INTRODUCTION (Box 20.1)

Ethics and surgical intervention must go hand in hand. In any other arena of public or private life, if someone deliberately cuts another person, draws blood, causes pain, leaves scars and disrupts everyday activity then the likely result will be a criminal charge. If the person dies as a result, the charge could be manslaughter or even murder. Of course, it will be correctly argued that the difference between the criminal and the surgeon is that the latter causes harm only incidentally. The surgeon’s intent is to cure or manage illness and any bodily invasion that occurs only does so with the permission of the patient.

Patients consent to surgery because they trust their surgeons. Yet what should such consent entail in practice and what should surgeons do when patients need help but are unable or unwilling to agree to it? When patients do consent to treatment, surgeons wield enormous power over them, the power not just to cure but to maim, disable and kill. How should such power be regulated to reinforce the trust of patients and to ensure that surgeons practise to an acceptable professional standard? Are there circumstances in which it is acceptable to sacrifice the trust of individual patients in the public interest through revealing information that was communicated in what patients believed to be conditions of strict privacy?

These questions about what constitutes good professional practice concern ethics rather than surgical technique. Surgeons may be expert in the management of specific diseases but may have little understanding of how much and what sort of information is required for patients to give valid consent to treatment. Surgeons can understand the delicate techniques associated with specific types of procedures without necessarily knowing when these should be administered to patients who are unable to consent at all. Surgeons can recognise their own mistakes and those of colleagues without knowing how much should be said about them to others. And so it goes on.

Traditional surgical training offers little help in the resolution of such ethical dilemmas. This chapter provides guidance which is morally coherent, widely endorsed and legally justifiable. Our focus will be the practice of surgery within the UK, although much of the analysis will also apply to surgical work elsewhere.

RESPECT FOR AUTONOMY (Box 20.2)

What is the difference between a veterinary surgeon and a surgeon who treats humans? Both are trained in anatomy, physiology, biochemistry and the other clinical and surgical skills required to care for the bodies of their patients. As a by-product of employing these skills, both invade these bodies in ways which can cause harm in order to meet need. Finally, both work within...
the same duty of care, to protect their patients’ life and health to an acceptable standard. To distinguish between the two types of surgeon, we must ask other questions. What is the major difference between animals and humans, and how does this difference create special duties for human surgeons which are of no concern for those who work only with animals?

We can only wonder at the attributes and abilities of many animals, characteristics to which humans can only aspire. For example, we can respect the big cats of the African plains, because of their strength and speed, for behaving in the unique ways that characterise their species. The same can be said of humans. What makes us unique as animals is our autonomy, our ability to formulate both goals and beliefs about how these should be achieved. Humans can attempt to plan their lives on the basis of reason and choice in ways which other animals cannot. Therefore, when we talk of the particular type of respect which it is appropriate to show to humans, the focus should primarily be on our autonomy rather than our particular physical characteristics. Respect for human dignity is respect for human autonomy.

It is for this reason that surgeons have a duty of care towards their human patients which goes beyond just protecting their life and health. Their additional duty of care is to respect the autonomy of their patients, their ability to make choices about their treatments and to evaluate potential outcomes in light of other life plans. Such respect is particularly important for surgeons because without it the trust between them and their patients may be compromised, along with the success of the surgical care provided. We are careful enough at the best of times about whom we allow to touch us and to see us unclothed. It is hardly surprising that many people feel strongly about exercising the same discretion in circumstances in which someone is not only going to do these things but to inflict what may be very serious wounds on them as well.

For all of these reasons, there is a wide moral and legal consensus that patients have the right to exercise choice over their surgical care. In this context, a right should be interpreted as a claim which can be made on others and which they believe that they have a strict duty to respect, regardless of their own preferences. Thus, to the degree that patients have a right to make choices about their treatments and to evaluate potential outcomes in light of other life plans. Such respect is particularly important for surgeons because without it the trust between them and their patients may be compromised, along with the success of the surgical care provided. We are careful enough at the best of times about whom we allow to touch us and to see us unclothed. It is hardly surprising that many people feel strongly about exercising the same discretion in circumstances in which someone is not only going to do these things but to inflict what may be very serious wounds on them as well.

