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The (Mis)Informed Consent and The Forgotten Doctor-Patient Relationship

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Abstract

The simple informed consent and a strong doctor-patient relationship may be the surgeon's best tools for avoidance of malpractice claims, yet this powerful duo continues to receive little attention by our educators. This institutional oversight results in hugely inflated insurance premiums and needless heartache for surgeons and patients/families alike. What constitutes the standard of care for a proper elective surgical informed consent, plus a few pearls on the doctor-patient relationship shall be presented.

Keywords

surgical operative informed consent, standard of care risks, risk management, complications, doctor-patient relationship, malpractice, negligence

Introduction

This article seeks to examine shortcomings and better establish the current standard of care (SoC) as it relates to a proper informed consent (IC) for elective cosmetic or plastic surgery and presents some suggestions for risk mitigation.

Background

As a plastic surgery resident, I had the honor of training under one of the giants, Dr Mark Gorney (Pres. ASPS, 1983). As founding member on the Doctor's Company* Board of Governors, the leading provider of professional insurance for plastic surgeons, and its Medical Director, I doubt anyone had more expertise on the subject of cosmetic surgery IC. Gorney published extensively and lectured many times on the national stage on matters regarding patient selection, risk management, and medical law; yet as one of his mentees, I knew him more for sharing his vast wisdom one-on-one while hunched over the OR table. Sadly, Dr Gorney (1924-2014) is no longer with us, but I shall hopefully do him honor by discussing this topic, specifically what are the necessary elements to meet the minimum standards for a properly executed IC.

I also tip my hat to my father John O. Baeke, a physician and surgeon for 50 years, who never felt the sting of a single professional claim. I will share a few of his secrets here as well.

Though I have been a plastic surgeon for over 30 years and have reviewed over 500 (potential) negligence cases as a retained expert, I am still learning. Reviewing cases allows me to find (what I believe to be) breaches in the minimum SoC; and simultaneously identify best practices that I often integrate into my own methodology.

I try to stay abreast of the current curriculum in medical schools and residencies of my particular specialty. I do this by speaking with recent graduates and academic clinicians/professors.

What I have concluded is that today the same amount of attention (or lack thereof) to the supremely important topic of IC is being provided to our medical students as when I was their age. In my case, Medical Jurisprudence class carved out a whopping 50 minutes per week, for one whole semester. Of that 16 hours, I estimate only 30 minutes was devoted by my medical school to the subject of what constitutes a proper surgical IC and the closely intertwined subject of the doctor-patient relationship. The latter typically involved people-skills foreign to most of the white-coats practicing at the University of Anywhere.

There is no excuse for this academic dereliction. This lack of focus suggests an institutional belief that malpractice lawsuits are more driven by surgeons' incompetence in the operating room rather than the consultation room. How many surgeons today are needlessly paying jacked-up professional

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liability insurance premiums, only because they were sent into the world of private practice without awareness of how a proper IC and solid doctor-patient relationship could avoid most negligence claims?[1]

None of us graduated directly into a practice which was 100% elective cosmetic surgery. We have all had some degree of experience with reconstructive, even emergent surgery. I suppose the case could be made that the bar is lower for the minimum SoC required of the surgeon in such cases. When expediency is of a premium, matters of life/limb/sight are pressing, blood is dripping on the floor, locating the appropriate consent-giver impossible, and so on, all might justify relaxing the normal IC processes.[2]

What this also says is nowhere in the arena of surgery is the IC bar set so high as in the case of elective cosmetic surgery. Here, no claim can be made that the pressures of time rushed performance of a proper IC. Indeed, unlike all other surgeons who take a sick patient with the intention of making them well, we cosmetic surgeons operate on patients who are already well.[3]

As a plastic surgeon whose practice is (pun intended) top heavy with breast surgery, I shall use elective primary breast augmentation as my frequent example, but the same principles apply to most any elective cosmetic surgery:

> [When referring to the patient, I shall use the pronoun "she" preferentially as ~90% of elective cosmetic patients are feminine. When referring to the surgeon, the pronoun "he" rather than "he/she" is used, as according to traditional Webster etymology, "he" is not masculine, but gender-neutral.]

