Consent for Mastoidectomy: A Patient's Perspective

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Abstract

Nineteen patients who had undergone mastoid surgery were asked to identify which risks of mastoid surgery they felt were important to be informed of prior to surgery. This was compared to twenty ENT consultants' answers on which risks they routinely discuss with patients preoperatively.

Our results show the "average" patient would expect to be consented for all of the risks we asked about except for keloid scarring and altered taste, compared with the "average" consultant who would discuss all risks routinely except for bleeding, intracranial complications and keloid scarring. The most obvious difference between doctor patient opinions is the topic of intracranial problems arising from surgery, 84.2% of patients would want to be warned about this but only 20% of surgeons routinely mention it. (P Value <0.001)

The main reasons for consultants omitting discussion of intracranial complications were their rarity and patients potentially finding it distressing

However recent court rulings indicate that these reasons are invalid and not giving comprehensive consent may be indefensible.

INTRODUCTION

The potential side effects of undergoing mastoid surgery are varied and range in severity from minor to life threatening. Among the more serious risks are facial nerve palsy, intracranial infection and a dead ear, therefore consent for these procedures should be comprehensive to allow the patient to make an informed decision about their treatment. [1]

In addition mastoid disease that is left untreated can have fatal consequences. It is also therefore a vital part of the consenting process to discuss the sequelae of not having surgery.[2]

Several papers have examined the consenting practice of surgeons when discussing mastoid surgery but none so far appear to have related the findings to patient expectations.[3,4,5] As Lynch et al found in a review of 500 medico legal disputes in obstetrics and gynaecology that 7% arose from failure of communication this is an important factor to consider.[6] Despite the study focusing on one particular specialty the results are probably reflective of medico legal disputes in general.

METHODS

A list of eleven risks known to be associated with mastoid surgery was compiled from a review of the medical literature.[1,2,3,4,5,7,8,9] These were used to form part of a postal questionnaire which was sent to all fifty two otolaryngology consultants in the West Midlands.

The questionnaire asked the consultants which of the risks they routinely discussed when consenting patients for mastoidectomies, the incidence they quoted of these risks and any reasons for omitting certain risks from their consent process.

In addition we asked them if they mentioned any other risks not covered in the questionnaire, whether the incidence of complications they quote is from their own practice or published data, have they changed their consenting practice in the present climate of increased litigation, have they had any issues with patients experiencing complications they had not been consented for and finally whether they routinely discussed the risks of leaving the disease untreated.

Using the ENT theatre logbook we identified all of the 34 patients who had undergone a mastoidectomy in a two year

period at our institution (WRH) from April 2003 to April 2005.

We were able to contact 19 of these individuals in a telephone survey performed by the same person. A severity scale of 1 to 5 (5 being the most severe) was used and the patients were asked to allocate a grade to each of the 11 complications. They were also asked to clarify that if they graded a complication as severe (grade 4 or 5) this reflected that they felt they should know about them prior to surgery.

They were also asked if they had been happy with the consent for their operation and if they felt discussing the risks of not having surgery were important and to grade this accordingly.

RESULTS

Of the 52 questionnaires posted to the consultants we received 28 replies, of these 8 reported they did not undertake mastoid surgery, leaving us with twenty useable forms.

All 19 of the patients contacted were happy to participate in the telephone survey.

Table 1 demonstrates the distribution of the patients' grading for each risk. As already mentioned any risks graded as a 4 or 5 were taken to mean that the patient attached enough significance to the risk to want to know about it during consent and this was confirmed by each patient at both the start and end of the telephone interview. These results were used to calculate for each risk the percentage of patients in our survey who felt that risk should definitely be discussed preoperatively.

Figure 1

Table 1: Patients' Grading of Risks

	Number of patients grading each risk				
Grade Number	**1**	**2**	**3**	**4**	**5**
Facial N palsy				3	16
Tinnitus		3	5	4	7
Decreased hearing	1	2	1	4	11
Vertigo	1	2	3	9	4
Bleeding	6	1	4	3	5
Infection	2	2	2	5	8
Intra-Cranial	1		2	1	15
Recurrence	1		3	5	10
GA	2	3	2	4	8
Taste Alteration	2	3	10	3	1
Keloid Scarring	4	3	3	6	3
No surgery			1	1	17

Overall 17 patients were completely happy with the consent they received for their surgery, leaving two that were dissatisfied. The reasons for this are detailed in the discussion.

A similar table (Table 2) was constructed for the consultant figures, together with the range of incidence quoted for each risk throughout the sample and comments explaining why they would not routinely consent for a certain risk.