For all of these reasons, there is a wide moral and legal consensus that patients have the right to exercise choice over their surgical care. In this context, a right should be interpreted as a claim which can be made on others and which they believe that they have a strict duty to respect, regardless of their own 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. For example, patients can even refuse surgical treatment which will save their lives, either at present or in the future through the formulation of advance directives specifying the types of life-saving treatments which they do not wish to have if they become incompetent to refuse them.

**INFORMED CONSENT (Box 20.3)**

In surgical practice, respect for autonomy translates into the clinical duty to obtain informed consent before the commencement of treatment. The word ‘informed’ is important here. Because of the extremity of their clinical need, patients might agree to surgery on the basis of no information at all. Agreement of this kind, however, does not constitute a form of consent which is morally or legally acceptable. Unless such patients have some understanding of what they are agreeing to, their choices may have nothing to do with planning their lives and thus do not count as expressions of their autonomy. Worse still, if patients are given no information, their subsequent choices may be based on misunderstanding and lead to plans and further decisions which they would not otherwise have made.

For agreement to count as consent to treatment, patients need to be given appropriate and accurate information about:

- their condition and the reasons why it warrants surgery;
- what type of surgery is proposed and how it might correct their condition;
- what the proposed surgery entails in practice;
- the anticipated prognosis of the proposed surgery;
- the unexpected hazards of the proposed surgery;
- any alternative and potentially successful treatments for their condition other than the proposed surgery, along with similar information about these;
- the consequences of no treatment at all.

With such information, patients can link their clinical prospects with the management of other aspects of their life and the lives of others for whom they may be morally and/or professionally responsible.

Good professional practice dictates that obtaining informed consent should occur in circumstances which are designed to maximise the chances of patients understanding what is said about their condition and proposed treatment, as well as giving them an opportunity to ask questions and express anxieties. Where possible:

- A quiet venue for discussion should be found.
- Written material in the patient’s preferred language should be provided to supplement verbal communication.
- Patients should be given time and help to evaluate their own understanding and 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 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.

Surgeons should always attempt to approximate these conditions, even when they might not be completely achievable.

Good communication skills go hand in hand with properly obtaining informed consent for surgery. It is not good enough just to go through the motions of providing patients with 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.

Informed consent

- Suppose a surgeon says: ‘When I am trying to determine how much information to give my patients about the surgery they need, I always think of Mum.’
- ‘What might he/she be getting at?’
- ‘But you signed the consent form!’ says a surgeon to a protesting and litigious patient, injured as the result of a well-known surgical risk, who complains that he/she was not properly informed.
- ‘What should the surgeon have done to minimise the risk of such protest and potential legal action?’

With such information, patients can link their clinical prospects with the management of other aspects of their life and the lives of others for whom they may be morally and/or professionally responsible.

Good professional practice dictates that obtaining informed consent should occur in circumstances which are designed to maximise the chances of patients understanding what is said about their condition and proposed treatment, as well as giving them an opportunity to ask questions and express anxieties. Where possible:

- A quiet venue for discussion should be found.
- Written material in the patient’s preferred language should be provided to supplement verbal communication.
- Patients should be given time and help to evaluate their own understanding and 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 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.

Surgeons should always attempt to approximate these conditions, even when they might not be completely achievable.

Good communication skills go hand in hand with properly obtaining informed consent for surgery. It is not good enough just to go through the motions of providing patients with 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 first language is not English;
• asking patients if they have further questions.

When there is any doubt about their understanding, surgeons should ask patients questions about what has supposedly been communicated to see if they can explain the information in question for themselves.

Surgeons have a legal, as well as moral, obligation to obtain consent for treatment based on appropriate levels of information. Failure to do so could result in one of two civil proceedings, assuming the absence of criminal intent. First, in law, intentionally to touch another person without their consent is a battery, remembering that we are usually touched by strangers as a consequence of accidental contact. Surgeons have a legal obligation to give the conscious and competent patient sufficient information ‘in broad terms’ about the surgical treatment being proposed and why. If the patient agrees to proceed, no other treatment should ordinarily be administered without further explicit consent.

Negligence is the second legal action which might be brought against a surgeon for not obtaining appropriate consent to treatment. Patients may have been given enough information about what is surgically proposed to agree to be touched in the ways suggested. However, surgeons may still be in breach of their professional duty if they do not provide sufficient information about the risks which patients will encounter through such treatment. Although standards of how much information should be provided about risks vary between nations, as a matter of good practice, surgeons should inform patients of the hazards that in their view any reasonable person in the position of the patient would wish to know. In practice, this is probably best decided through surgeons asking themselves what they or a close relative or friend should be entitled to know in similar circumstances. Only through supporting this standard of disclosure of information linked to the requirements of a reasonable person can surgeons help to ensure that they, their relatives, and friends will be treated with respect and dignity.

