Consent can be made easier

During a surgical consultation, potential complications are discussed. But, how much we should mention?

We discuss complications so the patient can say no to surgery if they decide not to take the risk. Complications can be presented as a list, sometimes long, and academic. Sometimes patients decide the surgeon lacks positivity because complications are discussed. A patient can easily conclude "if something untoward happens, I have nobody to blame but myself."

It is time to rethink the issue and use the consent idea so it becomes more valuable, rather than a list recited, possible but remote, forced upon us and repeated with a tone of resentment and reluctance. Consent can be a useful tool instead of a catechism.

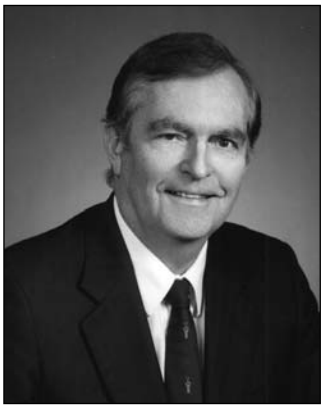
Suppose we focus on what we know patients want when they come to see us. For example, patients want a diagnosis expressed clearly in common language by a relaxed surgeon with time to explain. They want the surgeon's opinion as to the one best way to fix a problem, and why the surgeon thinks that way is best. If there is another way, one which is not as good but still a reasonable choice, they want to hear that too, especially if it offers something good, such as a faster recovery.

It is not a good idea to present a long list of available options. This implies that the choices are more or less equal and shifts responsibility to the patient. It implies the surgeon is only a technician, and diminishes his or her role as a physician; one that offers a reasoned judgment based on training and experience. He or she becomes the waiter delivering the meal the patient has ordered.

First comes the history and examination. Then the best operation or treatment is presented. Now is a good time to bring up the concept of risk, ie, that surgery cannot be done without risk, and that generally speaking, patient and surgeon can act as partners to reduce that risk.

Everyone knows that bleeding and infection can follow surgery but they may not know that these can affect the result in ways that can have implications, eg, skin loss or loss of an implant. So, when these things are mentioned, the tone is that of accepting the risk and reducing it if possible, understanding that these things do occur, and the importance of early treatment.

As this discussion proceeds, there will come a point when the surgeon sees that the patient trusts the surgeon. It might be a comment, it might be an imperceptible change from anxiety to relaxation, but it signals that the consent idea has been accepted, and that trust has occurred. This trust is a nonverbal way of saying "I know you cannot predict everything that will happen to me, but I have decided I can depend on you if things go wrong, and you will see that I am looked after."



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If the surgeon does not see this happen it means no matter what he or she said, or how extensive a list he or she gives, consent is at best doubtful or has not occurred, and he or she would be best not to proceed with surgery, at least at that time.

Making notes about this can be useful in performing surgery. Short paragraphs on issues such as the problem, the surgeon's prime opinion, the main complications and how these could affect the result, prevention and treatment could be helpful. This way, we could avoid presenting long standard complication lists in the tentative belief that we are somehow liable if we do not mention the one complication which eventually occurs, even if it is rare. Our job is not to be bookkeepers of fate, but rational presenters of our experience of risk, and our mastery in treating these unfortunate events leading to eventual success.

The consultation can be as important as the surgery, and should be paid recognizing this, for this is where the major weighing, balancing and thinking is done.

A consent takes time to consider, so the patient should be given time to make a decision one way or the other. The day of surgery is a good time to review, but not the time to do a consent for the first time, unless surgery is emergent.

So, with a reasoned progression of thinking, the visit and consent can be made easier. Simple descriptions of the individual's problem will remind the surgeon of the unique aspect of each patient and aid in reminding him or her why this operation is better than an other operation. In doing so, we can avoid the rote repetition of long complication lists which tend to hinder and alarm, and serve little useful purpose.

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