

PERSONAL OPINION/CLINICAL TIPS

I would like to urge all readers of our journal to take part in the informal section titled Personal Opinion or Clinical Tips. Anything that you came across during an overseas visit or in your own practice that could be of help to others should be shared.

I am sure you have specific ways of doing an operation which can be beneficial to other colleagues. It may be just one small aspect of an operation.

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Informed consent for surgical procedures in the Gauteng Health Care Sector

Introduction

Informed consent for surgical procedures in the Public Health Care Sector presents the treating surgeon with a practical and ethical challenge, especially if the patient is from a low socio-economic background, has had poor or no education or where language barriers exist. The official language in hospitals is English. For purposes of this paper, the target group for obtaining consent is adult patients older than 18 years who have the ability to agree to a legal document (i.e. criminally responsible).

Method used to obtain consent for elective surgical procedures

A doctor usually explains the planned surgical procedure to the patient at the relevant clinic. Technical information is explained in simple layman's terms. Where applicable, radiological pictures are often used as a tool to visibly explain procedures. If the patient does not understand English, nursing staff members are used to translate into one of the Nguni or Sotho languages. The patient is subsequently booked for surgery, but the legal document **TPH 3 (81/500909) Consent for Operation** is only signed upon admission to hospital.

When the patient is admitted, which is usually a day prior to surgery, the procedure is explained to the patient a second time by a doctor in the presence of a professional nurse. On this occasion, the doctor emphasises the post-operative treatment, possible complications and expectations of the patient. Again simple layman's terms are used. The TPH 3 is signed

in duplicate by the patient and countersigned by two witnesses. If the patient is illiterate an ink thumbprint of the patient is placed on the TPH 3. It is the responsibility of the ward, in other words the professional nurse, to double check that the consent is legal.

The nursing staff receiving the patient in theatre will also scrutinise the TPH 3 form for errors. We must, however, point out that by this time the patient has had pre-medication, which can influence his or her judgement and concentration.

One of the doctors on the operating team has to take responsibility for the abovementioned process.

Method used to obtain consent for emergency surgical procedures

The planned surgical procedure is usually explained to a patient in the emergency-room area. The same steps are followed as in the clinical set-up, with the difference that the TPH 3 is signed immediately in the casualty area. If the patient cannot sign the form due to illiteracy or an extreme injury, an ink thumbprint is used.

Often the intern on call explains the procedure to the patient while the registrar is scrubbing for going into theatre. Though sometimes unavoidable, this method is legally unacceptable.

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Informed consent

Informed consent will remain a topic of ongoing debate. It is impossible to cover all the possible angles. The mainstay remains an honest and open relationship between the surgeon and the patient from the onset.

I begin with a formal explanation of the pathology, expected course and possible solutions. I insist on having a relative or friend present. At this stage it is possible to get an idea of the patient's grasp and capacity to understand.

I then attempt to tailor the information accordingly.

Having suggested a specific treatment regimen the detail regarding hospital stay, anaesthetic modalities, expected mobilisation programme, time off work and sport are discussed. Arthroplasty patients require detailed discussion of implant possibilities and relevant preferences.

The possible side-effects of present medication regimens, drugs to be discontinued not allowed peri-operatively and/or specific additions, e.g. LMW heparin in place of Warfarin are discussed.

Possible complications of a procedure are also discussed as well as general and specifically relevant details for the given procedure.

Unfortunately, an ever-increasing amount of time has to be spent on discussing funding matters. I attempt to leave this responsibility with the patient, arming him or her with information regarding the choice of implants, relevant quotes from the suppliers and hospital, and then

leaving it up to the patient to communicate with his or her funders. The problem is, unfortunately, that many of, particularly, the older patients are vulnerable to exploitation by the system, and therefore require more assistance.

Documentation in my file is a formal consent form, fairly standard in accordance with examples readily available from the hospital. This is signed by the patient and a witness. I also have an additional information form, explaining that the funders do not necessarily approve all the codes that are reasonable to charge, and that procedure coding is done according to guidelines from the SAOA. On this form it is also again stressed that the funders may not bear full responsibility for the cost of an implant of choice. This form is also signed and kept on file.

In the report I send to the referring doctor, I also specifically mention that I have discussed the pathology, implications and possible complications of the impending procedure.

Pre-operatively I confirm the consent, making sure the patient and family are comfortable.

