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CASE SERIES AND REPORTS

Is the team leading surgeon criminally liable for his collaborators' errors? Judges confirm responsibility and condemn an otorhinolaryngologist

Il chirurgo capo-équipe risponde penalmente anche per gli errori dei suoi collaboratori? I giudici confermano la responsabilità e condannano un otorino

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SUMMARY

In current healthcare, delivery of medical and surgical treatment takes place in a multidisciplinary manner. This raises the problem of distinguishing the conditions under which the person who has properly carried out his duties, respecting the related leges artis, can be held responsible for damages materially caused by another member of the medical team. Jurisprudence has developed the so-called "principle of trust" for which every member of the team can rely on the fact that other members are acting in compliance with the leges artis of their specialisation. The Supreme Court has limited the application of this principle. The authors examine the jurisprudence on responsibility of the team in otolaryngology and conclude that individual liability should be limited to the specific expertise of the individual specialist.

KEY WORDS: Team leader responsibility • Principle of trust • Équipe responsibility • Legal medicine

RIASSUNTO

Nella realtà sanitaria contemporanea, la prestazione terapeutica si svolge in forma multidisciplinare. Si pone, quindi, il problema di distinguere a quali condizioni colui che ha espletato correttamente le proprie mansioni rispettando le leges artis a lui richieste, può essere chiamato a rispondere del danno materialmente causato da altro membro dell'équipe medica. La dottrina ha elaborato il "principio di affidamento", approssimativamente traducibile in "principle of trust", ossia ogni membro dell'equipe può fare affidamento sul fatto che gli altri soggetti agiscano nell'osservanza delle leges artis della loro specializzazione. La Suprema Corte ha limitato l'applicazione di tale principio al fine di aumentare la possibilità di evitare eventuali errori dei colleghi. Gli autori esaminano la giurisprudenza che si è formata sulla responsabilità in équipe in casi di interesse otorinolarigoiatrico e concludono che l'ambito della responsabilità dovrebbe essere circoscritto alle specifiche competenze dei singoli.

PAROLE CHIAVE: *Responsabilità capo équipe • Principio di affidamento • Responsabilità d'équipe • Medicina legale*

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Introduction

The medical profession, especially a surgical one, often requires the multidisciplinary collaboration of many professionals, each with their own expertise. This type of activity raises some delicate matters concerning the criteria to determine individual responsibility within the multidisciplinary team. Can a physician, who has correctly performed his duties and followed the guidelines within his own area of expertise and specialisation, be required to answer for the harmful behaviour of another member of the team? Does he have the duty to supervise and verify the correct professional behaviour of the other team members?

Every professional is required to exercise a level of expertise as high as his degree of specialisation [1]. Complicity in any accidental crime can be present when a party knowingly partakes in said crime perpetrated by others. That also happens when the physician is aware of other professionals being tasked with a patient's treatment [2].

It should be clarified that each individual, within the broader medical or surgical team, works to safeguard the patient and not to supervise the work of other physicians or prevent their mistakes. Medical-legal literature [3] and court proceedings [4] concerning professionals' collaboration apply the principle of trust to the colleagues' work; this allows the individual professional of the medical or surgical team to dedicate himself with diligence, prudence and expertise to the specific duties of his own competence, free from the burden of monitoring the work of someone else. Therefore, he must trust that his colleagues correctly fulfil their part of the job and must be held responsible only for his own negligent conduct.

The logic behind this principle is clear: if a member of the team were required to watch over each step of his colleagues' activity, aiming at preventing or solving possible mistakes, he would not be able to concentrate on his work. On the other hand – and the authors do agree on it – it is not realistic that a single professional has all the competences and expertise necessary to perform a complex task, like surgical intervention, especially in a reality – such as the present – in which all disciplines have become increasingly specialised.

