INFORMED CONSENT - Episode 2

PRESENTER: In 2015, almost 60 years of conventional medical practice was legally challenged in a landmark case regarding consent to treatment.

I'm Murray Anderson-Wallace and in the second podcasts of three I'll be exploring the legal, ethical and practical implications of the judgement and the new guidance produced by the Royal College of Surgeons, "Consent: Supported Decision-Making"

In our first podcast, we considered the legal context for this change. In this episode, I'll be discussing the benefits of this change beyond the law - and exploring some of the challenges for practicing surgeons.

PRESENTER: So obviously there's been this legal shift so that's a clear impetus for needing to do something different? What are the benefits of this different approach that you're suggesting?

LESLIE HAMILTON: Well we talk about patient-centred care and that rolls off the tongue very easily, but actually this is putting the patient at the centre of the process and it's tailoring it to each individual patient which is what we want to do.

PRESENTER: That was Leslie Hamilton, a Director of Professional Affairs and Council Member of the Royal College of Surgeons. Sue Hill is a Consultant Vascular Surgeon and a Council Member of the College.

SUE HILL: At one end of the spectrum there is still the very respected elderly patient who wants you to tell you what to do, wants you to be the paternalistic or maternalistic doctor, and they find it very difficult to make decisions, and actually will say to you, 'you decide for me'. At the other end of the spectrum you've got reasonably well-educated people who want to know everything there is to know about their condition. So you really do have to tailor your discussions to the patient in front of you. A lot of patients do as they're told, still, by their doctor,

if that's the GP; they often don't have the conversation with the doctor or with their family as to what they actually want. And that's where the difficulty comes, because when you start digging down into a patient's views, you'll find they may not be what you suspect they are.

PRESENTER: Clare Marx is the President of the Royal College of Surgeons.

CLARE MARX: Every surgeon will have had the conversation with the patient where eventually they turn to you and say, 'what would you do Doctor', or 'I'll leave the decision up to you Doctor'. There are times that it's important, if a patient invites you to help you in that way to make that sort of decision but on the whole we have to realise that the process of someone walking in with a pain in the hip and us simply saying, 'I'll do you a hip replacement' is no longer appropriate. There is a lot more to be achieved in the conversations.

PRESENTER: In our first episode, we met Mr Roberts, his daughter Claire - and our fictitious surgeon. The dramatisation was based on two real medico-legal case studies involving consent to surgery.

In this episode, we return to the story some weeks after Mr Roberts' surgery to hear how things went.

SURGEON: So Mr Roberts, I hear that you are not too happy with how things have gone? Are you in pain?

MR ROBERTS: It's not so much the pain - that was bearable - but the rest of it - I mean I was nearly 10 days in intensive care, my family have been worried sick. I feel just completely useless now - I can't do anything, I can't even move my hand properly – see? I thought this might be a temporary thing but I was told in the hospital that it's likely to be permanent

SURGEON: I'm afraid that's true.

MR ROBERTS: Well if I'd known it would be like this I wouldn't have gone for the surgery!

SURGEON: But we went through the options together and I thought we all agreed that surgery would be the best thing for you. You did give your consent – I have the signed form here.

MR ROBERTS: Yes, but that was in the hospital when I wasn't really sure what was going on, and the young doctor who gave me the form seemed in such a terrible rush…

SURGEON: I'm very sorry about that, Mr Roberts, but I got the clear impression that you were very happy about all the decisions we took when we met - and you discussed it with your daughter. I did say that the recovery period can be a bit difficult.

MR ROBERTS: But I didn't realise you were going to take the vein out of my arm!

SUREGEON: Actually it was an artery…

MR ROBERTS: Whatever it was. I thought it would just be from my leg.

SURGEON: We did discuss it at the time - I distinctly remember. I recommended TAR over the standard graft because it increased your life expectancy.

MR ROBERTS: But I can hardly feel my fingers of my left hand now! If I'd of known, I would never have agreed.

SURGEON: I am very sorry you feel that way. All operations carry risks and I apologise if you feel that that was not made clear to you, but the possible loss of sensation in the hand is regarded as relatively minor in comparison to your increased life expectancy. You are right-handed aren't you?

MR ROBERTS: Yes, I'm right-handed. But it's not so much the number of years I was worried about… you see now I can't play….

SURGEON: I'm afraid I don't quite understand.

MR ROBERTS: The piano. I need both hands to play the piano and now my hand is almost useless - I can't move enough to play. And that's what I was so looking forward to. Playing with my grandchildren – they're all learning instruments too – we play together.