Finally, surgeons now understand that when they obtain consent to proceed with treatment then patients are expected to sign a consent form of some kind. The detail of such forms can differ, but they often contain very little of the information supposedly communicated to the patient who signed it. Partly for this reason, the process of formally obtaining consent can become overly focused on obtaining the signature of patients rather than ensuring that appropriate types and amounts of information have been provided, and have been understood.

Both professionally and legally, it is important for surgeons to understand that a signed consent form is not proof that valid consent has been properly obtained. It is simply a piece of evidence that consent may have been attempted. 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.

PRACTICAL DIFFICULTIES (Box 20.4)

Thus far, we have examined the moral and legal reasons why the duty of surgeons to respect the autonomy of patients translates into the specific responsibility to obtain informed consent to treatment. For consent to be valid, patients must:
• be competent to give it – to be able to understand, remember, deliberate about and believe whatever information is provided to them about treatment choices;
• not be coerced into decisions which reflect the preferences of others rather than themselves;
• be given sufficient information for these choices to be based on an accurate understanding of reasons for and against proceeding with specific treatments.

Surgeons will face four key practical difficulties in aspiring to these goals.

First, surgical care will grind to a halt if it is always necessary to obtain explicit informed consent every time a patient is touched in the context of their care. Fortunately, such consent is unnecessary because patients will have already given their implied consent to whatever bodily contact is required in order to fulfil the therapeutic goals when they gave their explicit consent to treatment. Yet the fact that this is so underlines the importance of obtaining proper and explicit consent in the first place, along with taking care to note any sign of the patient withdrawing that consent or placing restrictions on it – for example, through verbally refusing or physically resisting specific aspects of care.

Second, some patients will not be able to give consent because of temporary unconsciousness. This might be a by-product of their illness or injury, or it could simply be the result of the administration of general anaesthetic. The moral and legal rules which govern such situations are clear. If patients are at risk of death or of serious and permanent disability if surgery is not immediately performed, then the situation is one of medical necessity and intervention can occur without consent. However, surgery not entailing such risks should be postponed until patients regain consciousness and are able to give informed consent for themselves. Surgeons must take care to respect this distinction between procedures which are therapeutically necessary and those which are done merely out of convenience, even when in the course of one operation they discover problems unknown to the patient which they believe to require further surgical work. For example, a surgeon was successfully sued for battery by a female patient for performing a hysterectomy thought to be in her best interests when all that she had explicitly consented to was a dilatation and curettage.

Third, informed consent may be made impossible by incompetence of other kinds. In the case of children, parents or someone with parental responsibility are ordinarily required to give explicit written consent on their behalf. This said, surgeons should:
• 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

Failure to do so could result in one of two civil proceedings, assuming the absence of criminal intent. First, in law, intentionally to touch another person without their consent is a battery, remembering that we are usually touched by strangers as a consequence of accidental contact. Surgeons have a legal obligation to give the conscious and competent patient sufficient information ‘in broad terms’ about the surgical treatment being proposed and why. If the patient agrees to proceed, no other treatment should ordinarily be administered without further explicit consent.

Negligence is the second legal action which might be brought against a surgeon for not obtaining appropriate consent to treatment. Patients may have been given enough information about what is surgically proposed to agree to be touched in the ways suggested. However, surgeons may still be in breach of their professional duty if they do not provide sufficient information about the risks which patients will encounter through such treatment. Although standards of how much information should be provided about risks vary between nations, as a matter of good practice, surgeons should inform patients of the hazards that in their view any reasonable person in the position of the patient would wish to know. In practice, this is probably best decided through surgeons asking themselves what they or a close relative or friend should be entitled to know in similar circumstances. Only through supporting this standard of disclosure of information linked to the requirements of a reasonable person can surgeons help to ensure that they, their relatives, and friends will be treated with respect and dignity.

Finally, surgeons now understand that when they obtain consent to proceed with treatment then patients are expected to sign a consent form of some kind. The detail of such forms can differ, but they often contain very little of the information supposedly communicated to the patient who signed it. Partly for this reason, the process of formally obtaining consent can become overly focused on obtaining the signature of patients rather than ensuring that appropriate types and amounts of information have been provided, and have been understood.

