INFORMED CONSENT - Episode 3

PRESENTER: In 2015, the landmark 'Montgomery' judgement created one of the most significant shifts in informed consent to treatment in more than 60 years of medical practice.

I'm Murray Anderson-Wallace and in this the third and final podcast in our series, I'll be exploring the legal, ethical and practical implications of the judgement, and discussing the new guidance from the Royal College of Surgeons, "Consent: Shared Decision-Making"

In the first episode, we considered the legal context for the move towards supported decision-making and in the second, we considered the benefits, beyond the law.

The move towards 'supported decision-making' places new demands on the behaviour of clinicians. It involves a quite subtle but fundamental shift in the relationship between patients and their doctors. For many, this will be welcome development, but for others it may feel at best unusual - and at worst, an abdication of responsibility.

In this final episode, I'll be discussing how surgeons can ease the transition and consider some of the practical implications.

Leslie Hamilton is a Director of Professional Affairs and Council Member of the Royal College of Surgeons.

LESLIE HAMILTON: The emphasis in the past has very much been on the signing of the consent form, which actually in legal terms didn't have any validity if the patient could show they weren't given the information, but that's where the emphasis was.

PRESENTER: Sue Hill is a Consultant Vascular Surgeon and Council Member of the College.

SUE HILL: What we are wanting to do is support their decision-making, not have them consent to have a procedure performed, and as

things stand we very often to into the consultation to take their consent. That's the wrong approach. We should be helping them make a decision as to how we treat them.

LESLIE HAMILTON: In future, for a straightforward procedure, then there won't be an issue because there may not be many alternatives and the patient can decide whether or not they want it, but for the more complex procedures, or for a patient with lots of co morbidities where there may be some debate about the benefits the patient may get, or increased risks, I think that's going to have to be a senior person, because ultimately that person will have to weigh up what that patient can take in, and also the benefits and risks to that specific patient.

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

CLARE MARX: And I also think it's really important that if a doctor doesn't know what the procedure is, they shouldn't actually try and take consent for it. Trying to consent someone for an operation that you've never seen, don't know anything about, don't really understand, is hopeless. I often say to trainees when they first come in, 'why don't you sit in on a couple of cases so that we can actually have an experience of that, and then perhaps we can have a conversation about what you feel comfortable in doing'; because it may be they won't feel comfortable in taking it as far as the full consent, but they may feel comfortable in having some of the preliminary discussions and then coming through and asking the senior person to come, depending on the magnitude of the procedure, or just depending on the way the patient reacts to the information they've been given.

SUE HILL: So there can be a huge number of people involved and then, remember, the patient will go home and have extra pressures from friends and family away from you; and nowadays of course they can look things up on the internet, which can be completely unreliable.

PRESENTER: Clare Marx.

CLARE MARX: It starts before they ever get referred to hospital, and I find it very interesting that quite often I will ask somebody, 'what have you and your GP discussed about this?' and the answer will be 'nothing, he has just referred me to see you'. I do think conversations that need to be had at every opportunity, in dumping information on patients about all these risks. All

we're doing is really just offloading this risk profile onto them, and it's all in the way you have that conversation; 'how much can I tell you at the moment about that', or 'would you like to read about it', or 'can we ask you do discuss that with the nurse practitioner', or 'do you want to just discuss particular areas that you might have heard about that you feel might be important for you to understand better'.

PRESENTER: What are your thoughts about the use of recording devices or smart phones and so on to document conversations?

LESLIE HAMILTON: I think from the patient's point of view that would be a very valuable aid, and with modern devices it's so easy to do; the reason we haven't done it in the past it was too cumbersome but now with smartphones they can just switch it on. And the medical defence organisations are very clear in their guidance that this is a perfectly reasonable thing for a patient to do. But it comes back to the important point about recording the content of the discussion and giving the patient a copy of that afterwards so that they have a record of what was discussed. Some surgeons even feel that it's appropriate to dictate that in the presence of the patient so they can hear what's being said and they can adjust it accordingly. Much of what we do in medicine and surgery there's not a strong evidence base for, so we're familiar with that. From the patient's point of view, there's good evidence to show that if the patient feels involved in the decision-making process it reduces the number of complaints so communication is better, and that they're more satisfied with their treatment, which is ultimately what we want as surgeons.

PRESENTER: So you're suggesting that it takes a shift in terms of the way that people ask questions and communicate, but also there is a practical implication here, is there not?

