Consent In Surgical Practice: A brief review

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Abstract

Consent is an instrument of mutual understanding between the patient and the doctor. This protects the doctor from accusations if obtained in a proper manner. A valid consent represents patients' trust in the medical profession; therefore, it is very important for the surgeons to understand the ethical and legal values of the consent.

INTRODUCTION

Patients' consent to a surgical procedure reflects his trust in the surgeon who is going to handle his body. This faith of the patient in the medical profession is sometimes lost when some untoward incidents occur which are not well communicated by the treating physician. With the hype created by the media nowadays, there is an upsurge in medico-legal cases; therefore, it has become more important for the surgeons to obtain a valid consent before undertaking any procedure.

ETHICS AND LAW

Surgical practice is governed by medical ethics, which refer to the universal principles on which medical decisions should be based; to a large extent this governs the beliefs and actions that influence the day to day judgments of doctors. To a variable extent the practice of surgery is influenced by the need for self-protection, but in trying to avoid litigation, a surgeon may over-treat or over-investigate, in ways that are not just unnecessary but even unethical. The guiding principle in practice should be that the patient's interests are paramount though some factors like self interest, money, resources, and individual skills do influence the judgment.

Every person has right to have his or her bodily integrity protected against invasion by others and a surgeon who performs an operation without a patients consent commits an assault in the eyes of the law. Therefore, the treatment against the patient's will can rarely be justified.

CONSENT

Consent is an instrument of mutual communication between doctors and patient with an expression of authorization/permission/choice by the latter for the doctor to act in a particular way. As a general rule, medical treatment, even minor, should not proceed without having first obtained the patient's consent. Consent may be expressed or it may be implied.

IMPLIED CONSENT: Allows patients for general physical examination and routine investigation without obtaining a written consent.

EXPRESSED CONSENT: Either oral or a written agreement after discussing the proposed treatment or procedure with the patient.

The patient must be capable of understanding the explanation, regarding the nature, purpose, and risks of the proposed investigation or treatment together with alternatives available and likely outcome of the treatment.

INFORMED CONSENT

Informed consent has introduced a new element to the medical treatment. It is no longer a simple matter for the patient to consent to a technical assault. Consent now is based on knowledge of the nature, consequences and alternatives associated with the proposed therapy. The patient should be fully informed, so that he can make up his mind in the light of the relevant circumstances.

Counseling and delivery of appropriate information is an integral part of normal clinical management. The surgeon must answer truthfully and as fully as demanded to any questions by the patient. The patients should be treated as intelligent rational people to whom important matters should be explained in reasonable detail. In fact, it is good medicine to involve the patient fully in decision making[1].

PRATICAL ASPECTS

A patient may be entitled to sue for the damages for battery or claim negligence on the ground that a doctor failed to obtain consent. Therefore, accurate, adequate and relevant information must be disclosed prior to consent for treatment.

Consent should always be obtained by a medical practioner, who is sufficiently knowledgeable to explain the proposed treatment, any alternatives, likely outcome and any significant risk and failure of treatment. Operation-specific or disease-specific risks must be explained. There should be a mutual agreement between patient and physician regarding the course of the treatment. This shared decision making represents the best blending of physician expertise and patient choice[2,3,4].

A valid consent satisfies the following conditions[5,6]:

The patient should be competent to make a health-care decision, he/she should be able to understand their illness and treatment requirement, risks and benefits of the treatment options.

The patient should receive adequate information to make a health-care decision.

There should be no coercion to accept the treatment; the patient should consent freely.

The decision should include a treatment recommendation.

The consent for anesthesia and surgery should also include a discussion regarding several foreseen or anticipated situations like unexpected findings during surgery or outcome after surgery. Studies show that there is a variable practice among the physicians regarding consent and their understanding of ethical and legal requirements of informed consent[7,8,9,10].

Providing the patients with informative and educational material regarding their illness and treatment also enhances the value of informed consent[11].

Consent should be obtained in a reasonably short time before the procedure. If extra procedures become necessary, a fresh consent should be obtained.

