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Editorial- Educational

Informed Consent- Do We Really Understand It?

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Medical practitioners are aware of the need to obtain consent for interventions or procedures but the concept of informed consent has placed an additional onus on physicians to explore alternative procedures and detail all risks and benefits. This may involve an explanation of relatively rare complications or side effects previously considered too infrequent to mention. However, practitioners are still uncertain as to how much information should be provided to patients and how to balance cultural intricacies with standard consent requirements. The legality of consent now places a very significant responsibility on the doctor to have explained risks, benefits and alternate treatments.

Therefore, what is "Informed Consent" and who is best qualified to obtain it and where?

Informed consent is an interactive process that facilitates the useful exchange of information, which would allow the patient to make an informed, balanced and independent decision about management or a planned intervention. This concept of information exchange has changed radically from 1861 when divulging information to patients was considered unnecessary and not within their rights as **"Your patient has no more right to all the truth than he has to all the medicine in your saddle bags"**[1].

However by 1914, an opposing view had emerged that "Every Human Being of adult years and sound mind had a right to determine what shall be done with his own body and a surgeon who performs an operation without the patient's consent commits an (criminal) assault"[2]. Prior to this seminal case, doctors tended to adopt a paternalistic approach and viewed themselves as best able to judge what was or was not, in the patient's best interest. This view of universal medical beneficence has been further challenged by certain high profile medical cases where physicians have been found guilty of criminal assault and even homicide to the point where informed consent is now not just about giving the patient enough information but is also clearly about protecting the doctor and the hospital. It is particularly relevant to surgeons who must not perform any procedure simply for convenience.

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It is vital that every due precaution is taken to ensure that the information is delivered in a clear and unhurried manner and that the patient understands what is being said, has had time to think about it and obtain additional information or indeed a second opinion if needed. Cases that progress to the courts are often won or lost on this simple element of communication and information transfer. Despite this, there could be a discrepancy between the information available to the doctor and what is ultimately relayed to the patient. Remnants of paternalism persist and doctors often fail to detail all potential benefits and complications on the basis that it may cause the patient distress, or that it is such a rare complication with infrequent potential. In this event, the court will generally consider what a reasonable patient would like to know, or had known, prior to giving consent. In 1956, an eye surgeon did not explain the risks of complete blindness in the normal eye as a result of operating on the other, already impaired eye, even though the risk was very rare[3]. The court found that the surgeon is guilty on the basis that a reasonable patient would not have agreed to a procedure that could render her completely blind. Rarity of a complication does not justify withholding this information especially when negative consequences can have a significant impact on the quality of life.

It is true, however, that some patients do not wish to hear bad news or worry over matters which they view as being of rare possibility only. Rather, they seek to focus on the likelihood of a successful procedure. The doctor must thread with significant caution in this increasingly uncommon situation; however, the delivery of information may be culturally tailored to suit as in telling a patient consenting for a Whipple procedure (pancreaticoduodenectomy) that there is 90% chance of survival rather than a 10% chance of mortality from the procedure.

Informed consent should be obtained by a competent, well-trained doctor who is familiar with the procedure and who is able to define risks and benefits. The task should not be delegated to a very junior doctor, nor taken in a rushed manner. Any questions or concerns that the doctor cannot answer should be referred to a senior colleague. It is best, but not essential, to obtain consent in the OPD and allow time for the information to settle, to make reference to information leaflets which are widely appreciated by patients as are simple diagrams of the intended procedure.

Traditionally, a single consent was obtained on admission for all the potential procedures that may evolve from that one admission. In today's complex medical and surgical environment, with an increasing awareness of potential complications and an increasingly litigious society, it is expected that separate consent must be obtained for any procedure in every hospital admission. If informed consent has been obtained in the OPD, simple admission consent is sufficient to allow the patient into hospital but beyond this, additional and separate consent is mandatory for central lines, epidurals, blood transfusion, admission to ICU etc., all of which carry a negative risk potential.

In essence, informed consent means giving all the information to the patient that enables them to make a balanced decision concerning their care, even if that complication is rare and especially if a potential complication could upset the quality and equilibrium of a patient's life. Medical ethics and consent are generally taught to undergraduates now but all doctors must be familiar with the legal requirements of informed consent.

REFERENCES

1. Holmes OW. Currents and Counter Currents in Medicine: With Other Addresses and Essays. In: Mills S, eds. Clinical Practice and the Law. 2nd edition. UK: Tottel Publishing, 2007: 73.
2. Schloendorff v Society of New York Hospital; Courts of Appeal of New York, 1914. Available at: http://biotech.law.lsu.edu/cases/consent/Schoendorff.htm. Accessed in November 2014.
3. Chalmers D, Schwartz R. Rogers V. Whitaker and Informed Consent in Australia: A Fair Dinkum Duty of Disclosure. Med Law Rev 1993; 1(2):139-59.