I believe the IC is the surgeon's best tool to prevent medical malpractice claims. Not because it allows us to wield the scalpel better or because it provides some ironclad legal defense. Rather it becomes the bedrock for the honored doctor-patient relationship.

The Informed Consent

A proper IC is not simply a document shoved under the patient's eyes, whereby she is told to sign at the "x." Rather, it should be an open exchange of information between doctor and patient; a 2-way discussion culminating with the execution of an agreement of understanding, the document we commonly call the Surgical or Operative IC.[1,4]

The IC process begins with the initial consultation. Though today many practices will delegate this function to "patient counselors" and other mid-level and lower-level proxies, it is an abrogation of the attending surgeon's responsibility to not be the primary deliverer (and recipient) of this critical (often intimate) information. **The patient rightfully has the expectation that she should hear this information from the individual who will be seeing her naked, cashing her check and touching her with a knife.** In fact, in all (or nearly all) 50 states, the physician has the *affirmative duty* to disclose this important information. Though the answers to her questions may be the same even if uttered from the mouth of some assistant, coming from the surgeon makes the answer much more credible and reassuring. The unintended consequence of a surgeon highly involved in the consultation process is a dramatic increase in closure rate (% appointments proceeding to surgery) and isn't that what we all want? If spending 45 rather than 10 minutes with a new consult increased your closure rate from $< 30\%$ (the national average) to $> 90\%$, would you do it?[1,5]

Unfortunately, though the constraints of managed-care practices have forced modern-day physicians to become a slave to the clock, we must not allow that mindset and practice model to dictate how we manage our elective aesthetic patients. Here, the time-honored practices perfected by family doctors of the 1900s can and should still direct how we care for this subset of individuals. The 2 styles of practices can co-exist under one roof. Perform the flash-dance with the HMO patient. However, the cash-paying aesthetic patient believes and (possibly rightfully so) deserves more time and attention from the surgeon than her managed-care cohort. Certainly, the latter group is responsible for a higher percentage of malpractice claims. The additional time spent up front can be one of the best investments a surgeon can make.[1,5]

Following the consultation, the surgeon should memorialize in the medical record the details of this IC conversation, not merely checking some box indicating a comprehensive IC (supposedly) happened. He should avoid overuse of the cut and paste within the electronic health record. To meet the minimum SoC, the medical record documenting the consultation should reflect the IC conversation included these basic elements.[6,7]

Basic Elements of the Informed Consent

Expectations

> The IC is a *bilateral* process. Both surgeon and patient need to be actively involved in the discourse. A properly executed IC must conclude with both patient and surgeon having the same realistic expectations.

Mutual respect. First impressions matter and are lasting. It may seem old school, but a patient will respect the physician more if he presents with a humble demeanor and well-dressed, not looking like he just finished 30 over par. [HINT to my "cooler" counterparts: Ditch the scrubs. Walk into the hospital or office wearing a suit and tie and you instantly command respect.]

Likewise, a physician cannot help but have lesser thoughts of a patient wearing grunge whose thumbs are flying off her "dumb-phone." The message is, "she's wasting my time."

Once high mutual respect is established between surgeon and patient, everything will fall into place.