However, within the scope of medical activities, the Supreme Court has ascribed a somewhat definite value to the principle of reliance. First of all, such a principle of trust in someone else's conduct cannot be legitimately pointed to when the party who chooses to rely on said conduct is already at fault for having breached given precautionary principles or for having omitted certain conducts, and, despite all that he or she trusts others to nullify said breach or remedy a given omission [5]. Secondly, the team leader has the duty to supervise, monitor and coordinate the work of the other physicians. Therefore, he must carry out his tasks with diligence, but is also required to coordinate the activity of his collaborators and watch over their professional behaviour in all the phases of the operation, including the post-operative course [6]. In particular, the team leader's duties do not end at the moment he exits the operating room: in the subsequent phase, he must always ensure, even through a delegate, that correct assistance is granted to the patient and that the appropriate therapeutic treatment is provided [7]. On this basis, a logical deduction consists in overlapping the role of the team leader with that of the physician responsible for the entire ward: the latter is also responsible for the omissions of nurses; the fact that nursing staff has not informed him about the condition of a patient does not reduce his responsibility, being his duty to inquire about the patient's conditions [8].

Monitoring is essential even when there are indications suggesting that the behaviour of one of the team physicians is incorrect. In this case, the team leader must perform further diagnostic evaluations. Moreover, the team leader has to inform the members of his team about the patient's possible health problems that, if not disclosed, may influence clinical choices of the other physicians. For this reason, judges have condemned a surgeon who had not informed the anaesthesiologist about the patient's cardiac pathology for manslaughter [9]. The team leader also has the responsibility to control and monitor preoperatively. This is why a head physician has been condemned for the mistake of one of his assistants, who had failed in reaching diagnosis. Unfortunately, as an ultrasound investigation had not been performed preoperatively, the surgeon removed a healthy organ instead of the sick one [10]. Therefore, a surgeon should not completely entrust a diagnosis made by a colleague: the surgeon who performs a surgery following an indication of a colleague, even if part of the team, is considered imprudent and responsible for the loss of a healthy organ [11].

The third limit to the principle of trust consists in the following rule: each and every health professional must know and verify the correctness of the activity performed previously or contextually on the same patient by another colleague, even if specialised in a different discipline. If the latter commits mistakes that may have been prevented even by a physician non-specialised in the same field, all the colleagues of the team are held responsible [12]. Therefore, according to the Italian Supreme Court, when a member of the team recognises that the behaviour of a colleague may jeopardise the patient's health, he has the duty to inform both the team leader and that negligent colleague.

If some members of the team are specialised in the same field, it is easier to watch over other colleagues' actions and, therefore, the chances are greater to timely correct mistakes. Conversely, when specialisations are different, it is likely that the judge does not find any responsibility, considering the mistake as not noticeable of specialised competence. In case of a multidisciplinary team, the team leader must coordinate the work of the other physicians in the various phases of the intervention. In that case, he does not have many opportunities to recognise the mistakes of other people, as he does not have the skills necessary to argue about the decisions of the other team members, especially if with different expertise. Anyhow, if a common mistake appears preventable by non-specialised physician, the same principle of responsibility applies to both the team leader and the other members of the team.

Moreover, the principle of trust may not be applied to the physician even when the team leader gives him directives that are not correct and appropriate. The Italian Supreme

Court has recognised a physician responsible for manslaughter who did not manifest his dissent to the team leader's decision, proposing an alternative solution. The collaborator is not a mere executor of orders, but must evaluate critically the work of other physicians, including the team leader [13]. The judges stated that when a member of the team does not agree with his head physician's opinions, his/her dissent should be written down [14].

Case report (The case judged by the Criminal Appeal Court, Section IV, 28 July 2015, n. 33329) [15]