CLARE MARX There's a really important issue which is that as we're squeezed in terms of our consultation time, we have to find better ways of getting into the conversation. As clinicians we're really bad at interrupting our patients and we're very scared of actually asking those open questions. What's really interesting is that, I was listening to a study which said, 'if you ask an open question, the chances are they're not likely to talk for more than about 90 seconds maximum before they stop. In a 10 minute consultation actually I think you can allow people a pretty good talk.

SUE HILL If you're saying, 'what can one do' I think first of all one has to just step back a little, and remember this is not a routine consent; so the procedure for anybody is not a routine procedure, even if it's something that we regard as very simple, say a hernia repair, for that patient is pretty important, an out of the ordinary occurrence. So we need to give time, give attention, and actually give the patient an opportunity to ask questions, but I think we also need to push them to ask questions. Very often, patients will sit quietly while you tell them what you think of the procedure, what you are aware of as the complications, and you need to actually say, 'do you have any questions, is there anything I haven't made clear?' So I think we need to actually push the patients a little more.

LESLIE HAMILTON: 'The doctor's duty is therefore not fulfilled by bombarding the patient with technical information which he cannot be reasonably expected to grasp, let alone by routinely demanding a signature on a consent form' – the judge actually said that, because they know that's what happens.

PRESENTER: In our first podcast, 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 our second podcast, we returned to the dramatisation some weeks after Mr Roberts' surgery to hear how things went.

In this final episode we return to Mr Roberts and ask him to reflect on the outcomes of his surgery - and the overall effect on his quality of life.

MR ROBERTS: When he told me about taking it out of my leg, and told me about taking it out of my chest and my arm, he said there'd be some complications, we talked about bleeding and various other things, but he didn't say anything about loss of sensation. He said 'he does them all the time', you know when Claire said about Mrs Henderson, he said 'oh yes', he said, 'I do 3 or 4 of these a week'. You know, to him it's just a run of the mill operation; to me, of course, it was unique. I felt sort of a little bit of pressure from him as though he was looking at me and saying 'you'd be a fool if you don't take the 97%, don't take the 3%' – he did actually say that I think at some point, he said 'in my opinion or my team's opinion', and then he said something about 'well if you want to do this you could go, it's not my

decision, you've got to go back to your cardiologist', and I thought, 'I can't even remember who the cardiologist was', but I'm 79 years old, in biblical terms I've already had 9 years bonus haven't I, so living longer isn't actually a problem for me, and in fact the longer you live, you know, I've got some elderly friends whose quality of their life is awful. So I wasn't interested in a longer life, what I was interested in was the quality of my life, and in fact, looking back on it, actually the quality of my life's worse now, and I'm going to live longer with it! That's no option is it eh? So I'm going to live longer – so what!

CLARE MARX I've certainly been aware that I've got back to my office and thought, 'that was not a really good conversation', and I think the change that has happened really makes it vitally important that we now are brave enough when that happens to actually maybe get back in touch with the patient, invite them back in so that we can try and have a better conversation, and really be sure that both they are happy and we are happy that we understand what's going on. And that is time-consuming, and you do have to be quite brave to do it, but I think it's going to be worth it in the long run.

LESLIE HAMILTON: So even though it's now the law, and it would seem to need a big shift in the whole system, by spending a little more time with the patient, tailoring the discussion to that individual patient, and discussing alternative treatments with them, and recording the decision-making process, will go a long way to both providing better patient care, and meeting our legal obligations.

PRESENTER: What role do you hope that the new guidance from the Royal College of Surgeons will have in supporting people in this change?

CLARE MARX: We hope after the amount of thought and discussion that very senior clinicians and other members of teams have put in to this guidance, people will look at it seriously, consider it, and be open-minded about what they can do in terms of changing their whole environment in the process of getting consent.

LESLIE HAMILTON: In summary, we have to tailor the information we give to the individual patient, we have to make them aware of all alternative treatments, and their risks and benefits, and we have to respect the right of the patient to choose something that we may think is not in their best interests.

CLARE MARX: We are always interested in feedback; we really would like to know if people find certain aspects useful, we'd like to know what aspects people vehemently disagree with, and if we've got it wrong then we would obviously look at that, but I think we've got to seize the moment and actually make the changes now, but we just don't have the luxury of not changing.

END OF EPISODE 3

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.