Purpose: the patient's perspective. From the patient's perspective: the purpose of the IC is to be educated as to: (1) what is the condition/diagnosis possibly requiring surgery, (2) what treatment options exist, (3) how likely is surgery to produce/maintain the desired results, (4) what are the relative advantages/disadvantages/recovery comparing the different options, (5) what are the potential risks/complications/side-effects/consequences for each option, (6) types of anesthesia, (7) pre-operative and post-operative instructions, and most importantly, (8) "Do I trust the surgeon." This is the minimum standard.[2,3,5]

Purpose: the surgeon's perspective. From the surgeon's perspective, "Do I feel comfortable operating on her?" The patient too needs to listen *and* talk (be wary of the spouse/boyfriend who controls the narrative). The surgeon should ask open-ended questions and determine precisely her expectations. We surgeons tend to be great talkers, and poor listeners. Making a drawing during the consultation showing, e.g., where there is breast asymmetry, degree of ptosis, etc. is extremely helpful for both patient and surgeon. Many providers will also use computer-generated photo manipulation software. It is a good practice to provide copies of any diagram or predictive images for the patient to take home. The consultation should not terminate until the surgeon is satisfied he precisely understands the patient's motivations, is convinced of her strong desires, is confidant she has a basic understanding of what she might be consenting and will be reliable in following instructions. There is no shame in simply saying, "I'm sorry. I don't believe I am the man for the job." This too is the minimum standard.[5,8,9]

In my opinion, the most common predictor of a medical negligence claim, is when both patient and doctor do not have the same expectations. A patient entering the OR with expectations higher than the surgeon's, is a prescription for big problems. For unless the surgeon way over-delivers, there will be mutual heartache.

When a surgeon wheels a patient into the operating theater and touches her with a knife, he has just entered into an unspoken/unwritten yet binding relationship with that patient (a "blood covenant," if you will) whereby he commits to provide whatever care necessary until the patient is sufficiently healed or care has been terminated/transferred to another, equally skilled provider. Though this agreement may not be defined in such graphic terms, it is properly assumed by all patients to be bona fide and should never be forgotten. I once had a chief medical officer who did not understand this legal tenet by refusing my authorization to see a patient post-operation because of her indigency![8,10]

Finally, someone (typically not the surgeon) needs to explain the financial policies. If there is a complication, does the surgeon have complication insurance, e.g., BLISCare[**] or is the patient held financially responsible?[11,12]

Key Players

Everyone's an expert. At the beginning of a consultation, it is often good to "de-program" the patient, as her head may be filled with misinformation. "Wisdom" obtained from what she trusted to be reliable sources, e.g., social media, former patients, sorority sisters, other doctors, and believe-it-or-not, your own receptionist, may need to be drug into the trashcan. Learning what your patient knows is as important as what she does not know. Listen and re-educate.[13]

Who is the surgeon?. The critical part of the IC, namely, the verbal communication, should be performed between the surgeon and the patient. Medical students and residents should have the opportunity to witness how the attending surgeon performs this duty. Should a resident-physician be performing the IC and surgery, it should be clearly explained to the patient, that a surgeon-in-training, who will be overseen by the attending staff surgeon, may be performing the surgery; likewise, for a first surgical assistant (FSA) performing a *significant* role. If the attending surgeon is "overseeing" another operator, will he still be in the operating theater or elsewhere in the hospital (the legal tenet of "captain-of-the-ship" or *superior respondeat*)? The patient should be asked, "Are you OK with this?." Remember, unless you have told her otherwise, the patient is paying you. . . and only you. . . to perform the *entire* operation. Q: How do you respond to a patient who had one breast closed by a FSA? "Doctor, why does my left breast scar look different than my right?." The surgeon is liable for the actions of his subordinates, the tenet of *vicarious liability*.[7,10]

Witness. Having a witness (e.g., a medical assistant) present for the consultation is always good. This person's presence should be documented.[2]

Minor patient. Though not legally mandatory, it shows true compassion when the patient is an unemancipated minor (e.g., otoplasty) to invite the child to participate in the conversation, even though ultimately, it is the parent/guardian who will be signing the consent.

By the way, there is no commandment, "Thou shall not perform cosmetic surgery on anyone under 18 years of age." I can attest to having 17-year-old patients who were wise beyond their years, and 30-somethings who were intellectual pygmies. No intracranial shazam happens on a patient's 18th birthday. As surgeons, patients expect us to exercise professional discernment.[2,4,8,14]

So, who is in control?. Continuing the above analogy, the surgeon may be the "Captain-of-the-ship," however, it is

the patient who decides if this ship is even going to set sail, and she cannot make that overriding decision without first being given all the necessary information, by the "Captain."