Figure 2

Table 2: Consultant Questionaire Results

Risk	No. that always mention	%	Incidence (Ranges)	Comments
Facial N	19	95	<0.1-<1%	Rare but more risk if no operation Not unless extensive disease
Tinnitus	14	70	1-<10%	
Decreased Hearing	19	95	<1–50%	
Vertigo	17	85	<1-5%	
Bleeding	9	45	1%	
Infection	14	70	2-5%	
Intracranial	4	20	<1%	Rare (n=14) Distressing for patient
Recurrence	20	100	1.25%-30%	Very variable depends on disease
GA	8	40		Should be done by Anaesthetist (n=10)
Taste	16	80	1-20%	Only if 2nd ear or occupational e.g. wine taster!
Keloid	2	10		Only in certain individuals (n=7)
Other				Re-operation (n=2) Dead Ear (n=1) BIPP allergy + intracranial BIPP (n=1)

Additional risks included were specifically the need for re-operation (n=2) although this was probably covered by many when talking about the risk of recurrence. One consultant consented specifically for a completely dead ear in addition to loss of hearing. The only other additional risk that one respondent always consented for was that of intracranial placement of BIPP, as he had experienced this during his practice.

The additional information from the survey of the consultants, including whether they had altered their consenting practice and if they had had any issues with patients experiencing complications that they had not be warned about, is shown in Table 3. Half of the sample reported that when quoting figures for incidence of complications they used figures from their own practice. Only one had altered his consenting practice by spending more time on consent and being more comprehensive due to increased medical litigation. A quarter of the sample had had issues with patients experiencing complications that they had not been consented for including pain, altered taste and intracranial placement of BIPP leading to chemical encephalitis and death.

Figure 3

Table 3: Additional Consultant Results

Quoted figures	Own - 10	Published- 3	Combination - 7
Changed Practice	Yes – 1	No - 15	1.Spend more time 2. More comprehensive
Issues	Yes – 5	No – 15	1.Pain 2.Intracranial BIPP leading to chemical encephalitis and death 3. Altered taste 4. Not specified
Discuss no surgery	Yes – 20		Minimise if elderly

All of the consultants discussed the risks of not having surgery as it was felt that this discussion should come before even talking about the risks of having surgery.

Finally a comparison table was composed (Table 4 and Bar Chart 1) which directly compared the percentage of patients rating each risk as severe with the percentage of consultants who routinely discussed the respective risks.

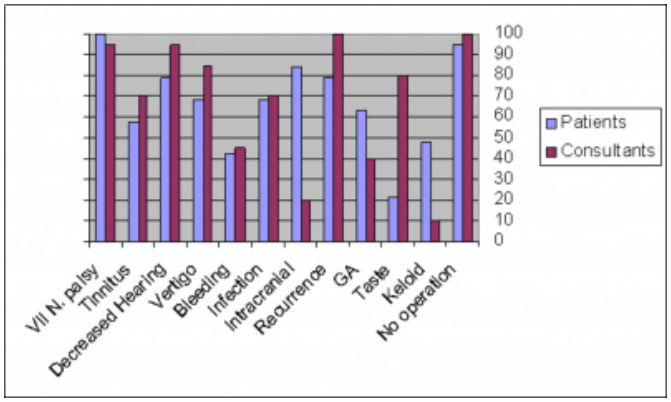
Figure 4

Table 4: Comparison of Patient and Consultant Results

Risk	% Patients rating risk as severe	% of Consultants routinely discussing risk	P values
Facial N	100	95	1
Tinnitus	57.8	70	0.51
Decreased Hearing	78.9	95	0.18
Vertigo	68.4	85	0.27
Bleeding	42.1	45	1
Infection	68.4	70	1
Intracranial	84.2	20	<0.001
Recurrence	78.9	100	0.05
GA	63.2	40	0.20
Taste	21.1	80	<0.001
Keloid	47.4	10	0.01
No Operation	94.7	100	0.49

Figure 5

Bar Chart 1: Comparison of Patient and Consultant Results



If 50% or greater of the two groups deemed the risks important it was assumed that this would represent the average patient's or doctor's opinion.

The figures illustrate that the 'average' patient would expect to be consented for all of the risks except for keloid scarring and altered taste compared with the 'average' consultant who would discuss all risks routinely except for bleeding, intracranial complications and keloid scarring.

Not discussing keloid scarring seems reasonable as less than half the patients would expect this to be mentioned. In addition a common sentiment (n=7) among the surgeons was that although not regularly talked about, it would be so in patients with a previous history or increased likelihood.

Similarly, not discussing the risks of undergoing a general anaesthetic appear justified as despite the majority of patients expecting this, it was widely felt by the consultants (n=10) that it was the domain of the anaesthetist.

The most obvious discrepancy between doctor patient opinions is the topic of intracranial problems arising from surgery. Reasons for omitting this from the consent were that it was rare or unduly distressing.

The only risks that consultants unanimously agreed would always need discussing were the risk of not having an operation or of the disease recurring.

