# Consent

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Dr. A, who is employed in a private hospital was referred a case of suspected acute appendicitis by the emergency doctor. The patient, a young female in her late 20's was duly seen by Dr.A late at night and again the following morning. A consent for appendicectomy / laparotomy was taken and surgery in the form of a Laparoscopy followed by laparotomy and appendicectomy was undertaken for a perforated appendicitis.

The patient made a largely uncomplicated recovery but was upset with her unsightly laparotomy scar which was hypertrophic. The patient's mother, who had a background experience in nursing was likewise unhappy about the nature of the operation and explanation proferred in taking the consent. In her complaint to the MMC, the patient stated a few circumstances which made her unhappy. This included;

1. The nature of the consent for surgery which was inadequate as the surgeon never explained that a laparotomy may be required and the nature of the incision involved. She stated that had she known about the latter possibility, she would have requested for a second opinion. The patient insisted that she was only told that she had appendicitis and that an appendicectomy was required.
2. A laparoscopy had been performed when this was not stated in the consent form.

An inquiry was held by the PIC during which the doctor insisted that he had explained the full nature of the surgical procedure to the patient including the possible need for a laparoscopy and laparotomy. However, these were not witnessed and the case notes made no mention of these facts. After hearing submissions from both parties, the PIC decided to recommend to the council that an inquiry be held. The charges read as follows;

1. Not providing thorough professional attention to the patient by failing to explain the details of the surgical operation.
2. Not providing competent and professional management to the patient by failing to obtain a written consent for a laparoscopy thereby failing to meet the required standard of care and professionalism.

At a subsequent hearing at the council level, it was agreed that there were no grounds to support the charge as the doctor had acted in the best interest of the patient in managing her condition based on his clinical assessment and findings during surgery.

## Lessons from the Case

It is unlikely that this case would have materialised had the practitioner obtained proper informed consent for surgery and provided adequate documentation in the progress notes.

Informed consent is not merely a signature on a consent form. It is a process whereby a mentally competent patient agrees to undergo a procedure after discussion of the indications, alternatives, potential side effects and complications. The physician must personally advise the patient, in a manner the patient understands, of all material medical information and risks of treatment. Providing this information enables the patient to make an intelligent

and informed decision about whether to undergo a proposed treatment or procedure. Failure to provide patients with sufficient information for informed consent places a physician at risk for a legal claim for injury from a complication or unanticipated outcome of the procedure—even if it was not the result of negligence.

In patients undergoing urgent abdominal surgery, such as in this case, the process may be compromised by the fact that the individual is in pain, or is under the effects of analgesia or by the need to intervene rapidly in situations where the precise diagnosis and likely outcome are unknown.

The information generally required to be discussed with a patient in order to obtain an informed consent includes:

1. A description of the patient's condition, including diagnosis or suspected diagnosis
2. The nature and purpose of the proposed treatment or procedure and the anticipated benefits
3. The material risks, complications, or side effects of the proposed treatment or surgery, including death or serious injury, if applicable
4. Medically reasonable available options or alternatives, including non-treatment, and the probable benefits and risks of each alternative
5. The material risks of not having the proposed treatment or procedure

Use of non-technical language to communicate the above essential information to patients is essential. Involvement of the patient's family members to the extent possible and encouragement of questions is recommended. It is obvious from this case that the family members were not involved in the decision making and consent taking process and the fact that the patient's mother had a nursing background and was not informed of the management plan pre-operatively probably played a significant part in events leading to the complaint.

The informed consent process must be fully documented in the patient's medical record with a recording of the date and time and pertinent content of your informed consent discussions with the patient. Documentation of any other activities that were part of the process to inform the patient, such as provision of informational pamphlets or materials to the patient should be likewise included. The documentation must be detailed enough to reflect that the patient was provided with the information required to give an informed consent, demonstrated understanding of the information, and gave or refused consent to treatment.

Use of a 'standard" consent form routinely used by physicians and healthcare facilities does not relieve a physician of the obligation to discuss the material risks, benefits and alternatives with the patient. The patient's signature on a "standard" consent form stating that the patient is giving informed consent, unaccompanied by supporting documentation of the consent process, may not protect a provider against a claim or complaint alleging failure to obtain a proper informed consent.
Any consent form that is used should be written in lay language that is easily understandable and medical terms used in it should be explained. The form must be

dated, timed and signed by the physician and the patient or the patient's authorized representative. A member of the clinic or hospital staff may witness the patient's signature on the consent form. If an interpreter was used for the informed consent discussion(s), document in the patient's medical record the interpreted language, the name and relationship, if any, of the interpreter, and the date and time of the discussions.

The guide above is not exhaustive but would certainly help physicians reduce unnecessary complaints from patients or relatives that may lead from an unanticipated outcome following any procedures or surgery.

Further reading

1. General Medical Council. *Seeking patients' consent: the ethical considerations*. London: General Medical Council, 1998

*2. Explaining the Risks and Benefits of Treatment Options: Suggestions for Hospital Doctors*, Royal College of Physicians, 2006