Language

To set proper expectations, you the surgeon should begin with an introduction to your patient where you introduce yourself as "Doctor _____." Likewise, you greet her as "Miss (or Mrs.) _____." Introducing yourself without the professional prefix, and instead by your first name may seem to make you more friendly, but risks making you seem inexperienced when things go wrong. Your patient is not looking for a BFF or surgeon with a goofball Instagram name. She's looking for a doctor whom she can respect.

Every conversation should avoid terminology the patient does not comprehend. If it is obvious the individual is not sophisticated, then "dummy-down" the conversation. Always begin by inviting the patient to interrupt, should anything not be clearly understood. It is good practice to intersperse the conversation with the question, "Do you understand?" just to affirm the patient is tracking.[2,3,15]

Make certain to use lay language when printing the title of the operation on the IC document. For example, instead of (or in addition to) "Bilateral Augmentation Mammaplasty" write something like "Placement of Silicone Breast Implants in Right & Left Breasts." Note: When doing something "Off-Label," those 2 words must be written on the IC.[2]

Conversely, in the rare situation where you are consulting on a physician who is a patient, depending on his specialty, you have the luxury of using some med speak.[15]

Naturally, if there is a language barrier, use trained or robo medical translators.

(Body) language. If the aim of the IC is to establish a solid doctor-patient relationship built on trust, then words unspoken become important. A handshake is always appropriate. Unless examining a supine/prone patient, you should never stand for the consultation. Sitting on a rolling stool (even if the patient is pacing) allows you to be less intimidating. Sitting far away from the patient with arms crossed, conveys a coldness. Look the patient in the eyes but show her you are taking careful notes. If she rambles, tactfully refocus the conversation. Leave no doubt at this moment, she is absolutely the most important patient in your life.[1,9]

The Surgical Plan

For starters, even though every surgeon has a financial motivation for the patient to proceed to surgery, this monetary conflict of interest must not prevent you from being the voice of reason. I remind the cosmetic surgery patient, what she is desiring is completely elective. Thus, one option is always, "Do Nothing." This is often an important reality check, especially for the patient who might be caught up in the enthusiasm of the moment.

Next, all bona fide treatment options. . . even if it is an option the surgeon does not personally perform, or does not believe *in his hands* may be best. . . should still be offered to the patient. Again, if the surgeon is incapable or unwilling to offer a particular option; this should be so stated.

In the case of breast augmentation, at a minimum the options discussed must include: (1) cup size, (2) incision location, (3) implant style (profile and saline/silicone), and (4) pocket location.

In my opinion, too many surgeons allow their arrogance to render them deaf to the desires of the patient. Almost daily young women tell me of having breast augmentation surgery performed where they were simply told, "I will be doing your surgery this way"; or "Here is what type and size implant you need."

It should not matter if the surgeon believes the patient's desires for cup size is not aesthetically "proportional" (whatever that is), the surgeon's only consideration should be, (1) does the patient understand what the results will look like? and (2) can I place that size of implant safely (in the case of large implants)?

Surveys have shown that the number 1 complaint of women who have had breast augmentation is displeasure with their final bust size.[3] Like you, I have had new patients who say, "I just don't want anyone to wonder if I have implants." While others say, "Damnit, I want the whole world to see I have implants." We are each entitled to our own concept of beauty.

Remember, long after you have forgotten the patient's name, she will be stuck with the results of your decisions. Therefore (again assuming you can do it safely), always best to give the patient what she wants, not what you want.

