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# Responsibility in the Operating Theatre: *the Guidelines are still Controversial*

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So far, we made Surgery somewhat *safe for* the patient. Nevertheless, once in a while we have *to save* the patient *from* Surgery.
Now, we are faced with another concern : *to save* the surgeon *from* lawyers.

There are three levels as far as norms are concerned : the moral, the deontological and the legal ones. The mirror image of norms is represented by the three levels of responsibility. Nevertheless, this simple concept is beyond the compass of most medical minds ignoring those intertwined levels and as a matter of consequence the place, the variety and the role of the legal level.

If there is no problem for the lawyers to understand the various legal theories and doctrines and to choose one of them depending on the case, the surgeons and the anesthesiologists working in the operating room have, however, lots of reasons to be anxious about the malpractice consequences that the choice of one doctrine over another can cause.

This is the reason why to study the topic of responsibility in the operating room (O.R.), we have to resort to both a trans-disciplinar and a multi-disciplinar approach. Multi-disciplinarity by putting side by side the tools of different specialities ; trans-disciplinarity by learning how to use the tools of other specialities.

However, the combination of both can lead to further lack of understanding and/or to conflicts. To avoid such a drift we must first of all describe the semantics (*words being the basic tools for communication*) and the general context (*the environment*) of the legal aspect of responsibility in the O.R.

## I. The words of Law

Therefore, let's be trans-disciplinar by learning the words of Law, which are the tools of lawyers and judges.

A ***Right*** is an ability, a faculty. It is any interest, property or privilege recognised and protected by law. It is the freedom to exercice any power conferred by law. It is also some kind of *messenger* for an individual to the different systems of the society (e.g. rights of workers, rights of patients).

An ***Offence*** (un délit, een schuld) is committed when the right has not been respected or followed.

A ***Duty*** implies a ***moral obligation***. This is why Ethics are in the centre place for philosophers like the monumental Emmanuel Kant, and why law and policy have to be somewhat moralised ; keeping in mind that laws and legal rights are evolving in the wake of Ethics. If a duty implies a moral obligation, in order to understand this concept we have first to define what a "moral fact" is. In fact, one does not know what morality is ; one only knows that it does exist !

A ***moral fact*** is the establishment of the absence of indifference of the human conscience towards our actions : "There are things to be done and things not to be done". A moral fact is the feeling towards human action in consideration of the intentionality of the agent, the liberty of the agent, the responsibility (the imputabilty) of the agent to which is associated the feeling of obligation.

The latin word and the german philosophical expression for responsibility are "Imputabilitas" and "Schuldfähigkeit" ; which clearly means the consequences of my acts can be imputed to me ; I am responsible of the consequences of my acts.

In other words, *to be moral* means to deal with my own duties ; *to be a moralist* means to deal with other people's duties. Needless to say that in the modern hospital environment surgeons and anesthesiologists are surrounded by moralists !

Laws and Rights have not the first place. Duty – as a moral obligation – has the first place.

What is ***Justice*** then ?

Justice is the value of equality and equity before being the conformity with laws (*jus* in latin).

But if Justice is a value, it is also a Virtue (the most complete Virtue said Aristotle).

Nevertheless, Justice is an active Virtue, because it gives us the opportunity to fulfil the moral obligation (duty) of allowing to preserve the hierarchical harmony

of the society by keeping each one of us at his place, by attributing to each one of us his fair share and function.

Law is second to Justice. Law is in the dark shadow of Justice ; it doesn't shine. When law is wrong or unjust, it is our duty to combat it. Ideally, Laws should be in harmony with Justice and move together in the same direction. It is our moral duty as citizen to try to reach this goal. Once more, this is the reason why "Laws and Rights are evolving in the wake of Ethics"

## II. Error and discipline

In the real life, we are confronted to moral, deontological and legal norms, and as a matter of consequence, we have to assume moral, deontological and legal responsibilities. However, the context of the real life is a changing one. In our daily professional environment and as far as responsibility is the point to be made, we have to admit that even if the norms are still there, it is often their application that is changing and evolving. Furthermore, the modern environment is unfortunately characterized by confusion of styles and concepts.

