

An Audit of Consenting Practises in Trauma

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Citation

A Ghosh, W Mbchb. *An Audit of Consenting Practises in Trauma*. The Internet Journal of Orthopedic Surgery. 2009 Volume 16 Number 1.

Abstract

It is a requirement by law for every surgical patient to have informed consent. The literature suggests that consenting of elective patients, which is usually performed by senior staff, is of a higher standard than that for emergency cases (1). However the consenting of trauma patients is often left to junior doctors who may have no previous orthopaedic experience. It has also been noted in the literature that a significant proportion of medical negligence claims are as a result of poorly informed consent (2). The aim of this study was to determine the quality of informed consent in trauma patients in a busy district general hospital.

INTRODUCTION:

It is a requirement by law for every surgical patient to have informed consent. The literature suggests that consenting of elective patients, which is usually performed by senior staff, is of a higher standard than that for emergency cases (1). However the consenting of trauma patients is often left to junior doctors who may have no previous orthopaedic experience. It has also been noted in the literature that a significant proportion of medical negligence claims are as a result of poorly informed consent (2). The aim of this study was to determine the quality of informed consent in trauma patients in a busy district general hospital.

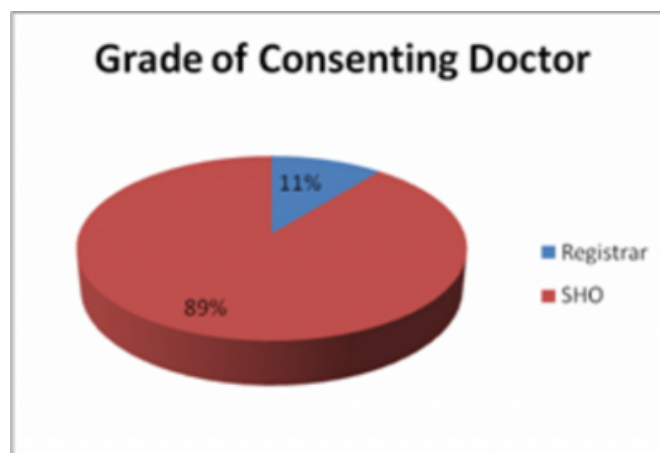
METHODS

The consent forms of all trauma inpatients were reviewed over two separate occasions set three months apart. Adequate and clear documentation of procedure and side were noted. Specific interest was taken in the noting of complications related to the procedure. The use of abbreviations, benefits of procedure and the grade of doctor taking consent were also noted.

RESULTS

Total number of consent forms reviewed was 74. Of these only 8 (11%) were by registrars with 60 (81%) by SHOs and 6 (8%) by Foundation House Officers.

Figure 1



Multiple abbreviations were used to document procedure (e.g. ORIF, DHS, MUA) and often multiple possible procedures were listed. Although side was listed in every form, in 12 (16%) an abbreviation was used. In 10 (13%) of forms no benefits of procedure was documented. The listing of complications was noted against each procedure. When applicable infection was the complication most noted (97%) followed by bleeding (94%). The risk of DVT/PE was not noted in 37% of cases in which risks are sufficiently high. Nerve damage was omitted in 18% of cases which included procedures for olecranon fractures and radial shaft fractures. Risk of dislocation or leg length discrepancy was not mentioned in any case when consenting for hip hemiarthroplasty. Only 8 cases (10%) documented possible failure/need for further operative intervention. Only 6 cases (8%) listed possible scar complications. In contrast 60 cases (80%) listed possible anaesthetic complications.

CONCLUSION:

The consenting of trauma patients is often left to junior doctors and appears to be poor in various aspects. New guidelines from the General Medical Council (GMC) (3) and guidelines from the Department of Health (DoH) (4) do not appear to be strictly adhered to, especially with regards to informing patients of important complications. Suggestions are made to adequately train junior doctors in the practice of obtaining consent such that the levels of care provided may be improved.

References

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