A trick to confirm the patient fully comprehends the proposed surgical plan, is asking, "Will you tell me what you understand I will be doing in surgery?" Document having asked this. In the case of a breast augmentation, the patient might reply, "I will have a general anaesthesia. My incisions will be partway around my areolae. You are going to place Allergan*** 400cc low-profile silicone gel implants in front of my muscle". There is no room for her to comment, "Whatever you say is fine by me."[8]

Risks and Complications

Risks. Risks are defined as those pre-existing conditions and behaviors, which can be easily identified pre-operatively as increasing the likelihood of a complication. Most of these should be apparent based on questions answered on the new-patient health questionnaire; e.g., smoking, diabetes, problems with prior surgery, and mental illness. In the rush to see the next consult, do not overlook some important "yes" box the patient checked in her written health inventory. The SoC merely requires the surgeon to have informed the patient how a particular condition or behavior might adversely affect the

outcome. Based on this information, either patient or surgeon might decide not to proceed. From the surgeon's perspective, whether a particular risk (e.g., smoking) mandates avoidance of a surgery involves some professional discretion.

Complications. However, the IC discussion regarding complications is different. Which potential complications does the minimum standard expect a patient to be informed? This is known as the *prudent patient test*. Answer: Those which are the most ominous and those which are the most likely.

The former group would obviously be a rather short list. This would include death, a consequence more often associated with anesthetic complications. [Note: Anesthesia should provide their own IC.]

The latter group ("most likely") is a bit more broad. To keep the list manageable, I subscribe to the teaching of Dr Gorney by describing those complications that have a generally accepted risk rate of $\geq 1\%$. So, in the case of a breast augmentation, certainly I will discuss such things as hematoma/seroma, infection, capsule contracture, poor wound healing, scar formation (often genetic-based), sensory changes, implant failure, need for future surgery, and so on. But, unless asked, I will likely not spend time discussing events, such as pneumothorax, symmastia, and allergic reaction for the simple reason each has a likelihood $< 1\%$. [Comment: I actually consider capsule contracture not a complication of breast augmentation, but rather a *side-effect*, and Dr Gorney agrees . . . but that is a topic for another day.][2,7]

Experience

The patient needs to have some awareness of the experience of the surgeon. A simple comment like, "This is an operation which I have performed often," or contrarily, "This is a complex operation which I have performed only a few times, but am highly confident in the results you will receive." or something apropos.[11]

Supplemental Information

Studies have shown the average patient only retains 35% of what she is told. A good scheduler will encourage patients come prepared to take notes. The more opportunities critical information is provided to the patient, the less likely as a plaintiff she will later suffer from "selective amnesia." Inquire what independent research she might have done, e.g., other websites (and document this). Providing her with supplemental information (i.e., in addition to the physician consultation) via brochures, in-office videos, interactive software, or directing them to your educational website is strongly encouraged, and should be documented. Repetition works.[2,9]

Execution

Though the IC document is signed pre-op (yet prior to administration of any sedatives), it is inappropriate for any elective cosmetic surgery IC consultation to happen the day of surgery. This should happen at least 1 day prior, allowing the patient time to consider her decision. I recently reviewed a case where the surgeon (reportedly) had the patient sign the multipage IC, while supine on the gurney!

Surgery which has any degree of urgency or is reconstructive (i.e., not elective aesthetic) will often require an IC be performed much closer to the actual surgery, and is not considered part of this article. But performing, (for example) an initial breast augmentation or facelift consultation and then proceeding to surgery that same day, would be completely below the acceptable SoC.

Frankly, the IC discussion does not need to be carved out, wholly separate from the consultation. If diligence is performed in giving a comprehensive consultation, all the elements of the IC shall have been covered. Always conclude the consultation by asking the patient, "Do you have any questions for me?" All that then remains is execution of the IC document.

Photos

Permission. As the adage goes, "One photo is worth a thousand words." Taking pre-operative, intra-operative, post-operative photos is standard operating procedure for any cosmetic/plastic surgeon, and should not require special consent by the patient. A single sentence within the IC should suffice. In fact, if she knows the images will always be kept as part of her confidential medical record, it should be a red flag if she refuses photography.