Two simple examples : surgeons and anesthesiologists are expected to deliver professional care in a complex and ever-evolving health care system. To do so, they must comply with what could be considered as two basic moral, deontological and legal norms ; the one exemplified by a politician and the other by a U.S military general (1) :

a. An *error* is an error. But an error does not become a *mistake* until one has decided not to correct it (John Fitzgerald Kennedy).
b. *Discipline* is doing what is right when nobody is watching (Four-Star General Schumacker, U.S. Marine Corp, 7 May 2004 at the U.S. Senate hearing about the army personnel misconduct in Irak).

## III. No-fault compensation law

Although full disclosure of medical errors is increasingly recognized as an ethical imperative, health care providers often shy away from taking personal responsibility for an error and believe they must «"*choose words carefully*" or present a positive "spin"» (2). Spin doctors while choosing words too carefully are in fact lying by omission and practicing the sin of non disclosure. This is a bad move because honesty and common sense can in fact save a lot of energy wasted in malpractice trials.

A transformation in how the medical profession communicates with patients about harmful medical errors has begun. Within a decade, full and frank disclosure of these events to patients is likely to be the norm rather than the exception. Making disclosure of harmful errors to patients an expectation in medicine and giving providers the tools to turn this principle into *disciplined* practice may prove to be critical steps in restoring the public's trust in the honesty and integrity of the health care system (2).

As a positive consequence 30 U.S. states have adopted **«I'm sorry» laws**, which to varying degrees render comments that physicians make to patients while explaining the unfortunate occurrence of an error inadmissible as evidence for proving liability (3). In other words, if the physician clearly says the truth to his patient, he will most likely not be taken to court.

By analogy and to make a long story short, the spirit of the «I'm sorry» laws is roughly the principle behind the 15 May 2007 law in Belgium : the so-called "*no-fault compensation law*" (*Wet betreffende de vergoeding van schade als gevolg van gezondheidszorg - Loi relative à l'indemnisation des dommages résultant des soins de santé*).

However, there is still a long way to go because the implementation of this law has been postponed and we have to wait for the decrees of execution. In addition, one problem persists without receiving any clear answer so far : who will pay what as far as compensation for damage from health care activities are concerned ? Indeed, the current law does not specify what the insurers and the Community' contribution to the financing of the system will be.

## IV. The «intuitu personae» contract (4-7)

For the patient, the identity and the personal qualities of the other involved party – the surgeon – is often decisive to enter into a contract with the surgeon. In such circumstances, one can speak of «intuitu personae» contract. In principle, this contract may not be transferred to other agents for its execution. On the other hand, the surgeon who is making the "offer" to contract is not forced to accept everybody as contracting party. This is in line with Art.49 of the Code of Deontology (Code van plichtenleer – Code de déontologie) : "The surgeon is entitled to refuse any operative decision whose indication is insufficiently justified or for any other legitimate motive".

By the intuitu personae contract, the *offering* party (the surgeon) remains free to accept or not the other *demanding* party (the patient), except in an emergency situation (i.e. life-threatening situation).

## V. Contractual responsibility of the surgeon for all the other auxiliary participants (e.g. members of the O.R. team : anesthesiologists, assistants, nurses)

### A. *The intuitu personae aspect of the contract between the surgeon and the patient*

Generally the patient who will be operated has met the surgeon in the outpatient clinic or in the hospital setting.

As a consequence, a contract is implicitly and/or explicitly concluded between both parties. In practical terms, the patient does not contract with other members of the personnel who will be involved in his surgical treatment, i.e. anesthesiologists, scrub nurse, O.R. technicians. Very often the patients does not even know them and is not the least concerned by *identifying* them.

In fact, the patient most often *trusts* the surgeon for the choice of the auxiliaries and for the practical organisation of the operation which is part of his deontological duty as formulated by Art. 50. "In order to offer the patient the best possible care, the surgeon must choose competent operative auxiliaries. He is *responsible* for this choice".

However, the surgeon is unable to perform **alone** all the operative and peri-operative tasks. Therefore, he has to delegate several specific tasks to other physicians, nurses, technicians.

Furthermore, in well organised anesthesiology departments, preoperative anesthesiology consults have been developed. Nevertheless, this modality can vary from one hospital to another, taking into account one major disparity : the chronic shortage of anesthesiologists.

B. *The contractual responsibility of the surgeon for the mistakes made by a member of the team*

In accordance with the contract concept, which is a legally binding agreement, the surgeon is bound to be responsible for the other persons who are involved in the execution of the contract, or part of it. The *mistakes* made by the auxiliaries can be considered as the surgeon's own mistakes. In case of absence of execution of a contractual obligation, to put the blame on either the surgeon (principal debtor) or on auxiliaries is legally of no importance for the patient who suffered harm.