Both professionally and legally, it is important for surgeons to understand that a signed consent form is not proof that valid consent has been properly obtained. It is simply a piece of evidence that consent may have been attempted. 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.

PRACTICAL DIFFICULTIES (Box 20.4)

Thus far, we have examined the moral and legal reasons why the duty of surgeons to respect the autonomy of patients translates into the specific responsibility to obtain informed consent to treatment. For consent to be valid, patients must:
• be competent to give it – to be able to understand, remember, deliberate about and believe whatever information is provided to them about treatment choices;
• not be coerced into decisions which reflect the preferences of others rather than themselves;
• be given sufficient information for these choices to be based on an accurate understanding of reasons for and against proceeding with specific treatments.

Surgeons will face four key practical difficulties in aspiring to these goals.

First, surgical care will grind to a halt if it is always necessary to obtain explicit informed consent every time a patient is touched in the context of their care. Fortunately, such consent is unnecessary because patients will have already given their implied consent to whatever bodily contact is required in order to fulfil the therapeutic goals when they gave their explicit consent to treatment. Yet the fact that this is so underlines the importance of obtaining proper and explicit consent in the first place, along with taking care to note any sign of the patient withdrawing that consent or placing restrictions on it – for example, through verbally refusing or physically resisting specific aspects of care.

Second, some patients will not be able to give consent because of temporary unconsciousness. This might be a by-product of their illness or injury, or it could simply be the result of the administration of general anaesthetic. The moral and legal rules which govern such situations are clear. If patients are at risk of death or of serious and permanent disability if surgery is not immediately performed, then the situation is one of medical necessity and intervention can occur without consent. However, surgery not entailing such risks should be postponed until patients regain consciousness and are able to give informed consent for themselves. Surgeons must take care to respect this distinction between procedures which are therapeutically necessary and those which are done merely out of convenience, even when in the course of one operation they discover problems unknown to the patient which they believe to require further surgical work. For example, a surgeon was successfully sued for battery by a female patient for performing a hysterectomy thought to be in her best interests when all that she had explicitly consented to was a dilatation and curettage.

Third, informed consent may be made impossible by incompetence of other kinds. In the case of children, parents or someone with parental responsibility are ordinarily required to give explicit written consent on their behalf. This said, surgeons should:
• 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 surgically proposed and why;
treatment provided that they too can understand, remember, deliberate about and believe information relevant to their clinical condition.

When such competence is present, children under English law can provide their own consent to surgical care, although they cannot unconditionally refuse it until they are 18 years old. With the exception of the latter, these provisions illustrate the importance of respecting as much autonomy as is present among child patients and remembering that, for the purposes of consent to medical treatment, they may be just as autonomous as adults.

If competence is severely compromised by psychiatric illness or mental handicap, other moral and legal provisions hold. If patients lack the autonomy to choose how to protect themselves then others charged with protecting them must assume the responsibility. Yet, care must be taken not to abuse this duty. For example, adult voluntary psychiatric patients have the same rights to consent to and refuse treatment as any other competent adult. Even when they have been legally detained for compulsory psychiatric care, it does not follow that such patients are unable to provide consent for surgical care. Their competence should be assumed and consent should be sought. If it is established with the help of their carers that such patients are also incompetent to provide consent for surgery and that they are at risk of death or serious and permanent disability then therapy can proceed. However, if treatment can be postponed then this should be done until, as a result of their psychiatric care, patients become able either to consent to or refuse it. As with children, respect should always be shown for as much autonomy as is present.

If, for whatever clinical reason, adult patients are permanently incompetent to consent to surgery, therapy can again proceed if it is necessary to save life or to prevent serious and permanent injury. In the UK, the final decision to proceed with surgery that is elective and can be postponed rests ultimately with the surgeon. It does not depend on the views of the relatives of the patient. The moral justification for this is that the patient’s professional carers are more likely to act consistently in their best interests than their relatives.

Thus, it is always a futile exercise in the UK to ask the relatives of incompetent patients to sign consent forms for surgery on adults who cannot do so for themselves. Indeed, to do so can be a great disservice to relatives, who may feel an unjustified sense of responsibility if the surgery fails. This said, relatives should be treated with politeness and consulted about issues which pertain to determining the best interest of patients. In other legal jurisdictions, relatives can be given powers of guardianship to provide consent for surgical treatment, although even here surgeons should ensure that such powers are vested in the specific person asked to provide it.