A 16-year-old girl was hospitalised in the hospital of Vibo Valentia for a peritonsillar abscess with oedema. After admission, the otorhinolaryngologist surgeons administered antibiotic (cephalosporin) and corticosteroid therapy; the disease evolution did not show any evidence of exceptionality [16-19]. In the following days, the patient's condition worsened and required the drainage of the peritonsillar abscess; this is a possible evolution of a treatment-resistant condition [20]. The Italian Association of Otolaryngology developed national guidelines on tonsillectomy in 2008, revised in 2011, that also included indications for medical and surgical therapy in case of peritonsillar abscesses. Guidelines recommend treating peritonsillar abscess in children and adults with systemic antibiotics, abscess incision and drainage according to the patient's clinical conditions. In case of complications, guidelines recommend a careful clinical observation with hospitalisation to monitor the airways. The decision to perform a tonsillectomy can be postponed after resolution of the acute phase [21]. The patient was treated according to the above-mentioned guidelines. Following drainage, she developed respiratory difficulties that required tracheotomy. In the operating room, the anaesthesiologist tried twice to induce general anaesthesia with the administration of and relative intubation [22]. However, both the curare muscle relaxant effect and the abscess caused the complete obstruction of the respiratory tract and did not allow endotracheal intubation. Such condition resulted in asphyxia and oedema, worsened by the intubation attempts. The anaesthesiologist tried an emergency tracheostomy, but the scalpel also incised the oesophagus and some vessels. The patient died of cardio-circulatory arrest due to asphyxia induced by the curare treatment utilised during general anaesthesia. Therefore, the girl's death was due to an anaesthesia error. The judges condemned the anaesthesiologist but also the otolaryngologist, even if establishing that: a) ENT therapy was appropriate; b) instrumental exams with laryngoscope and fiberscope had been carried out; c) the decision to perform a tracheostomy was correct. Hence, the judges did not find any element of negligence or imprudence. Even if the problem regarded the anaesthesiology field, the otolaryngologist surgeon should have evaluated the consequences of the anaesthesia with curare which would have paralysed the vocal cords, and then the tissues violently struck by the intubation attempts. The experts agreed that if the patient had not been treated with curare and not subject to wrongly performed intubation attempts, she would have continued to breathe autonomously, maintained the normal oxygen saturation and survived. Actually, the otolaryngologist did oppose verbally to anaesthesia with curare and suggested the anaesthesiologist to perform an optical fibre bronchoscope guided endotracheal intubation. Such a technique would have facilitated intubation, in accordance with the anaesthesiology guidelines [23]. The anaesthesiologist refused because the optical fiber bronchoscope tube was too short. According to the judges, the otolaryngologist, being himself the team leader, should have had impeded the anaesthesiology procedure that caused the fatal event. For these reasons, the judges condemned him since, as a physician, he had the necessary skills to evaluate the risks related to the anaesthesia with curare and, as a team leader, he should have suspended the surgical procedure, which was urgent but not an impelling emergency. According to the judges, as the anaesthesiologist has specialist expertise, in case he makes a mistake, he has to respond personally for his own choices. Anyhow, if the anaesthesiologist mistakes the operative manoeuvre, the team leader, on the basis of his own expertise, must intervene on the anaesthesiologist and propose solutions which he/she considers most appropriate. What if the anaesthesiologist refuses to comply? Again, according to the judges the team leader might as well stop the surgical operation and ask the anaesthetist to leave the operating room.

Discussion

With this judgment, the Supreme Court reaffirms that each member of the team, including the team leader, must recognise and prevent mistakes within his area of competence, even if committed by other members of the team. The judges state such principle in order to safeguard the patients' health; this means that each professional must control and monitor the behaviour of his colleagues. However, in this way the principle of trust is valid only in theory as, in practice, it is not applied. In fact, said principle entails that each and every team member must be able to focus on those tasks in which his or her competencies do apply, without having to oversee his colleagues' work,

and must only answer for the mistakes of his or her making. On the contrary, the above-mentioned Supreme Court rulings entail every professional's duty to watch over his colleagues' behaviour. This complicates the surgical operation and is risky for the patient as, having to monitor the activity of others, the professional might not be adequately focused on his own. To avoid that the physician is sentenced without a real fault, the Supreme Court states that the professional may be condemned for somebody else error only if such error is clearly noticeable and is not of "specialistic" nature. Anyhow, in the otorhinolaryngologist branch, this rule might raise some problems, as both the anaesthesiologist and the otolaryngologist act in the same anatomical district. Yet, this does not necessarily imply that the otolaryngologist is able to recognise the anaesthesiologist's error. Furthermore, when the anaesthesiologist's behavior is inconsistent with the otolaryngologist's knowledge, it should be considered that they have two different specialisations. The diversity of skills should limit the specific responsibility of each individual. It would be, however, advisable to ascribe criminal liability only to those cases where gross negligence is involved [24].

In conclusion, the surgeon should respond only to surgical errors. Similarly, the anaesthesiologist should only be responsible for anaesthesia-related risks. Consequently, it seems excessive to claim that the otolaryngologist team leader has to prevent the anaesthesiologist from performing the anaesthesia and that the team leader is responsible for the errors made by a physician with different expertise.

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