The mistakes made by the auxiliaries or other members of the team, including the cardiologist or the internal medicine doctor while executing their obligations in the frame of the perioperative contract can then be imputed to the surgeon *(the surgeon being the most easily identifiable scapegoat)*. Such is the essential of the legal doctrine in Belgium and France. The Dutch doctrine is going somewhat in the same direction. One can agree or disagree with such a doctrine but it is rather logical inasmuch as the surgeon is often the only one contractually bounded to the patient, the only one clearly identified by the patient, the only one who has promised something to the patient.

On the other hand, the auxiliaries eventually without having been identified by the patient, without being directly bounded by the surgeon's contract, are nevertheless involved also in the execution of the contract.

Considering that the patient is trusting the surgeon who will perform the operation, the surgeon has the obligation to dutifully provide him with the best care that are up to date with the latest scientific evidences. This is directly in line with Art. 34. (modified on 18 August 2001) of the Code of Deontology which mentions : "§1. Both to make a diagnosis and to initiate or pursue a treatment, the physician must commit himself to dutifully offer the patient the best available care, that are up to date with the latest scientific evidences ; §2. The victim of a medical mistake has the right to compensation for the damage and each physician must be insured for that purpose".

According to such legal theory, the surgeon can be taken responsible for the mistake made by the anesthesiologist as this physician substitutes himself for the accomplishment of part of the surgeon's initial contractual obligation. This substitution being made sometimes without the informed consent of the patient, e.g. the anesthesiologist performing the anesthesia and the one having examined the patient preoperatively might be two different physicians. Such a situation is often the case too for general surgery. In France, the surgeon can be held as the principal debtor for the mistakes made by a member of the team in his function as auxiliary. In this field, several judgments have provided *legal precedents* (i.e. legal precedent being judgment used as an authority for reaching the same decision in subsequent cases – *jurisprudence – rechtspraak*).

In Belgium, there is no legal precedent on this question of the surgeon's responsibility for auxiliary – but there is well one exception ! Of course, it is the exception that is interesting for us (i.e. Correctionele Rechtbank van Leuven, 30 juni 1992). The Tribunal declared that the surgeon can be held responsible for the mistakes made by the anaesthesiologist.

Practically, such a decision is often difficult to enforce due to the fact that the identity of the team member who made the mistake has to be determined with certainty ; which can be impossible when a large team was involved in the surgical treatment.

As you can imagine, the legal precedent that hold the surgeon contractually responsible for the mistakes of the anesthesiologist or of any auxiliary is controversial and more and more criticized. Controversial because it does not take into account the fact that Anesthesiology is now a full medical speciality with its own training and credentials. In addition, such legal precedent does not consider the evolution of medical sciences and is once more the illustration that : «Laws are lagging behind Techno-Scientific breakthrough» just as «Laws are evolving in the wake of Ethics».

It is even more controversial, because it does not take into account the fact that the distribution of tasks between surgeons and anesthesiologists must be reflected in a wise hierarchy of responsibilities. Indeed, the anesthesiologist is no more, as it was in the past, a

simple auxiliary of the surgeon. He is acting as an independent agent for the execution of his task. It is precisely because the surgeon is widely incompetent in the fast moving field of anesthesiology that he is calling anesthesiologists for help.

Based on *the techno-scientific ground,* there is no more an explicit or implicit subordination of the anesthesiologist to the surgeon. However, based on the *legal ground,* it is still a matter of fact that the surgeon accepts a general mission. Therefore, the surgeon could still be held contractually responsible for all the mistakes and errors. Unfortunately, he will remain on the frontline of the legal battlefield for some time yet !

The only way for the surgeon to partially deal with this 'legal precedent discrepancy' between the reality of the *techno-scientific ground* and the reality of the *legal ground*, is to declare beforehand implicitly or explicitly that he considers to be exempted of the responsibility for certain obligations that are to be executed by other independent agents.

