Do You Have Consent?

INCISION

Part 4 – Particular challenges in obtaining consent

Obtaining valid patient consent is one of the most fundamental pre-operative responsibilities of surgeons. In 2015 there was an important development in the UK case law – the now well-known Montgomery decision - which resulted in a sharp increase in claims against healthcare professionals generally arising from the consenting process.

Since then we have been carefully monitoring legal and practical developments and gathering real-life case studies from Incision members and other specialist surgeons. Understanding the current legal landscape and the practical challenges will help surgeons keep their processes updated to promote good practice in obtaining consent. In turn, this should help prevent unnecessary claims or regulatory proceedings from arising in the first place and, provided it is properly documented, will make it easier to defend any claims that do arise.

This short series of four guidance notes is intended to help busy Incision members. Even now, nearly four years after Montgomery was decided, we still regularly come across current examples via the medico-legal helpline service of surgeons misunderstanding their obligations.

A recap on the current UK law was provided in Part 1 of this series. The upshot of the legal changes is that the process of consent will often be best approached in these broad stages:

- Obtaining the patient's medical and social history (covered in Part 2 of this series);
- Obtaining consent for ancillary matters, such as clinical photographs;
- Consulting with the patient, including providing patient information leaflets (covered in Part 3 of this series);
- Final consent to go ahead with the intervention/treatment leaflets (covered in Part 3 of this series).

In this guidance note, the last in this series of four, we look at some particular practical situations where obtaining valid consent can present a challenge.

Consent for ancillary matters such as photographs

Clinical photographs of the patient may need to be taken. At an appropriate point in the consent process, the surgeon should explain the purpose of taking photographs and the fact that they will form part of the patient's medical records. The patient's consent to the photographs being taken should be recorded in writing, ideally by the patient signing a suitable form, before any photographs are taken.

In the vast majority of cases, getting consent to take clinical photographs of the patient is extremely straightforward as the vast majority of patients understand that they are a necessary part of clinical recordkeeping and will consent straight away.

Nevertheless, we know of Incision members who have been faced with practical difficulties even in this aspect of the process. For example, one surgeon had a patient who simply refused to allow clinical photographs to be taken of her lower body (where the surgery was to take place), on the basis that she found the idea of the photographs "intrusive" and was worried it would exacerbate her clinically diagnosed PTSD.

We gave medico-legal guidance that without consent to the photographs they could simply not be taken. Without clinical photographs the surgery could not properly go ahead, given the importance of those records in complying with the duty to make and keep proper records. We recommended that the patient be referred to her existing mental health team to assist with ascertaining whether she could or would consent to the photographs with the necessary support and if not then it would be much safer for the surgeon to not go ahead with surgery for that patient.

While examples such as this are rare, they do highlight how important it is to avoid treating consent as a 'rubber stamping' exercise and be alert for patients that have unusual needs that give them problems with even routine aspects of their care.

Can the 'patient pathway' affect the validity of the consent?

In our view, yes it can.

We have dealt with a number of cases where a patient paid for the procedure upfront on a non-refundable basis after only a preliminary consultation (a cynic would say 'sales pitch') from an employee of a private healthcare provider company. Only then was the patient allocated to a self-employed surgeon to actually carry out the surgery. While more detailed consultations with the surgeon did follow before the actual surgery, the purported consent for surgery was very questionable because by then the patient had made a financial commitment. The particular examples we have seen have arisen in the context of elective eye surgery or aesthetic surgery, in relation to companies that specialise in marketing certain procedures to the general public, and contract with self-employed surgeons to carry out the actual surgery. In principle the problem could arise in any situation where the surgeon does not have control over the whole consenting process.

The General Medical Council and the law are clear that it is the surgeon who ultimately has the responsibility for obtaining valid consent. This is the case even if in practice the majority of the informing and consenting process is purportedly taken care of by other healthcare professionals. This is also the case even if the self-employed surgeon does not have any real control over when he or she sees the patient for the first time or how long he or she has with the patient to deal with consent before surgery. If a patient brings a claim for compensation alleging a lack of consent, the surgeon's defence team will of course endeavour to 'pass on' some of the legal liability to the company that actually took conduct of the initial stages of the consenting process. Ultimately, the best outcome in that situation is sharing liability with another defendant, rather than being able to completely defend the claim.

While it is possible to 'delegate' the consent process, this should only be done if the treating surgeon is confident that i) the person obtaining consent is suitably trained and qualified, ii)

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the person obtaining consent has sufficient knowledge of the proposed investigation or treatment and understands the risks involved.

Therefore we would recommend that all self-employed surgeons should endeavour to find out exactly what the 'patient pathway' is for private patients in the organisations they work within, and particularly what information patients are provided with (if any) by others before they reach the surgeon. The surgeons should ideally review that material (which could include 'sales scripts', patient information leaflets or even patient information videos) and decide what else the patients need to be able to give valid consent. This is particularly important if the other healthcare provider makes it a contractual obligation to use patient information materials or consent forms produced by them.

The surgeon should also consider whether the financial arrangements between the patient and the other healthcare provider will make it difficult to ensure that valid consent is actually being obtained in each case. Based on that, the surgeon can make a better informed decision about whether it will be safe to provide self-employed surgical services through that organisation, or whether they will be at risk of taking the consequences of another organisation's inadequate patient consenting process.

Consenting for anaesthetic risks

Other examples of how the 'patient pathway' can affect the quality of the consent process and the vulnerability of the surgeon comes from observations that Incision members have made about certain differences between the NHS consenting process and that in many private hospitals.

In the NHS the patients are often sent for an assessment appointment led by nurses and anaesthetists who will specifically assess the anaesthetic risks for the patient and advise them in preparation to be consented for surgery later on. By contrast, it is often the case in private hospitals that there is no equivalent process to deal with anaesthetic risks specifically. The surgeon has to take charge of consenting the patient for the anaesthetic risks and the patient may not even meet the anaesthetist until the day of surgery itself.

The upshot for surgeons in these situations is that they need to be sufficiently well informed to be able to ensure that the patient is warned of any material anaesthetic risks, as well as surgical ones, or risk being liable for a consent failure if an anaesthetic risk manifests.

Final thoughts

Surgeons care deeply about their patients. While most agree that driving up standards is essential, some feel frustrated that this has caused the growth in process-driven care that risks depersonalising patients. In this context, Montgomery should be considered a cause for optimism because it requires healthcare professionals to consider each patient from a holistic point of view and to understand how a proposed procedure will affect them personally. Nevertheless, this has created an increased risk for surgeons because it is now rare for a claimant's pleaded case to not contain allegations about a failure to obtain informed consent. Documentation is key and following the above processes will help protect you. If the documentation is lacking or does not exist at all, it will be impossible for your lawyer to defend you against such allegations.

If you want to discuss any of the matters issues raised in this note, please don't hesitate to call the medico-legal helpline on 0333 010 2826.

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