How to consent patients

I attended a morning seminar at the recent College Congress in Liverpool about how to properly and legally consent a patient for a procedure. There has been a lot of interest in this of late following the Montgomery ruling, in which a mother sued her obstetrician for a complication during labour which resulted in her child suffering cerebral palsy. Complications happen and are inevitable in medicine, but this case hinged around whether the consenting process had been robust enough for the patient to properly decide whether a vaginal delivery or a caesarean section was the correct way forward. We consent patients in various ways for practically every interaction we have with them so I was intrigued about what the legal expert attending this seminar would say and in particular what the expert would say in relation to the practise of ophthalmology.

It was almost half past seven in the morning when the smartly dressed bespectacled advocate started his presentation. He informed us he was the only practising member of the Scottish Bar who was dually qualified in both law and medicine and so was uniquely qualified to guide us through the minefield of modern medico-legal practice. As he outlined the three stages of a medico-legal claim, the burden of proof and other various aspects of the Law, my mind started to wander and it was only with great difficulty that I was able to maintain my attention. Why would this man abandon medicine for this nebulous field in which nothing was certain and experts for hire could argue, sometimes successfully, that the moon was made of cheese, black was white and up was down?

After some time of this bamboozlement the speaker announced that the interactive session would begin in which he would provide real world examples and invite us to consider whether the cases presented would pass or fail the tests he had outlined regarding the duty of care. I thought this would be equally tedious but was in fact very wrong about that. A case of unexpected sympathetic ophthalmia was presented, though by a speaker unfamiliar with ophthalmology to an audience unfamiliar with the case. It was interesting how quickly order broke down as people started arguing about what the operation performed actually was – it had been described as a 'removal of scar tissue' – and what the local practice was at their own hospital. Keen young ophthalmologists started volunteering how thorough their own consenting process was, while others would ruminate about the nature of the operation and others still would argue that it was the person who managed the sympathetic ophthalmia who should have been sued.

As the advocate answered the questions it became increasingly clear that the Law was nothing if not demanding with respect to the information given to patients.

Consent was a process and not an 'event.' Signing a form and expecting the process to be finished was hopelessly inadequate. So what about operations performed the same day as the consenting process was commenced and said form signed? The advocate chuckled at those who would consider such proposals in line with what the Law demanded. Some people volunteered that they did this as part of their own practice. A comment was made about 'one stop' anti-VEGF clinics being utterly useless then and the speaker, presumably unaware of what anti-VEGF was, shrugged in what appeared to be potential agreement. But it was better for patients! Ah, but sometimes that is not in line with what the Law demands. We can't cover every single risk surely? But the Law demands every effort be made. What if we wrote in the notes 'every risk discussed'? Ah (slight chuckle) things written in notes may be useful but not much and that statement is useless. What about pre-printing all the risks on a sticker or form to make sure each one is covered? Pre-printed! The advocate was aghast! How could such blasphemy be considered?

Growing tired of this a man on my own table huffed that perhaps patients should be consented about the risk of crossing the road to get to the clinic as well. The speaker explained that that was far from standard practice, however some consideration of the dangers of the patient environment was also warranted. Somebody then volunteered how a patient had tripped in their own eye unit once and it was with great difficulty that the speaker got through his three cases. In fact, there may have been more than three cases but the pain of utter lack of consensus might have caused him to break off early.

So what did I learn about the consenting process for ophthalmology in the wake of the Montgomery ruling? I can summarise it for you so that you won't have to attend future seminars on this matter. Make sure you discuss all the risks with the patient using their own language, at an appropriate pace, and document that you have done so on the consent form and in the notes. Each consent is individual to a patient and an assessment must be undertaken regarding what the patient wishes to know prior to embarking on the consenting 'journey'. This assessment must also be documented in the notes in perfectly legible writing. Every risk must be mentioned, however rare, at the same time as respecting that the patient cannot understand and retain too much information at any one time. You must not make the patient anxious by telling them too much information or anxious by not telling them enough. It is important to mention all the risks but using pre-printed forms is out of order. This process must be repeated if the patient desires and must not be time dependent. Getting the patient to sign a form is both absolutely mandatory for a valid consent but also utterly useless as a defence of a valid consenting process having taken place.

If you follow all these instructions you will be at an extremely low risk of being sued for negligence. Partly because a valid consenting process has been attempted; much like religious faith a perfect consenting process seems to be something people aim for but is in actual truth utterly out of bounds for normal people to even contemplate successfully achieving. But mostly because a consenting process fulfilling the Demands of the Law would take longer than a single human lifetime. Patients would grow old and doctors retire before a consent process became valid. And because of this nobody would be sued because of an unsound consent as no operations would ever take place. The phaco machines of the land, like the mills of Lancashire, would lie idle. Or, you will do as I do and get the patient to sign a useless piece of yellow paper knowing full well that legally speaking if the patient complains you never did have and never will have any legal protection and cheerfully carry on your business much as before; the medico-legal equivalent of the patient with gigantic inoperable abdominal aortic aneurisms that may burst at any moment and kill off our careers at a moment's notice. Who would consent to practise medicine under these strictures?

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