C. *The contract by which a member of the team (an auxiliary) agrees to undertake certain duties under his direct liability*

Once in a while, the patient is contracting directly (implicitly or explicitly) with a member of the team (i.e. the anesthesiologist, a scrub nurse…) who is not the surgeon. Then the responsibility of this member becomes contractual because - by some kind of agreement – he has engaged himself to perform certain tasks for the benefit of the patient. If such a binding agreement does exist, then the surgeon can not be held responsible as the principal debtor, because the self-contracting member of the team does not act any longer as a so-called contractual auxiliary of the surgeon. However, a debate is still open regarding the following question : «*As far as the parties have the capacity to contract, when a contract is actually concluded with a member of the team* ?». According to some legal theories, the willingness to reach an agreement is demonstrated by a preoperative visit or consult. According to others, the willingness to reach an agreement is almost always concluded between the patient and each member of the team. Those are going much further by resorting to three clinical and legal concepts (6, 7) :

1. The preoperative exam
2. Stipulation for somebody else (het beding ten behoeve van een derde – la stipulation pour autrui)
3. Tacit agreement (de stilzwijgende lastgeving – le mandat tacite)

1. The preoperative exam

Legal precedents (*jurisprudence* ; *rechtspraak*) establish that when the anesthesiologist is chosen by the surgeon or by the hospital, this choice can be ratified tacitly or expressly by the patient. As a matter of fact, such a ratification is enforced each time the patient submits himself voluntarily after informed consent to an exam and to preoperative care and/or tests performed by the anesthesiologist. Such a ratification results ultimately in a separate contract between the patient and the anesthesiologist
The most common situation is the one in which the anesthesiologist accomplish a preoperative visit to the patient, just before the operation or the evening before the operative day. A significant part of the Belgian and French legal doctrine is in favour of considering that such a preoperative visit is tantamount to a tacit consent, and as a direct consequence a contract arises as a result of the tacit consent.

2. Stipulation for somebody else (*het beding ten behoeve van een derde ; la stipulation pour autrui*)

According to some aspects of the Belgian and French legal doctrine, the absence of direct contact between the patient and a team's member does not rule out the foundation of her or his contractual responsibility. It is precisely here that the stipulation for somebody else is invoked.

The stipulation for somebody else can be defined as the guarantee given by the surgeon (*le stipulant, de stipulant*) that an undertaking will be honoured by another member of the team (*le promettant, de belover*) in favour of a third party (*the patient*). In other words : the surgeon (le stipulant, de stipulant) stipulates officially what must be done by another member of the team (le promettant, de belover) in order to provide appropriate care to the patient (the third party). Thereupon, by choosing (by contracting with) his surgeon, the patient does accept implicitly this stipulation. In consequence of such a legalistic construction, the patient is entitled to sue any member of the team in case of malpractice.

However, to draw the inference that the stipulation for somebody is a sound legal construction defining the relation between, on one hand, the surgeon and his auxiliaries, and, on the other hand, the *patient* is far from being convincing. For the simple reason that one can not deny the artificial aspect of this legalistic construction. Indeed, when a surgeon is stipulating for other agents, it is in part in his own interest and not only in favour of the patient. In other words : while a surgeon is organising personally all that is required to conduct safely and effectively an operation, he is doing his job and actually not giving an extra (contractual) right to the patient !

Furthermore, many logistic interferences have to be coped with at different hospital levels (ward, OR, ICU). Those logistic interferences being less and less under the direct control or even the remote supervision of the surgeon. In practical terms, very often the surgeon has

no more the opportunity to decide – or even to give his advice – about the choice of the anesthesiologist who will put his patient to sleep, about the scrub nurses who will assist him or about the equipment he will use.

There is even more room for criticism because any physician has the duty to inform and to get the consent of his patient before any diagnostic or therapeutic action. Therefore, one should raise the following question : «*Is the stipulation for somebody else compatible with the duty of any independant physician-debtor to obtain the informed consent from the patient and is it still compatible with the 2002 Bill of patient's rights law ?*

In fact, many aspects of the legalistic construction of the stipulation for somebody else infringe upon this 2002 law, at least as far as the informed consent of the patient is concerned. Therefore, the stipulation for somebody else does not appear any longer as a realistic basis to found the contractual responsibility of the different intervening parties.

In addition, our daily clinical practice experience demonstrates at nauseam that parties, such as the surgeon and the anesthesiologist, are not entitled anymore to organise by themselves many logistic aspects of the infrastructure and the environment indispensable to safely conduct a surgical operation. As a consequence – already well known in the anglo-saxon world – , we are assisting at the development of the new legalistic construction of "**Institution Litigation**". Institution Litigation meaning, in case of accident or incident, the sharing of responsibilities altogether between clinicians, nursing personnel, technicians of maintenance but also...managers and eventually even members of the board of trustees !