Publication. However, additional specific language within the IC granting the surgeon expressed permission to publish patient photos is the SoC. Image usage might be categorized for (1) purely professional education (e.g., medical journals or meetings), (2) patient education (e.g., professional brochures), or (3) promotion (e.g., social media, banners). Whatever language you chose to incorporate into your IC, there should be no doubt in the patient's mind what she is permitting. She may elect to authorize 1, 2, 3, or none of the above categories.

Published photos must adhere to the professional standards of anonymity. This is easier with body surgery. I sometimes even edit out skin lesions, jewelry, or tattoos. Certainly, facial photos require eye blocks. I have rarely had a patient refuse photography.

Implied guarantee?. Presenting before and after images (hopefully of your own patients) is important for a comprehensive IC consultation. Most cosmetic surgeons also utilize

social media, a practice website, waiting-room brag books, and other formats to demonstrate their surgical prowess. As you and I know, these photos typically show some of the finest work the surgeon has ever done. We all appreciate the marketing power of a phenomenal result. However, be aware that the *unintended* message prospective patients might receive from such self-promotion is that these OMG photos do not represent the surgeon's most phenomenal results, but rather are simply his average work and what every patient should expect. Might this be considered an implied guarantee? Again, the key to having a happy patient is realistic expectations. Be certain to clearly convey a disclaimer indicating not all patients will receive such perfection.[5,10]

Patient-supplied photos. Often patients (especially for breast surgery) will bring photos or downloaded images of what they hope to look like. This can be quite helpful determining patient expectations. It too may be a "red-flag" warning of unrealistic expectations. To these ladies, I will often explain, "If you were a block of granite, and I a rock sculptor, I could guarantee your new look. But we aren't. The breast is a 'malleable blob' and there are healing forces involved of which I don't have complete control. All I can do is promise I will do my absolute best to achieve the result you want." Make certain to keep copies of any patient-supplied images for the medical record.

In the special case of breast reduction surgery, where understanding the desired cup size of the woman can be especially difficult, I insist prior to surgery the patient brings downloaded images of women with similar stature and the desired bust size. No 2 people can agree what a D-cup size breast looks like. I actually tape these images in the OR for reference. (Yes, it always causes a chuckle.) Again, keep those in the patient medical record for later reference.

A Stale Informed Consent

Just as it is inappropriate for there to be a rush between the surgical consultation and actual surgery (at least a 1-day delay), I have had patients where circumstances (typically financial) dictated what would seem an inordinate delay between initial consultation and scheduling surgery. In these situations, I suggest she returns for a face-to-face refresher. This exercise is also valuable for the surgeon to remind him of any nuances he might have forgotten.

Information Overload

I have total disdain for radio commercials where in rapid voice the whispered legal disclaimer is cited; or the television commercial with half the screen covered with legal fine-print, that only appears for 2 seconds. Does anybody read the ridiculous consents we all rotely sign before uploading some app or the closing documents on a new home purchase? Of course not.

Yet, to an extent, many in our profession are guilty of the same practice. Shoving under our patient a thick stack of IC papers or having them scroll through a computer screen as the assistant says, "sign here, here and here" full well knowing they could not possibly have read everything.

This practice suggests we only do it as we (and those defending us from negligence claims) believe that this provides an effective legal-shield. Though it might, does it satisfy the *intent* of the entire IC process; to effectively educate the patient and develop a surgical plan? I submit, just like the total failure of radio, television, and the other cited examples to make us more informed consumers, overwhelming our patients with too many pages of IC fine-print equally kills the message.[1,16]

Somehow the legal profession keeps feeding the beast. To highlight the problem, another medical record I recently reviewed contained not a single page documenting the initial consultation yet included the ASPS's 59-page pre-printed IC. Good Grief! Does the patient need to be warned, "A review of the published medical literature regarding the potential damaging effect on children born of mothers with breast implants is insufficient to draw definitive conclusions that this represents a problem."[17]

Ironically, a few hospitals who historically kill a forest in the name of documentation have now streamlined their surgical consents to a mere 1 or 2 pages. At one teaching-hospital where I am on staff, the portion of their operative consent discussing the potential complications associated with augmentation mammaplasty is reduced to a mere 46 words. (Bravo!) It is the independent surgery centers who now seem to have this love affair with paper and ink.

