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The evolution of consent

An oration[1] prompts reflection on gaining patient consent. Do our current arrangements fail to fulfil their objectives?

If obtained only immediately before the planned intervention, the patient will have insufficient time to provide informed consent. Consent is often a singular event, and not the 'process' of gradual transference of information from surgeon to patient, followed by appropriate discourse. The wording of consent forms may baffle some patients, and forms can be difficult to read. The oration questions whether the law is stipulating an unachievable level of understanding on the part of those patients who in reality, lack capacity, resulting in an invalid consent.

Shokrollahi[1] suggests that our current form is not robust evidence of valid consent, that our process is paternalistic, and provides no pressure to facilitate excellence in the context of consent. Furthermore, he regards the current role of consent, a legal engagement between surgeons and their patients, as harmful to the therapeutic relationship.

At the heart of his solution is the substitution of a request for treatment (RFT), placing the patient 'at the centre' of the transaction, ensuring the provision of information of high quality, and assurance of more robust documentation. The RFT is proposed as a 'soft' method of assessing capacity. The inadequacies of our present system are thus addressed.

In assessing the value of these proposals, surgeons need to consider whether this will improve the quality of the information imparted. The speciality organisations have improved the standard of patient information, taking steps to provide uniformity. The RFT guarantees that information is provided at the earliest possible stage, ensuring that patients have enough time to reflect, and reach a considered conclusion. Whether this deliberation will prove to be more effective than the current disclosure remains to be seen. However, it must be acknowledged that to review the patients' entries on the completed RFT form would help assess their understanding.

For patients who cannot read or write in English, special arrangements could ensure the RFT form's completion. Otherwise, denying patients equal opportunities of reflection and deliberation would be discriminatory. By contrast, literate patients may choose to make only a minimal contribution on their form. The surgeon must then fully disclose details which any reasonable patient would need to know before giving consent. But even a minimal contribution by the patient may indicate improved engagement, and the RFT process, considered as a whole, will have increased the 'contact time' between surgeon and patient.

The form will eventually need to be signed by the operating surgeon. The present (at times hasty) disclosure of benefits, alternatives, risks and complications may be construed as 'talking down' to the patient. Surgeons will have to judge for themselves, whether a review of the patient's 'statement' and correction of resultant misunderstandings reduces the risk of this paternalism. If it does, this would be beneficial.

The assessment of capacity should begin at the first clinical contact. This leads to mutual understanding, forming the cornerstone of the therapeutic relationship. If there is doubt that the patient has capacity, advice must be sought.

Comparative data would reveal whether the RFT improves the determination of capacity. The final opportunity for assessing capacity, on the basis of the General Medical Council's (GMC) criteria,[2] will in either system be at the discussion following which the surgeon signs the consent form. If the patient lacks the capacity to provide valid consent, the procedure should be postponed, unless the clinical circumstances are such that the operation is immediately necessary either to save life, or prevent permanent irremediable harm.

The clinical circumstances determine the patient groups to whom the RFT may be relevant. Patients undergoing elective cosmetic surgery may have an imperfect understanding of the possible outcomes, whilst surgeons may misinterpret the patient's vision of the desired result; these misunderstandings need to be overcome. For patients whose capacity is impaired, or who are being treated as emergencies, the RFT might not address any current inadequacies of the consent process.

Providing evidence of a patient's consideration of information before deciding to consent for surgery, and of inde-

pendent decision-making before the final clinical encounter when the patient's 'statement' is checked and corrected, would be an improvement on the current evidential offering in a claim in negligence.

However, it provides a trap. The current form reveals nothing of a patient's ignorance; only affirmation of the clinician's provision of information. If the 'patient statement' is completed in a minimal fashion, or implies a lack of capacity, this needs serious consideration by the surgeon. If the 'clarification of treatment details' is then not completed exhaustively and wholeheartedly, the court may conclude that the patient misunderstood, or lacked capacity to consent. The litigant is thus provided with evidence of substandard care, a luxury that the current form does not provide.

Patients need sufficient time, information and clinical contact properly to make informed decisions. A mere signature does not demonstrate valid consent. Evidence is needed that the use of an RFT form will improve the situation. If it is proved so to do, the 'patient statement' may form the basis for further discussion with the surgeon. But introduction of evidence of the patient's misunderstandings and anxieties may have unintended consequences, if unmatched by a fulsome clinical response.

References

1. Shokrollahi K. Request for treatment: the evolution of consent. *Ann R Coll Surg Engl* 2010; **92**: 93–100.
2. General Medical Council. *Consent: Patients and doctors making decisions together.* London: GMC, 2008, s3.

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