Candour for surgeons: the absence of spin

R Wheeler

University Hospital Southampton NHS Foundation Trust, UK

ABSTRACT

Doctors are exhorted to be candid with their patients when clinical errors occur. This paper discusses the history of candour in surgical law as well as recommendations resulting from the Mid Staffordshire public inquiry. It also looks at why candour is necessary and where the threshold should lie. Provided surgeons understand that a duty of candour is engaged at a certain threshold of harm, then disclosure of misadventure to patients or their relatives becomes simply a matter for clinical judgement, just in the same way as a surgeon judges which potential operative complications need to be disclosed during the consenting process.

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CORRESPONDENCE TO

Robert Wheeler, E: robert.wheeler@uhs.nhs.uk

Doctors are exhorted to be candid with their patients when clinical errors occur. Is candour simply a synonym for truthfulness or does the word import more into a surgeon's duty to patients?

What is 'candour'?

The 17th-century origins of the word 'candour' have their roots from words for kindness, sincerity, freedom from deceit and purity.¹ Modern definitions of the word include 'stainlessness of character', 'freedom from reserve in one's statements' and 'frankness'.²

Candour is best construed as denoting a full disclosure of truth, motivated by wishing to confer benefit on the person to whom the information is being disclosed. In many respects, this is the opposite of 'spin', where only selected truths are disclosed while others are withheld. Lacking candour, those employing 'spin' prevent the listener from being as well informed as the informant. In this way, by controlling the information, it is possible to avoid giving listeners an opportunity entirely to judge the situation for themselves.

In daily life, your son might borrow your car to pick up a newspaper from the local shop. On his return, if asked whether he had managed to find your favourite paper, he could truthfully answer that he had but his candid answer would have been that he also scratched your car in doing so.

The history of candour in surgical law

Inevitably, this is rooted in litigation over the disclosure of information. The earliest English case may be that of *Gerber* (1934),³ when a doctor failed to tell his patient that

a broken hypodermic needle fragment remained inside him. Thirty years later in Canada, where a patient's bladder was entered inadvertently during a herniotomy, the surgeon failed to disclose this accident to the patient.⁴ Another surgeon acted similarly in the case of a patient who was not told of an ineffective sterilisation.⁵

In each case, 'ignoring' the injury or operative deficit deprived the patient of timely treatment of the ensuing complications and for failing to provide the necessary additional postoperative care, the surgeon was found to have fallen below the reasonable standard expected of him. Thus, these courts held that it was failure to deal with the situation that had arisen rather than failure to disclose the accident, for which the surgeon was liable.

Kueper broke new ground, in the case of a dentist who sealed his broken drill tip in the patient's root canal without telling her of this misadventure.⁶ He was held to have acted unreasonably and ought to have informed his patient of the occurrence as well as then discussing with her options for a remedy.

The stage was therefore set for the English courts to speculate on the existence of a doctor's duty to disclose medical errors. In the case of a burnt child who developed brain damage, the cause was probably anoxia as a result of failure of assisted ventilation during an interhospital ambulance transfer.⁷ Asserting that the duty to inform the patient is as relevant after the administration of treatment as it is before the therapy starts, the court noted: '*There is something seriously wrong with the law if it cannot be ascertained on the [claimant's] behalf exactly what caused his brain damage.*'⁷ Lords Donaldson and Mustill agreed that 'some thought should be given to what is the duty of disclosure owed by a doctor [...] to a patient after treatment'.⁷

This 'thought' was formulated in Ontario only a few months later. During a percutaneous lung biopsy, a trainee instead biopsied a man's spleen.⁸ When the patient asked about the results of the biopsy, the doctor replied that he had no results since he had not obtained the necessary tissue. Further challenged to explain what had been obtained, the doctor replied 'something else', without other comment. Later, owing to the injury, a splenectomy was required. Irrespective of the harm to the spleen, the court found that as a matter of law, the doctor should have told his patient of the splenic biopsy: *'The defendant's failure to be candid with the plaintiff was a breach of duty.'*⁸

This language was echoed by Lord Donaldson in a later series of cases, where his personal view was that 'the duty of candid disclosure [...] is but one aspect of the general duty of care, arising out of the patient/medical practitioner [...] relationship'.⁹ However, these English judicial utterings do not enjoy the status of binding precedent in the common law since they are *obiter dicta* (ie words said during litigation but that do not constitute a reasoned answer to the legal question asked of the court).

In 1998 the General Medical Council (GMC) supported these judicial hints at what constitutes ethical practice by incorporating them into its guidance: *'If a patient under your care has suffered serious harm, [...] you should explain fully to the patient what has happened and the likely long- and short-term effects.'*¹⁰

In 2000 *Good Surgical Practice* noted that 'if problems arise, full explanations must be given. Mistakes must be openly acknowledged'.¹¹ This amplified advice from the Senate that 'relevant information is effectively communicated to patients'.¹² None of this advice was controversial although the problem of harm to which the patient was oblivious was not addressed explicitly.