The IC need not be the place documenting all the details of the consultation. Leave that for the surgeon's consult note, your website, printed materials, and so on. Make the actual signed IC to-the-point, of readable font-size, and ideally, no more than 2 pages. The document should conclude with signed affirmation that the patient received, read and understood all important material provided verbally and via supplemental format. In the case of breast augmentation, I also provide the patient the implant manufacturer's URL for yet more important information.

The IC is a living process, constantly evolving as science and technology advance. What surgical options and complications the SoC requires a diligent surgeon explain today will look vastly different in the future.[18]

It is common for professional liability insurance carriers to request to see an example of your consent. Some insurance carriers will offer you their own IC templates. Be careful about blindly adopting these. [Remember, these are written by the same folks who brought us the 200 page mortgage closing documents.] **Again, is the purpose of the IC document to beat a lawsuit in court; or prevent one from ever being filed? Even if you win in court, your insurance premiums will still go up!**

In summary, the doctrine of informed consent stipulates the IC must be properly performed. This point cannot be overemphasized as legal teaching clearly states, ". . . a

surgical procedure performed without proper consent is an assault and battery."[19,20] Common law courts seem to concur.[21,22]

The Sacred Doctor-Patient Relationship

The IC Process Should Continue Long After the Ink has Dried

Here is possibly the most important message of this entire article. *A good doctor-patient relationship begins with the initial consultation and may last a lifetime.* This relationship allows the patient to feel a part of your team; appreciated and respected.

When you have a significant complication, the patient and family will be watching you closely. The delicate dance you perform during those initial moments are critical, which the family *will* remember. Be quick to share with the patient (or family) "*we* have a problem" or "I am worried." A good surgeon can say something like this while maintaining his strong character. Once in my career, I even broke scrub to tell the family why surgery was continuing well beyond my estimated time. Though that is unusual, indeed the longer you wait to inform the family and patient of a complication, the more of a divide you create within the "team."

Do not be defensive. Do not make excuses. Do not be shy about sharing your concerns with the family. Do not suggest explanations you know to be implausible. The fanciful explanations I have seen offered by defendant-physicians can be shameful.

When a significant complication happens, it is natural for the patient and family to feel helpless, vulnerable and out of control. If the family feels their involvement in the matter is discounted, this volatile mixture of emotions will manifest as contempt toward the surgeon.

If surgeons are (correctly?) criticized for having a "God-complex" then there is no better way to show your humanity than early involvement of the patient and family. If they feel they are your partner in the decision-making process, they will usually take partial ownership of the situation and not place you, the surgeon, in the cross-hairs of their dissatisfaction, disappointment and anger. Often the family will show you empathy! They can either become your cheerleader or formidable adversary.[23]

There are typically 3 motivations for any malpractice claim: (1) victim compensation, (2) determent of future acts, and especially (3) punishment of the defendant. A strong doctor-patient relationship can mitigate all of these.[1]

Surveys agree, doctors who allow themselves to come down from their Ivory Tower and demonstrate warmth and understanding to the patient beginning with the initial consult through any complication; are less likely to be sued than our peers who convey any sense of arrogance.[1,9,24]

It is a rare person who does not feel a deep sense of comfort when given a reassuring hug by the surgeon. I cannot overstress that enough. View any complication as your golden opportunity to shine. It is not an admission of guilt to say, "I am sorry this happened; we will manage it together." *Do this and you will be their white-knight.* Let them see you as defensive, attempting to shift blame and not consumed with their family-member's care and they will likely become alienated and start thinking lawsuit.[8,10]

Bad surgeons can get good results,

and Good surgeons can get bad results.

But what makes a surgeon, Great . . .

is how he deals with his complications.

-the author

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