DISCUSSION

The Bolam principle has been applied to consent since the 1950s which in summary is the rule that 'a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion, even though other doctors adopt a different practice.[10]

This has traditionally led to doctors consenting for risks only if they have an incidence of greater than 1%.

However more recently there has been a change in what is perceived as informed consent in the British legal system, which has been reflected by several court rulings and guidance from certain medical institutions.[11,12,13,14 15]

This appears to support the view that informed consent should not only include commonly occurring risks but also those that are rare yet have serious implications.

Therefore the concept of rarity cited by many consultants (n=14) as a reason for not discussing intracranial problems or by the one respondent who omits the risk of facial nerve palsy from his consent for the same reason now has the potential to lead to an indefensible medical negligence claim if these risks do occur.

It is now considered more important to divulge information

about procedures in accordance with what the reasonable patient would expect.[16]

We have demonstrated a difference in what patients expect and what doctors actually consent for, most notably the risk of intracranial complications resulting from mastoid surgery, as 84.2% of patients would want to be warned about this risk but only 20% of surgeons routinely mention it. This difference in opinion is statistically significant with a P Value of <0.001. Similarly keloid scarring was a risk that more patients wanted to know about than consultants actually consent for with a P value of 0.01.

At the other end of the spectrum were those risks that doctors discuss yet patients tend to be less concerned about, most notably altered sense of taste and recurrence (P values <0.001 and 0.05 respectively).

Increasingly it is recognized that although the consenting process should be tailored to each individual patient, it should include all risks that are common or those that, although rare, are severe. The need to carefully consider each patient's needs on an individual basis was highlighted by two of our patients. When asked about the risk of hearing loss the first patient rated it as a grade 1 as they were already completely deaf on that side, the second patient allocated it a grade of 5 since the ear to be operated on was their ‘good ear.’

The circumstances of how the consent is delivered are also important. Of the patients that were unhappy with their consent, one patient had been dissatisfied with only being consented on the actual day of surgery and strongly denied any previous discussion regarding the risks of the operation during their outpatient appointment. The other individual who was unhappy with the consent was a patient's mother who felt that the consent should be done when the child was not in the room. Her main concern was that discussing the drawbacks of surgery had been distressing for the child who was 8 years old at the time and she had been unable to ask detailed questions with her son present.

Medical paternalism is no longer acceptable and withholding information from patients in order to spare them psychological distress when consenting for treatment is invalid.[17]This is reinforced by the GMCs guidelines on consent which advise against making assumptions about patients' views.[18] This also contradicts previous thinking that giving patients excessive information about the risks of procedures, which they cannot rationally interpret due to their lack of medical training, may cause them to make a decision that is detrimental to their health.[19]Although some patients adhere to the old adage of ‘ignorance is bliss', the majority of individuals in our study wished to be fully informed and involved in their treatment decisions. In our society of increased litigation we unfortunately do need to practice defensive medicine and part of this is ensuring for our patient's sake as well as our own that we do give comprehensive consent for any procedure.

CONCLUSION

Patients are becoming increasingly involved with decisions regarding their health and British law appears to be supportive of this trend. For this reason it is vital to have detailed, honest discussions with each individual about any planned surgery. To do otherwise, even with the best intentions, is risky. Specifically the potential for intracranial complications should be broached with those undergoing mastoid surgery as their occurrence is improbable but not impossible and can have a significant impact on the patient, their relatives and the surgeon.

SUMMARY SHEET

- The potential complications of undergoing mastoid surgery are varied and range in severity from minor to life threatening.
- Several papers have examined the consenting practice of surgeons when discussing mastoid surgery but none so far appear to have related the findings to patient expectations.
- We set out to identify which risks patients undergoing mastoid surgery would expect to be informed about and compare it to those risks that ENT consultants actually consent for.
- Our results illustrate that the ‘average' patient would expect to be consented for all of the risks except for keloid scarring, bleeding and altered taste compared with the ‘average' consultant who would discuss all risks routinely except for intracranial complications, keloid scarring, general anaesthesia and bleeding.
- The most obvious difference between doctor patient opinions is the topic of intracranial problems arising from surgery, 84.2% of patients would want to be warned about this risk but only 20% of surgeons routinely mention it. (P Value

<0.001)

- Reasons for omitting this from the consent were that it was rare or unduly distressing.
- Traditionally doctors have consented for risks only if they have an incidence of greater than 1%.
- It is now considered more important to divulge information about procedures in accordance with what the reasonable patient would expect rather than what the reasonable body of medical opinion would discuss.
- In our society of increased litigation we unfortunately do need to practice defensive medicine and part of this is ensuring for our patient's sake as well as our own that we do give comprehensive consent for any procedure.
- Although some patients adhere to the old adage of 'ignorance is bliss', the majority of individuals in our study wished to be fully informed and involved in their treatment decisions.

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