Valid consent – A pathway to improved care

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By improving our practice in how we obtain a patient’s consent for surgery and anaesthesia we may discover a pathway to better perioperative care and end-of-life decision-making.

Obtaining a patient’s informed consent to undergo surgery may involve the consideration of multiple aspects of their care: the relative merits of an operative vs non-operative approach, the risks and benefits of regional or general anaesthesia, the impact of their co-morbidities on immediate and long-term perioperative risks, the psychological and social factors that may play a part in their recovery, and their likely outcome not just in terms of survival but also their quality of life. The role of the anaesthetist in helping the patient and surgeon towards informed consent is variable. Increasingly patients are brought in to hospital on the day of their surgery and there may be scant documentation regarding the subtleties of the conversations that have taken place concerning the decision to proceed to surgery. We have learnt from the Supreme Court judgement of Montgomery vs Lanarkshire Health Board that we need to be more fastidious in our explanations and in the documentation of relative risks.

Our role as anaesthetists varies. Sometimes it will be appropriate for us to limit our discussions specifically to the anaesthetic aspects of the patient’s care. Sometimes it will be appropriate for us to lead or coordinate more comprehensive discussions ourselves, or to call for a multidisciplinary approach, but as the General Medical Council makes clear in its guidance document it will always be part of our duty of care to patients to ensure that perioperative considerations include every aspect of care, not just survival, and that those considerations are properly documented. Towards the end of life these discussions can be particularly delicate, and for those patients especially we must ensure that the drive to shortened hospital admission times does not remove the opportunity to establish a real rapport between the patient, their family and all the staff involved in their care. Well-intentioned targets for hospital discharge and survival may distort clinical judgement regarding what is really best for
our patients, if we do not involve ourselves in the development of the standardized ‘care pathways’ that hospital managers and health-economists seem to favour.

The specialty of anaesthesia embraces many areas of expertise that are pertinent to discussions regarding perioperative risk and end-of-life care, but there is little uniformity in how we address those issues.

Preoperative assessment clinics have made some progress towards establishing a formal role for anaesthetists in the wider discussions about fitness for surgery, but there is considerable variation in how such clinics are conducted. Some hospitals have specifically established ‘high-risk’ anaesthetic pre-assessment clinics, but referral is usually made after the surgeon has already recommended an operation, and as an anaesthetist one can still be scheduled to care for a patient having had no prior involvement in their preoperative discussions. Additionally the scheduling of these clinics is often sub-optimal, allowing the anaesthetists insufficient time to preoperatively optimize a patient’s health. Weight loss, smoking cessation, and improvements of cardio-respiratory fitness cannot be accomplished within a short time-frame.

Obstetric practice has evolved to include anaesthetic input very early on in the mother’s care. Can that model be applied to other surgical specialties? The success of enhanced recovery programmes demonstrates that preoperative preparation, patient education, and formal processes of rehabilitation in the recovery phase from an operation can have a significant positive effect on patient outcome. In vascular surgery the re-organization of specialist units to include anaesthetic risk-reduction strategies and identification of high-risk patients has resulted in reduced mortality rates, but it has been more difficult to establish this approach in other surgical specialties. Beyond a few specific programmes our profession seems to have been slow to translate our knowledge of perioperative risk into benefit in the clinical setting.

To assist in making these decisions there are now several well-validated scoring systems that help us to quantify perioperative risk. When talking to patients undergoing complex surgery, or in whom co-morbidities have a significant impact on their perioperative risk, the scoring system produced by the American College of Surgeons (NSQIP) provides enough detail to form a useful basis for discussions. Perhaps it is time to make documentation of preoperative risk scores a routine part of our practice and to include in our discussions with patients how specific factors alter their perioperative risk and the risk of them suffering a significant deterioration in their quality of life postoperatively. That would be truly informed consent, but it cannot be done adequately just a few hours before the scheduled operation.

When obtaining ‘valid consent’ we have a duty to anticipate what might lie beyond the immediate postoperative period. In those patients in whom the end of their life seems imminent, we must be prepared to establish with them in a multidisciplinary context the extent to which they would wish for medical interventions to be applied and the limits to such care that we believe would be appropriate. Pain relief and dignity may be much more important objectives than prolonged survival and in some patients it is appropriate to establish that priority preoperatively in detail that extends beyond a ‘do not attempt cardiopulmonary resuscitation’ order.

Whether or not elective admission to an intensive care or high dependency unit is appropriate is often a difficult assessment, and we remain short of objective evidence on which to base such judgement. When surgeons, anaesthetists and intensive care consultants cannot reach consensus, or when intensive care beds are limited, it is difficult to find a rational approach to determining a patient’s priority for access to these limited resources. As the burden of healthcare costs continues to increase we must develop approaches to the limitation of care that are acceptable to society as a whole and which we feel comfortable about discussing with patients. We play a role as managers of a finite healthcare budget and we must ensure that the limited number of intensive care beds available are utilized most efficiently.

If we are to formally embrace perioperative medicine within our specialty, I believe we must change our approach to informed consent so that it includes wider considerations regarding perioperative risk. In high-risk surgery we will need to be more intimately involved in the initial discussions regarding a patient’s fitness for surgery, how we can improve it, what the consequences of their co-morbidities are and what can be done in the weeks or months before their surgery to mitigate those risks. We should be there to explain the benefits or lack of benefit of elective postoperative high dependency care, and to discuss with patients the realities of how the need for advanced postoperative interventions may introduce uncertainty into the scheduling for their surgery.

To achieve any of these ambitions we would need to reorganize the current pathways from general practitioner to surgeon to postoperative care to hospital discharge. It is an enormous task, and our involvement may not always be welcomed, but if our ambition is to be perioperative medicine specialists we need to demonstrate our commitment to properly informing patients of how the risks that they face throughout the whole of the patient pathway might best be modified.

Acknowledgement

The writer would like to thank Dr. Rhona Siegmeth, Dr. David Bogod, Dr Anna Bachelor and Dr Simon Fletcher for their helpful advice when preparing this manuscript.

References