PRESENTER: Clare Marx.

CLARE MARX: When things go wrong people are always unhappy aren't they?

LESLIE HAMILTON: Well the key thing here is the guy's a keen piano player, and that was one of his big hobbies and that was where he got his life satisfaction from, and he couldn't do it. And that's the big message, that it wasn't tailored to the individual patient.

PRESENTER: Sue Hill.

SUE HILL: Some patients come to my clinic thinking they have something they haven't, so quite often if I haven't met them before I say 'why do you think you're here', and you then get an understanding of what actually the patient perceives is the matter. Very often a person will arrive and they will be very passive in their approach, and you therefore will become very active in your approach to them. We have to make some decisions, we have to decide what's wrong with you and do what's best for you. Sometimes, patients are referred in with what the GP has picked up as an issue, blocked artery say, but when you say to the patient, 'actually, what is it that's troubling you', what is troubling them isn't the thing that they've been referred to you for.

PRESENTER: Do you think there at times, incentives for surgeons to go ahead with surgery where people are either ambivalent or undecided?

CLARE MARX: I like to think that people have enough work that they don't find themselves in a position where they're looking to do surgery and push people in to surgery that they're ambivalent about or undecided. And there is absolutely nothing wrong with saying, 'would it be helpful if we had another conversation in three weeks, six weeks', whatever it is. I know that's not what people want you to do because it's a single shot, but there will be occasions when that's what you have to do. It's more difficult if we're doing surgery for an acute condition, cancer and so on, when time may be of the essence. The really interesting feature that I find in patients today, is that very often people we would perceive as being quite unhealthy perceive themselves as being healthy. They will come in and tell you that they're very well and that they have no problems at all; they may be taking ten different drugs: heart failure, kidney failure, diabetes, blood pressure, heart arrhythmias, all these sorts of things, but they regard themselves as being perfectly normal. So one of the challenges that we have is that

when we are having conversations about either a complex or a non-complex procedure we need to get them to accept their own medical issues as part of the conversation that will lead on to the problems that we may or may not have in terms of complications. People will very often tell you, 'I've been to see the cardiologist, and he says I should just get on with this procedure'. One is faced with this situation where one knows that 'just getting on with this procedure' is likely to expose that patient to a not inconsiderable degree of risk.

PRESENTER: Sue Hill.

SUE HILL: You then have to look at the reasons why **you** want to operate on the patient, and it's a sad truth that with some of the more technical operations that we can perform, surgeons aren't always performing those operations completely altruistically. Surgeons do get pleasure out of performing technically demanding surgery, and just once in a while they may be doing it for their own pleasure as much as they're doing it for the patient's therapy. And you have to detach yourself from any emotional link to what you're wanting to do. So if a patient doesn't want it, and in your opinion they should have it, providing they understand and they have made the decision with full understanding, you just have to withdraw. It's not your problem. It's not a personal insult to you if the patient doesn't want to have the operation you're proposing.

LESLIE HAMILTON: There's evidence from surveys of doctors that if doctors are asked to put themselves in that position they often choose less treatment, or less invasive treatment, or treatment with fewer side effects than they would recommend to their patients. So it may be that if we communicate better to patients it will mean less treatment undertaken, as patients may opt not to undergo a procedure where a treatment if they don't feel they're going to get that much benefit in their circumstances.

CLARE MARX Surgeons love operating, that's the problem. It doesn't hurt us until something's not good; but you know we love operating, we're good at it, we know patients generally do well, why would we not want them to have an operation?

PRESENTER: The move to 'supported decision-making' places new demands on the behaviour of clinicians, and is a subtle but fundamental shift in the relationship between patients and their doctors. For many, this will be a welcome development, but for others it

may feel at best unusual, and at worst, an abdication of responsibility.

Next time, I'll be considering what surgeons can do to ease the transition and to help reshape consultations to support patients to make decisions that are tailored to their individual circumstances.

END OF EPISODE 2

END CREDITS

Mr Roberts was played by Lionel Guyett, Clare by Hilary Greatorex and the Surgeon was Simon Snashall.

Interviewees were Clare Marx, Leslie Hamilton and Sue Hill.

The series was presented by Murray Anderson-Wallace and written and produced by Murray Anderson-Wallace and Roland Denning. Professional advisors were Leslie Hamilton and Katerina Sarafidou. The Production Manager was Lesley Davis.

'Informed Consent' was an Anderson-Wallace production for the Royal College of Surgeons of England.