

EDITORIAL

The helpful hand grenade

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In this issue of the *Australasian Journal of Plastic Surgery*, author David Pennington gives us a comprehensive overview on 'How not to be sued'.¹ We would commend this article to all surgeons new and experienced.

As plastic surgeons, what is sometimes overlooked when we practise defensive medicine to try and avoid being sued, is how much we can inadvertently affect a colleague's practice by giving a second opinion. All of us will have complications. One report suggests that nearly 22% of surgical admissions will have complications.² This includes all adverse events, not those solely due to negligence. Truly negligent practice is actually very rare. A 2023 study from Finland analysed 8901 claims from 2011 to 2015, finding a claims rate of 1.2 per 1000 reference procedures (0.12%) and a compensation rate of 0.5 per 1000 (0.05%).³ This suggests that only a small fraction of negligent acts lead to claims, with neurosurgery, plastic surgery and orthopaedics showing higher rates (up to 3 per 1000).

Adverse outcomes do not necessarily reflect negligence. When a hurt and vulnerable patient seeks a second opinion after a less than ideal outcome, they can be managed in one of two ways. The first is a patient-centric, empathetic approach acknowledging that the outcome is not what was expected or hoped for, combined with an honest explanation of realistic expectations and complication rates. The second is a more surgeon-centric, egotistical approach which condemns the outcome and the original surgeon's practice, and will perhaps influence further unnecessary legal or medical board involvement. The first approach

requires personal reflection and an honest assessment of one's own fallibility, but also extra time, scrutiny, probably multiple consultations and requests for medical records from hospitals and colleagues. One cannot really give a fair second opinion without access to previous medical notes, correspondence and preoperative photos, yet how many of us go to that thorough level of detail before agreeing to operate on someone with a previous adverse outcome. It is easier to believe what the patient tells us, for example 'he never warned me of this', when a little more research could show exactly the opposite.

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While telling ourselves that we are only trying to help the patient, our action can even go against Section 3 of the Code of Conduct of the Royal Australasian College of Surgeons⁴ which clearly states:

A surgeon will...

- 6 *not criticise a colleague in an untruthful, misleading or deceptive manner*
 - 7 *not denigrate another surgeon or healthcare professional*
 - 8 *not seek to enhance their practice by actively denigrating or inhibiting a colleague's practice.*
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Further it is important that the person providing the second opinion is in fact an expert in that particular field of medicine, and that their expertise is current and informed by the latest techniques. Unfortunately, expert opinions are far too often provided by surgeons outside their scope of practice or by surgeons who are retired from active surgery and not aware of the latest developments in a particular field. Worse, some surgeons provide opinions completely outside their surgical discipline. A general surgeon providing an opinion on spinal surgery is an example.

The practitioner providing the second opinion must also consider the geographical constraints surrounding the initial surgeon's delivery of care. This is particularly important for patients receiving care in a rural or regional setting. Providing treatment in a major metropolitan teaching hospital where colleagues are readily available to provide help and guidance is vastly different to the rural practitioner practising solo in remote locations.

As in all areas of medicine, the four pillars of medical ethics—beneficence, nonmaleficence, autonomy and justice—must underpin and guide surgical care.⁵ The provision of a second opinion is no different.

The first two pillars come from the time of Hippocrates and basically mean 'help and do no harm'. The principle of beneficence is the obligation of a surgeon to act for the benefit of the patient: we might think we are benefiting the patient by believing their account of what transpired but if it is not wholly accurate and the patient subsequently feels somehow validated to embark on costly and potentially futile litigation it

may not be to their beneficence. Nonmaleficence is the requirement of a surgeon not to harm the patient. This principle 'supports several moral rules—do not kill, do not cause pain or suffering, do not incapacitate, do not cause offense, and do not deprive others of the goods of life.'⁵ Again the potential psychological pain and suffering associated with litigation can be enormous. Autonomy has been defined as 'Every human being of adult years and sound mind has a right to determine what shall be done with his own body'.⁵ It requires accurate and honest input from the surgeon giving the second opinion so that the patient can make a good decision about revisionary surgery. An honest and accurate opinion may let a patient come to terms with, and accept, a perfectly reasonable result and thus decide not to undergo further risky procedures. Lastly justice—this applies to external factors such as conflict of interest. It is not hard to see that a surgeon stands to gain financially from re-operating on a colleague's case, and the very fact of further cost can drive litigation.

Guidelines for providing a second opinion in surgical care

Adapted from principles endorsed by the American College of Surgeons⁶ and other global surgical bodies.

Purpose of a second opinion

- Confirm diagnosis/necessity—validate the initial diagnosis, surgical plan or need for intervention.
- Explore alternatives—assess non-surgical options (eg, medical management, physical therapy) or less invasive procedures.
- Patient empowerment—ensure the patient fully understands their condition, the risks of the procedure and their options so they have the information they need to make informed decisions.

Process for delivering a second opinion

- Independence and impartiality—avoid conflicts of interest (eg, no financial/personal ties to the initial surgeon); base recommendations solely on clinical evidence and patient needs.
- Comprehensive review—obtain and review all relevant records (imaging, labs, pathology, operative notes); conduct an independent physical exam and history-taking.
- Evidence-based approach—align recommendations with current guidelines and best practices; use multidisciplinary input for complex cases.

- Communication—discuss findings directly with the patient in clear, non-technical language; contact the initial surgeon with patient consent to clarify details or collaborate.

Ethical considerations

- Respect patient autonomy—support the patient's right to choose treatment without coercion; disclose all options, including the risks/benefits of no intervention.
- Professional integrity—avoid disparaging the initial provider; focus on objective differences in opinion; acknowledge limitations in your own evaluation (eg, incomplete data).
- Confidentiality—adhere to applicable privacy laws when accessing records.

Documentation

- Medical record—detail the review process, findings and rationale for recommendations; note agreements/disagreements with the initial opinion and reasons.
- Patient summary—provide a written summary for the patient, including diagnosis confirmation/ variations; recommended next steps (surgical/non-surgical); and key questions to ask other providers.

Follow-up and collaboration

- Referrals—refer back to the original surgeon or to a new provider if requested; facilitate referrals to other specialists for unresolved complex issues.
- Dispute resolution—if opinions conflict significantly, propose a third opinion or multidisciplinary review.
- Timeliness—ensure the second opinion does not delay urgent care.

Additional considerations

- Cultural sensitivity—address language barriers, health literacy and cultural beliefs.
- Legal awareness—document thoroughly to mitigate legal risks; avoid guarantees of outcomes.
- Education—surgeons should stay updated on evolving guidelines for second opinions.

A second opinion should foster trust, transparency and patient-centred care. Surgical societies^{4,7} emphasise that the goal is not to replace the initial provider but to enhance decision-making through collaboration and clarity. This structured approach ensures adherence to professional standards while prioritising patient welfare and informed choice.

In addition to the above guidelines, a simple honest self-reflection 'Have I ever had an outcome like this?', will in many cases be answered yes. Honest communication of that very fact to the vulnerable patient could go a long way to not throwing in a well-meaning, but ultimately not very helpful, hand grenade.

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