These people are now welcome to the club of those already responsible of what is happening in the O.R.

In conclusion, the growing weakness of the legalistic construction of the stipulation for somebody else has led to designing another construction : the Tacit Agreement.

### 3. Tacit Agreement (*de stilzwijgende lastgeving – mandat tacite*)

The conclusion of a contract between a member of the team and the patient can also be founded on a tacid agreement. This tacit agreement can be described as a contract by which one party (the principal – le *mandant* – the *lastgever*) asked another party (the representative – le *mandataire* – de *lasthebber*) to perform parts of the task in his name and for his count. Of course, the representative must first of all accept the task and have the capacity to perform it.

In daily clinical practice, this tacit agreement concept can be interpreted in two ways.

On one hand, the auxiliaries give the mandate to the surgeon to conclude in their name the tacit agreement with the patient. The surgeon having been chosen, because he is since the beginning of the therapeutic relation in contact with the patient and has been clearly identified by him. This first side of the alternative has been successful in the French legal doctrine. However, the major objection is most likely the fictitious aspect of the presumed consent of the different parties. It is a bit short, to assume that every auxiliaries would mandate the surgeon and that the patient would automatically (tacitly) accept each auxiliary as party of the contract. In addition, such a line of thinking denies and ignores the intuitu personae aspect of the medical contract.

On the other hand, it is the patient himself who gives the surgeon his tacit agreement (mandate) to choose his auxiliaries in order to provide him a safe and successful treatment. This second side of the alternative implies that the surgeon is allowed – *in casu* – to be assisted by any auxiliary that he considers competent, necessary and suitable. At first glance, this second side of the alternative is defendable. Indeed, there is a somewhat constructive overlapping between the legal, the deontological and the moral norms. Suffice it to say that here article 50 of the code of deontology is rather in line with article 1135 of the Belgian Civil Code :

**Art. 50.** In order to offer the patient the best possible care, the surgeon must choose competent operative auxiliaries. He is responsible for this choice.

**Art. 1135 C.civ–BW.** *(passim)* The conclusion of a contract by the mandated surgeon with other auxiliaries in the name and in favour of the patient might be considered as a consequence of the private aspect associated with the medical contract.

However, at a closer look, this second side of the alternative raises the following question :

*Is the core nature of the medical contract not prohibiting in fact a too lenient interpretation of the tacit agreement given by the patient ?*

Let remind us, once more, that the contract between the patient and the physician is first of all an *intuitu personae contract* based on the personal trust that has been established between both parties. Be happy with it or not but this personal trust binding may not be transferred purely and simply to another physician or to anybody else, because the physician would then give up his responsibility without having obtained the informed consent of the patient.

To put it more straightforwardly : law is tangled with the *ethical* foundation of the relation between patient and physician which is : "The encounter of a trust (patient's) with a conscience (physician's)".

## VI. Conclusions

In fact, the legal theories and doctrines consider the surgeon in the O.R. as the principal debtor and the other

participants as specific task's performing auxiliaries. Believe it or not, be happy with it or not but the legal theories are most likely more realistic, more practical and offer the best guarantee to the patient. Indeed, the patient will then be able to sue the member of the team that he knows best or to whom he is familiar, that is to say : the person that he has clearly *identified* and with whom he has established a tentative relation of trust at the beginning of the contract (ie. the principal debtor). Anyway, the principal debtor will always remain entitled to take the careless auxiliary to Court.

In other words, it is no more in terms of the hierarchy between members of the team (subordinates and superiors) that one has to approach the complex question of "responsibility-imputability-liability" in the O.R. In 2008, the approach has to be conducted while keeping in mind the inevitable and ineluctable hierarchy of clinical responsibilities towards a vulnerable patient.

Things are far from being simple and straightforward. Legal controversies are also far from being exhausted, even after the publication of the Belgian «non fault compensation law» of 15 May 2007. Nevertheless, from the *deontological* viewpoint, there is no doubt about the responsibility of the agents and about the direct liability of both the surgeon and the anaesthesiologist. Thus far, the deontology is clearer and more straightforward than the legal theory or doctrine. From the deontology viewpoint guidelines are not controversial any longer.

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