**Matters of life and death (Box 20.5)**

It has been noted that the right of a competent adult to consent to and refuse treatment is unlimited, including the refusal of life-sustaining treatment. Probably the example of this most familiar to surgeons is Jehovah’s Witnesses, who refuse blood transfusions at the risk of their own lives. There can be no more dramatic example of the potential tension between the duties of care to protect life and health and to respect autonomy, with autonomy always constituting the trump card.

The tension does not stop here, however. For there will be some circumstances in which the protection of the life and health of patients is judged to be inappropriate; in which they are no longer able to be consulted; and in which they have not expressed a view about what their wishes would be in such circumstances.

Here a decision may be made to withhold or to withdraw life-sustaining treatment on behalf of the incompetent patient. The fact that such decisions can be seen as omissions to act does not excuse surgeons from morally and legally having to reconcile them with their ordinary duty of care. Ultimately, this can only be done through arguing that such omissions to sustain life are in the patient’s best interests.

The determination of best interests in these circumstances will rely on one of three objective criteria, over and above the subjective perception by the surgeon that the quality of life of the patient is poor. There is no obligation to provide or to continue life-sustaining treatment:

- **If doing so is futile** – when clinical consensus dictates that it will not achieve the goal of extending life. Thought of in this way, judgements about futility should not be linked to evaluations of a patient’s quality of life.
- **If patients are imminently and irreversibly close to death** – in such circumstances it would not be in the patient’s best interest to prolong life slightly (e.g. through the application of intensive care) when, again, there is no hope of any sustained success. Not needlessly interfering with the process of a dignified death can be just as caring as the provision of curative therapy.
- **If patients are so permanently and seriously brain damaged that, lacking awareness of themselves or others, they will never be able to engage in any form of self-directed activity**. The argument here is backed up by morally and legally reasoning that further treatment other than effective palliation cannot be in the best interests of patients as it will provide them with no benefit.

When any of these principles are employed to justify an omission to provide or to continue life-sustaining treatment, the circumstances should be carefully recorded in the patient’s medical record, along with a note of another senior clinician’s agreement.

Finally, surgeons will sometimes find themselves in charge of 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 at the risk of life because of the respiratory effects of the palliative drugs. In such circumstances, surgeons can use legal justification administer a dose which might be dangerous, although experts in palliative care are

---

**Jehovah’s Witnesses** | Members of a millenarian fundamentalist Christian sect founded in America in 1874. They have their own translation of the bible that they interpret literally.
sceptical that this is ever necessary with appropriate training. In any case, 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. As intentional killing (active euthanasia) is rejected as professional and legal medical practice throughout most of the world, a potentially lethal dose is regarded as appropriate only when it is motivated only by palliative intent and this motivation can be documented.

Debates rage about whether or not it is realistic in such circumstances to believe that surgeons can or should keep all ideas out of their minds about helping such unfortunate patients to die, especially as we have seen that clinical decisions are already made that lead to foreshortening the lives of incompetent patients in specific circumstances. Deciding whether or not to risk life for palliative purposes will require an evaluation – by either the patient, the clinician or both – of whether or not the life in question is too valuable on other grounds not to risk it. Once a negative conclusion is reached and the risks are incurred, it seems difficult to continue in the face of continued and dramatic palliative failure then to purport to banish thoughts of the desirability of death from the scene. What is clear is that surgeons should document that their intent is purely palliative through only gradually and incrementally increasing doses of the drugs that they administer for this purpose.

CONFIDENTIALITY (Box 20.6)
Respect for autonomy does not entail only the right of competent patients to consent to treatment. Their entitlement to exercise control over their life and future corresponds to the duty of surgeons to respect their privacy – not to communicate information revealed in the course of treatment to anyone else without consent. Generally speaking, such respect means that surgeons must not discuss clinical matters with relatives, friends, employers and others unless the patient explicitly agrees. To do otherwise is regarded by all of the regulatory bodies of medicine and surgery as a grave offence, incurring harsh penalties. For breaches of confidentiality either must or may be breached in the public interest. There will be some circumstances in which confidentiality 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. It may be ignored in attempts to prevent serious crime or to protect the safety of other known individuals who are at risk of serious harm.