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Taking an informed consent

In my practice, I try to obtain informed consent in the manner I would like to be treated if I were the patient. Taking down a careful history and taking time to listen to the patient combined with a proper physical examination are essential for a correct diagnosis. That is what the patient came for.

Explaining the diagnosis is the first step towards obtaining informed consent. For that purpose, I have pictures and models in my surgery to show to the patient. I even make simple drawings to explain the exact nature of the health problem. Making the patient understand this is essential before explaining the treatment alternatives in lay terms.

As a second step, I mention the advantages and disadvantages of the different treatments and then elaborate on the one I think is appropriate. I give the patient enough space and time to consider the treatment options. As soon as I detect the slightest hesitation about my own proposal, looking the patient in the eye, I tell him or her to go home and think about it. In certain instances, if I see the patient is really uncertain, I arrange for a second opinion. Having been in practice for quite a while now, I find it much easier than in the past to handle this procedure as I will not force any patient to choose the option I propose. An unwilling or hesitant patient should be left alone.

The third step is to present the consent forms I have prepared and I usually sign on the dotted line in the presence of the patient who then also signs. Although I book the operation for a certain date I always

inform patients about the possibility of changing the date if necessary or to approach me if they need more information about the diagnosis or treatment. In certain instances, I would even invite the patient's close relatives to accompany him or her the next time to discuss the diagnosis and treatment.

Although I usually give patients enough information to understand why I need informed consent, I try not to frighten anyone off if I think the procedure is necessary. It would seem, however, that I do not always succeed in "keeping it light". I recently gave a patient a list of possible complications of a spinal operation to consider at home. Not only the patient but apparently also the whole family were devastated by the possible consequences of a spinal operation, like damage to the spinal cord or nerve root, paralysis or even death in exceptional circumstances.

This incident made me wonder whether all patients do in fact read the lists of complications I give them to study!

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Informed consent

Informed consent is a mutual agreement between the doctor and the patient to authorise specific treatment. The purpose of this process is to protect both the treating doctor and the patient.

Informed consent should start with a thorough discussion of the diagnosis. This should be explained to the patient in simple, understandable terms. The use of drawings, anatomic models, examples of relevant prostheses and an atlas are of tremendous help. As patients often cannot recall what the doctor has said, a handout can be given to the patient to study at home.

The natural history of the diagnosis should be discussed with the patient so that he/she is well informed and able to make an informed decision. The non-surgical (conservative) option should be discussed with the patient. The patient should know that conservative treatment is not without risks, and that it may be abandoned. Should surgery be the treatment of choice, the patient should be informed about the suggested pre-operative, intra-operative and postoperative treatment.

It is important that the patient should understand the purpose of the surgery, so that the doctor and patient are aiming for the same goal. Alternative options should be mentioned during the discussion. The patient should be allowed to raise questions should any uncertainty arise.

The risks involved with the treatment should be addressed. Common problems that may arise should be mentioned as well as the precautions taken to keep the treatment as safe as possible. Less common but dangerous complications should also be mentioned. Complications should be addressed as those complications directly connected to the surgery, i.e. g. bleeding, and indirect complications, e.g. problems due to anaesthetic. Should there be the possibility of blood transfusion, the patient should be informed.

Once the abovementioned matters have been addressed, the patient should be given time to ask questions. It may be a good idea to schedule a second consultation should there be uncertainty. A telephone number is supplied should the patient have any queries. A patient should be allowed to get a second opinion (should they wish). Nothing forbids the treating doctor to get a second opinion for reassurance.

Once the patient has agreed to the recommended treatment, written consent, preferably in duplicate, should be obtained from the patient. In the case of a minor, the parents or a guardian should sign the consent. Should the patient not be able to sign consent, his/her spouse may sign the consent.

The basic principles of consent should mention:

- name of patient on whom the procedure will be performed
- date on which the procedure will be performed
- exact nature of the procedure
- site of the procedure, e.g. left hand
- who explained the procedure
- date on which informed consent was signed
- that patient understands the procedure
- that patient was informed about the risks and possible complications of procedure.

In addition it is advised that you use block letters on the form and that you refrain from using abbreviations.

A copy of informed consent should be kept in the patient's file.

Before the patient is brought to theatre, the patient should be seen to confirm his/her identity, the procedure to be performed and the site where the procedure should be performed. It is recommended that this should be done as far as possible before the patient has had pre-medication. The site of the planned operation should be marked pre-operatively with a surgical marker.

Confirm that informed consent was correctly signed by the patient before you start the procedure.

These are a few practical hints which have made informed consent work in my private practice.

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