a road traffic collision was accompanied by family members including a sister who held a lasting power of attorney, providing her with the authority to refuse blood on her brother's behalf. After ensuring that this was correctly set out and registered with the Office of the Public Guardian, his wishes were followed and he died of his blood loss.

By contrast, an older patient in similar clinical circumstances was accompanied by an acquaintance who brought with them a document: an advance decision to refuse treatment (ADRT), in relation to blood transfusion. However, the ADRT was not applicable to life-saving treatment as the patient had not included in it a statement to the effect that his refusal applied even if his life was at risk – an essential requirement. The acquaintance was unable to provide cogent further evidence indicating any resolve that the patient might have had to die in these circumstances; transfused, he survived.

There were five enquiries relating to refusal of essential blood transfusion in children, including the blood required for pump priming in cardiac surgery. These were sharply divided into refusals by parents (all Jehovah's Witnesses) on behalf of their incompetent infants and those made by competent mature minor Witnesses. Parental refusal is characteristically dealt with by a court application, which if successful denies the parents of only the responsibility to decide to use blood. No other element of parental rights or responsibility is interfered

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with in this process and the brethren largely accept this process as absolving them of the responsibility for what is an excruciating decision.

Stoma surgery for imperforate anus was also refused, based on parental certainty of imminent miraculous spontaneous cure. We contemplated a court application given the increasing abdominal distention of this obstructed neonate but fate (in the form of concerned religious elders) intervened and allowed treatment to be provided with maternal consent. Epilepsy surgery in a child was initially refused by parents, leading to an enquiry about whether and how management should proceed. Eventually, after some days' consultation with grandparents, consent was provided; no explanation emerged.

One enquiry related to a patient refusing a COVID-19 vaccination prior to a Whipple's resection. The patient initially objected on the grounds of his human rights. He considered the notion of a pandemic fallacious, thus exercising his freedom of thought, protected under article 9 of the European Convention on Human Rights. Ultimately, consent was forthcoming.

Confidentiality

The notion of consent is as applicable to sharing secrets (and therefore to providing permission for the disclosure of private information) as it is to legitimising the otherwise unwanted touch. In our original report, 127 of 1,251 enquiries related to

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confidentiality¹ but only 5 of 154 enquiries were made in this surgical cohort.

One related to a wound photograph taken without consent for no reasonable purpose and another to the entirely inappropriate disclosure of adopters’ identities to the natural parent. Meaningful and sincere apologies were recommended, pending any action from these citizens. Surgeons contemplating asking a Persian-speaking daughter to interpret for disclosure prior to gaining her father’s consent for surgery also sought advice (the commercial telephone translation service was engaged) until it became clear that the father was fluent and had been educated at an English university. An enquiry one evening was made with respect to a man convalescing on a surgical ward. The police were seeking notice of the hour of his discharge. The enquiry led to the man being asked whether his information could be shared with the police and he declined, preferring the hospital not to become an arm of criminal justice.

Interaction of Mental Health Act and surgery

Four inpatients required urgent surgery while compelled by the Mental Health Act 1983 to be admitted and treated for mental disorder. Despite this comorbidity, three had capacity but were refusing consent to aneurysm resection, amputation and the fixation of a cranial plate. The third patient had induced a compound fracture of the skull through which they were attempting to pass objects

into their brain. In none of these cases could the Mental Health Act provide authority for surgery since that statute provides primarily for the treatment of mental disorder. In each of those three cases, a High Court judgement was obtained. The fourth case concerned a child needing fracture fixation, who eventually consented to treatment.

Thirteen enquires related to young people (often in secure mental facilities although sometimes not admitted compulsorily) swallowing sharp objects unsuitable for endoscopic extraction. This frequently involved cutlery but also included other paraphernalia. There was an accumulating risk of serious injury associated with repeated laparotomies (10 in one case). The common enquiry was whether conservative management was reasonable. The risks and benefits of retrieval were balanced against those of no operation. This approach to a ‘balance sheet’ usually enabled a clinical decision to be made to leave these objects (particularly cutlery) in the stomach.

DISCUSSION

If you ask a surgeon what ‘medicolegal’ entails, they will reply in a heartbeat: “Clinical negligence”. If you reflect on the content of medicolegal courses widely promulgated, it seems, momentarily, that they are correct. However, when viewed through the prism of 154 surgeons’ enquiries, you will see a tapestry of clinical dilemmas far removed from adversarial law. We present the clinical legal aspect of surgery, infinitely richer than litigation for fees and quantum. Patterns of dilemmas and routes to remedy (often avoiding courts altogether) are revealed. This is the rich lode of clinical surgery that preoccupation with litigation obscures, to the detriment of our patients.

We demonstrate the protean presentations of ‘surgical’ law. The diversity is no more surprising than the other stuff of surgery: anomalous anatomy, obscure pathology or the bizarre presentation of otherwise humdrum disease, such as distal ileal obstruction from an unanticipated bolus of adult roundworms. Equally, we have demonstrated recognisable

patterns of surgical law, whether in refusal of treatment, aspects of consent, the effects of incapacity or learning disability. Once identified, patterns of law are as recognisable as patterns of surgical pathology. Recognising a pathological pattern promotes a rational approach to a surgical remedy. Do not treat the primary before you have ascertained metastatic status. Likewise with the law. The notion that mature minors refuse blood on their own behalf while the parents’ objection to blood is manifest through refusal to exercise their parental responsibility to consent makes the Jehovah’s Witness dilemma in childhood easier, less confusing, to manage.

The relative lack of surgical enquiries relating to candour and confidentiality leave us clueless as to pattern but nonetheless concerned. The paucity of enquiries may be taken as a sign that surgeons are entirely in tune with this doctrine, making enquiry unnecessary. The number of enquiries in these fields from non-surgeons is greater by orders of magnitude; perhaps non-surgeon clinicians have not achieved this state of grace.

CONCLUSIONS

One benefit of documenting the surgical casemix seen in our department of clinical law is that it provides a starting point for the development of a ‘syllabus’ of surgical legal enquiries. We hope that by reading about these lacunae, surgical educators may set themselves the task of alerting surgeons in training about the legal considerations that arise alongside contemporary surgical practice. Just as surgical trainees must learn the basic sciences underpinning surgery, we propose that a working understanding of the legal frameworks that support them and their patients is beneficial.

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