RESEARCH (Box 20.7)
As part of their duty to protect life and health to an acceptable professional standard, surgeons have a subsidiary responsibility to strive to improve operative techniques through research, to assure themselves and their patients that the care proposed is the best that is currently possible. Yet, there is moral tension between the duty to act in the best interests of individual patients and the duty to improve surgical standards through exposing patients to the unknown risks which any form of research inevitably entails.

The willingness to expose patients to such risks may be further increased by the professional and academic pressures on many surgeons to maintain a high research profile in their work. For this reason, surgeons (and physicians, who face the same dilemmas) now accept that their research must be externally regulated to ensure that patients give their informed consent, that any known risks to patients are far outweighed by the potential benefits, and that other forms of protection for the patient are in place (e.g. proper indemnity) in case they are unexpectedly harmed. The administration of such regulation is through research ethics committees, and surgeons should not participate in research which has not been approved by such bodies.

In practice, it is not always clear what is to count as surgical research that should be subjected to regulation and what constitutes a minor innovation dictated by the contingencies of a particular clinical situation. Surgeons must always ask themselves in such circumstances whether or not the innovation in question falls within the boundaries of standard procedures in which they are trained. If so, what may be a new technique for them will count not as research but as an incremental improvement on personal practice.

Yet, if the improvement is to be thought of in this way, no conclusions can be drawn from it to alterations in standard practice or to an evaluation of their efficacy. Equally, there will be no consequences for surgical training; as the innovation in question should only have been attempted against the background of the already existing training and experience of the surgeon in question. If a proposed innovation exceeds these conditions then it does count as research and should be approved by a research ethics committee. Such surgical research should also be subject to a clinical trial designed to ensure that findings about outcomes are systematically compared with the best available treatment and that favourable
results are not because of arbitrary factors (e.g. unusual surgical skill among researchers) which cannot be replicated.

**MAINTAINING STANDARDS OF EXCELLENCE** *(Box 20.8)*

To optimise success in protecting life and health to an acceptable standard, surgeons must only offer specialised treatment in which they have been properly trained. To do so will entail sustained further education throughout a surgeon’s career in the wake of new surgical procedures. While training, surgery should be practised only under appropriate supervision by someone who has appropriate levels of skill. Such skill can be demonstrated only through appropriate clinical audit, to which all surgeons should regularly submit their results. When these reveal unacceptable levels of success, no further surgical work of that kind should continue unless further training is undergone under the supervision of someone whose success rates are satisfactory. To do otherwise would be to place the interest of the surgeon above that of their patient, an imbalance which is never morally or professionally appropriate.

Surgeons also have a duty to monitor the performance of their colleagues. To know that a fellow surgeon is exposing patients to unacceptable levels of potential harm and to do nothing about it is to incur partial responsibility for such harm when it occurs. Surgical teams and the institutions in which they function should have clear protocols for exposing unacceptable professional performance and helping colleagues to understand the danger to which they may exposing patients. If necessary, offending surgeons must be stopped from practising until they can undergo further appropriate training and counselling. Too often, such danger has had to be reported by individuals whose anxieties have not been properly heeded and who have been professionally pilloried rather than congratulated for their pains. Surgeons and anyone else discovered to have been participating in such ‘cover-up’ and ostracism should share the blame and punishment for any resulting harm to patients.

---

**Box 20.8**

**Maintaining standards**

- ‘Watch one; do one; teach one.’
  - What is unacceptable about this statement?
- ‘Surgeons have a responsibility never to criticise their colleagues’
  - Is this statement acceptable?

**CONCLUSION**

The two general duties of surgical care are to protect life and health and to respect autonomy, both to an acceptable professional standard. The specific duties of surgeons are shown to follow from these: acceptable practice concerning informed consent, confidentiality, decisions not to provide, or to omit, life-sustaining care, surgical research and the maintenance of good professional standards. The final duty of surgical care is to exercise all of these general and specific responsibilities with fairness and justice, and without arbitrary prejudice. The conduct of ethical surgery illustrates good citizenship: protecting the vulnerable and respecting human dignity and equality. To the extent that the practice of individual surgeons is a reflection of such sustained conduct, they deserve the civil respect which they often receive. To the extent that it is not, they should not practise the honourable profession of surgery.

**FURTHER READING**


www.bma.org.uk for general information on medical ethics.