SPECIAL CIRCUMSTANCES

Unconscious patient: A surgeon is justified in treating a patient without expressed consent if the value of what he seeks to protect is accepted to be of greater weight than the wrongful act he performs (treating without consent); this involves the necessity principle.

Consent in children and in the young: Parents/guardians must be consulted and their consent must be obtained. In the absence of parents, another relative or person in loco parentis can give consent.

In case of social-service childcare: Where the local authority has taken full parental rights, the director of the social service can sign the consent.

Surrogate consent: In circumstances where the patient has lost the capacity to consent an authorized surrogate decision maker who represents the patient is appointed formally or informally. The surgeon should discuss with the surrogate regarding consent for the treatment and obtain his consent.

Consent to testing for HIV: Testing a high-risk patient before an operation requires consent but testing without consent may be performed if the theater staff suffers contamination with a patient's blood. Even in these circumstances, it is wise to obtain patient's consent if possible.

Informed refusal: It is a surgeon's duty to explain the possible consequences of non-treatment and benefits of the treatment; if the patient refuses, it must be documented clearly. Discharge against medical advice also must be recorded with signature of the patient or guardian[12].

DOCUMENTATION

Most hospitals maintain consent forms, which carry description of conceivable risks and outcomes which are not easily understood by the patient. As the consent is an ongoing process, it is important to document the process. In addition to signing a form, surgeons should enter a note in the patient's record documenting that the full range of surgical complications, including death, has been discussed and all questions have been answered. The consent should be prepared in duplicate and a copy should be handed over to the patient. The doctor, patient and an independent witness should sign it[13].

CONCLUSION

Consent represents a patient's faith/trust in the medical profession. Good communication and mutual understanding maintain a strong patient-surgeon relationship. Although many issues regarding consent remain controversial, appropriate delivery of information and clear explanation of treatment risks and benefits is necessary to avoid legal complications. Adequate communication, proper dialogue at

proper time and involving the patient/guardians in decision making regarding therapy reduces the chances of malpractice claims[14,15].

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References

1. Laine C, Davidoff F. Patient-centered medicine: a professional evolution. JAMA 1996; 275: 152-156.
2. Whitney SN, McGuire AL, McCullough LB. A typology of shared decision making, informed consent and simple consent. Ann Intern Med 2004; 140: 54-59.
3. Marzuk PM. The right kind of paternalism. N Eng J Med 1985; 313: 1474-1476.
4. Quill TE, Brody H. Physician recommendations and patient autonomy: finding a balance between physician power and patient choice. Ann Intern Med 1996; 125: 763-769.
5. Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. N Eng J Med 1988; 319: 1635-1638.
6. Piper A Jr. Truce on battlefield: a proposal to different approach to medical informed consent. Law Med Ethics 1994; 22: 301-317.
7. Lidz CW, Meisel A, Osterweis M, Holden JL, Marx JH, Munetz MR. Barriers to informed consent. Ann Intern Med1983; 99: 539-543.
8. Mazur DJ. Why the goals of informed consent are not realized: treatise for informed consent for primary physician. Intern Med 1988; 3: 370-380.
9. Sulmasy DP, Lehman S, Levine DM, Faden RR. Patients' perception of the quality of informed consent for common medical procedures. J Clin Ethics 1994; 5: 189-194.
10. Meisel A, Kuczewski M. Legal and ethical myths about informed consent. Arch Intern Med 1996; 156: 2521-2526.
11. Ross N. Improving surgical consent. Lancet 2004; 364: 812-813.
12. Francis CM. Autonomy and informed consent. Medical Ethics, 2nd ed. New Delhi: Japyee Brothers: 2004; pp.54-65.
13. Wheeler R. Consent in surgery. Annals of the Royal College of Surgeons of England 2006; 88: 261-4.
14. Edwards WS, Yahne C, Thomas G. Orr memorial lecture: surgical informed consent: what it is and is not. Am J Surg 1987; 154: 574-578.
15. Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. Physician-patient communication: the relationship with malpractice claims among primary care physician and surgeons. JAMA 1997; 277: 553-559.

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