The Francis report: the Mid Staffordshire public inquiry

The Francis report¹³ and the ensuing government response causes us to consider 'hidden harm' more carefully since both shine light on 'candour'. Robert Francis QC lays out the evidence from those involved in the events at this hospital, together with the accumulated words of previous allied enquiries and interested public bodies. He addresses 'openness, transparency and candour' in Chapter 22 in the third volume. Recommendations 173–184 flow from this section, with five directly applicable to surgeons. Included in these are recommendations that practitioners should be honest, open and truthful in their dealings with patients, and provide full answers to any reasonable questions related to treatment. Francis recommends that:

*'A statutory obligation should be imposed to observe a duty of candour on registered medical practitioners [...] who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable.'*¹⁵

Francis supports this by recommending a criminal offence for doctors who obstruct this reporting or who mislead patients in relation to such an incident.¹³ *Hard Truths*, the government's initial reply to the Francis report, indicates that it is very unlikely that statutory obligations and criminal sanctions will be applied to clinicians.¹⁴ Instead, the existing professional obligations will be strengthened. Nevertheless, this is an opportunity to ensure that surgeons are clear as to how they can be candid with their patients.

Why is candour necessary?

In order to understand fully why Robert Francis QC felt that a statutory duty of candour was necessary, his report on Mid Staffordshire should be read.¹⁵ Nevertheless, more generally, bearing in mind the distinction already made between candour and truth telling, candour is needed to put the patient in the same position as the doctor, in terms of what clinical events have taken place. Simplistically, most surgical activity proceeds out of the patients' sight, either because they are anaesthetised or the operative field is screened from their view. If untoward events occur, how will the patients know unless they are told? How will they know that there are questions to ask unless they are told?

For the patient who unexpectedly loses his or her leg or eye during surgery, the loss will be self-evident. In modern times, bearing in mind the GMC guidance, any prevarication by the surgeon in fully explaining these outcomes should now be only of historical interest. However, surgery provides endless opportunities for the type of misadventure that will only become evident months or years later, such as losing broken drills down marrow cavities of bones or root canals of teeth, dividing the vas deferens during an inguinal hernia repair or using enough diathermy on a ureter to cause stricture but not perforation. Whatever your surgical specialty, you can doubtless envisage clinical circumstances where the patient will be oblivious to the misadventure unless you are candid with them.

It is still fair to ask whether non-disclosure matters. It can certainly be argued that trivial 'misadventures' are ubiquitous and to report them all would be absurd. (See below.) It was once commonplace to assert that selective reticence is part of good medical practice and that to burden patients unnecessarily will cause distress without providing them with any tangible benefit (unless it would put them in a favourable position to litigate).

Western society has for the moment settled firmly on the principle that autonomy of the individual has precedence over other considerations, reflected in the numerous opportunities for 'choice' in all fields of public services, from the education of your children to the timing of your bin collection. In this environment, choosing on the patients' behalf what they may or may not wish to know about themselves is anathema.

The threshold for candour

It follows that there must be some form of threshold for the engagement of candour. Breaking your thread during

arterial ligation creates delay and difficulty controlling the venous oozing may foreseeably amount to the need for transfusion that was otherwise avoidable but, surely, no reasonable colleague would suggest that we fall below the acceptable standard if these details are withheld postoperatively? Francis relies on death or serious harm as his threshold for disclosure.¹³ In its early response, the government is clearly tempted to cast the net wider and states that 'doctors and nurses and other health professions [should] be candid with patients when mistakes occur whether serious or not'.¹⁴

It appears that Parliament (via the *Care Act 2014*, section 81) will choose death or severe/moderate harm as a threshold and may amplify this in the regulations that accompany the Act (*Health and Social Care Act 2008 (Duty of Candour) Regulations 2014*). However, in the absence of a tight definition of moderate or severe harm, a vague threshold will be difficult to apply to the patient in front of us. The answer may lie in the law of disclosure for consent, where the legal history of candour began.

For many years, surgeons have had to provide sufficient information during the consent process to pass the threshold of the amount and quality of information that their peer group of surgeons would provide in the circumstances, thereby passing the 'Bolam test'.¹⁵ In more recent times, the courts have abandoned any reliance on surgical experts to tell them what the professional standard should be. Instead, the judges have relied on their own construction (as potential patients) as to what the reasonable patient would need to know in the circumstances to make an informed decision about whether he or she wishes to have the suggested procedure.

This has led to the unchallenged judgement of Lord Woolf that if '*there is a significant risk which would affect the judgement of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine [...] what course he or she should adopt*'.¹⁶

It may be that this can be transposed to serve as a template for the threshold for engaging the duty of candour: *If significant harm has occurred that the reasonable patient would wish to know about, then in the normal course it is the responsibility of a doctor to inform the patient of that significant harm and the way in which it was caused.*

Surgical specialties can speculate when the threshold could apply. In general surgery, if you divide an appendix

inadvertently during an operation on the sac of an inguinal hernia (and manage to complete the resection within the same incision, thereby rendering the amputation invisible), you will clearly disclose this to the patient. An unusually large diathermy burn to the underside of the liver as a result of mobilising it off the inferior vena cava would not pass the threshold (unless the patient asked that specific question) but making a hole during a pyloromyotomy certainly would. Deciding whether to disclose such incidents is well within the ability of any reasonable surgeon.

Conclusions

Some form of threshold is certainly required. We cannot expect explicit advice to be soon forthcoming on the degree of harm required to engage the obligation of candour to patients and their relatives from the government. At present, the threshold for disclosure offered by the GMC is 'harm or distress' but is not otherwise defined.¹⁷ Provided surgeons understand that a duty of candour is engaged at a certain threshold of harm (measured as suggested above), then disclosure of misadventure to patients or their relatives becomes simply a matter for clinical judgement, just in the same way as you judge which potential operative complications need to be disclosed during the disclosure for consent.

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