

Multidisciplinary Approach to Consent in Arthroplasty Surgery

Abstract:

The process of consenting has been in the heart of the surgical practice as the binding contract between the informed patient and the entrusted treating surgeon. This is to protect the patient's autonomy and respect their right to determine their treatment. Consent validity relies on the provision of procedure information and the capacity of competent patient to understand it. The Irish law states no medical or surgical treatment to be carried out without informed consent of the patient, however the law is not exactly clear in how much information to be provided prior to obtaining consent for administration of medical treatment or procedure. The Irish medical council guidelines published in 2008 defines the significant information as any risk over 1-2% or any risk of grave consequences. It also implies the patient understanding is crucial part of the process.

In busy surgical services time constraints in clinics make it difficult to give every patient the time to engage in proper informed dialogue and consent regarding their surgery. Moreover consent on admission is generally the responsibility of senior house officers who may not have a full understanding of the proposed surgical procedure and associated complications. Sometimes in an effort to protect the patients from unnecessary anxiety the gravest parts of the complications are omitted. Furthermore, recent literature has demonstrated a 38% failure rate to recall procedure specific information after the routine consenting and counselling procedure. The experience of providing patients with information booklets before surgery in an attempt to solve consent issues is becoming ubiquitous across all surgical disciplines.

Unfortunately the literature suggests providing information leaflets does not improve the level of understanding of the proposed procedure. Verges et al showed evidence that providing written information to patients undergoing coronary angiography did not modify their knowledge in respect to modalities and profits. Occasionally such deficits in the patients' knowledge is not sought nor volunteered by patients prior to signing consent forms. Patients may also have certain trepidation to question or seek explanations for information in the pressurised out-patient or admission ward environment. Lately, multimedia patient education in arthroscopy showed promising results in preoperative understanding of the procedure with a higher retention of the knowledge up to 6 weeks postoperatively.

In our orthopaedic unit we adopted a different approach to the problem. All patients who are undergoing an elective arthroplasty procedure are requested to attend the joint arthroplasty school with the desired members of the family. The school is co-ordinated by a joint specialist nurse and involves informal engagement by the entire multidisciplinary team. The team involves all disciplines that the patient will encounter from pre-operative assessment, anaesthesia, surgical, physiotherapy, occupational therapy and nursing. It takes the format of an open class where information is delivered through standardized multimedia presentations containing simplified information, anatomical models of the implanted prostheses, video of the proposed surgery and a supplementary package containing leaflets and guidance literature reflecting the joint school content. The information is delivered in chronological manner matching the inpatient experience including admission process, anaesthetic review, surgery, rehabilitation and physiotherapy, occupational therapy, preparation for discharge, community care, outpatient follow-up and annual follow up. The platform encourages open communication and dialogue where patients and their families interact and discuss their wishes and concerns regarding the surgery. This interaction between the patients allows them to share experiences and formulate better recovery plans.

The school allows patients to bring along a close friend or family member. This enables the immediate family to understand and know what to expect during the course of the surgery and the aftercare required. Patients are encouraged to see this person or family members as a coach or as a companion on the surgical journey. This empowers patients with the knowledge that they are at the core of the surgical procedure. On the other hand as surgeons this dynamic process provides us with a unique insight as to the issues and concerns that patients have regarding surgery. This experience does not eliminate the usual consent form or information booklets. Instead it adds depth and affirmation to the process by delivering the information in a timely relaxed fashion. This allows the information to be digested and adds clarity to the printed information making the content more understandable for the patient. It also makes the process more robust legally as the information has been delivered several times prior to obtaining the written consent agreement.

The trial in our institute showed great enhancement to the Rapid Recovery Program in the arthroplasty service. Through this approach we were able to enrol 478 patient in 2012 and 370. This led to improved day of surgery admission rate of 75% in those two years. This was also coupled with high satisfaction as reflected in the Patient Reported Outcome Measures (PROM). The concept of a joint school coupled with patient reading materials fosters an environment of education and understanding between patients and staff prior to surgery. The patients themselves give constant feedback as they are so involved in the process and this allows reciprocity of thought, ideas, change and feedback throughout their journey. Success of the programme is dependent on holistic care planning, coupled with the team work ethos which empowers the patient to take an active role pre and post surgery, the patients are guided, educated and encouraged to take ownership of their recovery.

KMS Mohamed, D Foy, D Cogley, DM Niall, E Sheehan
Midland Regional Hospital, Tullamore, Co Offaly
Email: khalid1100@gamil.com

References

1. White SM, Ashley M. Consent. *Anaesthesia & intensive care medicine*. 2012 April 2012;13:141-4.
2. Consent to medical and surgical procedures [web page]. Citizens Information Board; [updated 24/06/2010; cited 2013]. Available from: http://www.citizensinformation.ie/en/health/legal_matters_and_health/consent_to_medical_and_surgical_procedures.html.
3. Good Medical Practice in Seeking Informed Consent to Treatment [online PDF book]. Medical Council; 2008 [updated 27/02/2008]. Available from: <http://www.medicalcouncil.ie/News-and-Publications/Publications/Information-for-Doctors/Good-Medical-Practice-in-Seeking-Informed-Consent-to-Treatment.pdf>.
4. Anderson OA, Wearne IM. Informed consent for elective surgery--what is best practice? *Journal of the Royal Society of Medicine*. 2007 Feb;100:97-100.
5. Wheeler R. Consent in surgery. *Annals of the Royal College of Surgeons of England*. 2006 May;88:261-4.
6. Oosthuizen JC, Burns P, Timon C. The changing face of informed surgical consent. *The Journal of laryngology and otology*. 2012 Mar;126:236-9.
7. Verges M, Leclercq F, Davy JM, Piot C, Gervasoni R, Pasquie JL, Cornillet L, Sportouch-Dukhan C, Raczka F, Cung TT, Macia JC, Roubille F. [Are patients undergoing coronary angiography well-informed? Prospective evaluation of the effectiveness of written information]. *Annales de cardiologie et d'angiologie*. 2011 Apr;60:77-86.
8. Arthur VA. Written patient information: a review of the literature. *Journal of advanced nursing*. 1995 Jun;21:1081-6.
9. Astley CM, Chew DP, Aylward PE, Molloy DA, De Pasquale CG. A randomised study of three different informational AIDS prior to coronary angiography, measuring patient recall, satisfaction and anxiety. *Heart, lung & circulation*. 2008 Feb;17:25-32.

10. Cornoiu A, Beischer AD, Donnan L, Graves S, de Steiger R. Multimedia patient education to assist the informed consent process for knee arthroscopy. ANZ journal of surgery. 2011 Mar;81:176-80..
11. Blum ML, Kumar P, Tran P. Multimedia patient education to assist the informed consent process for knee arthroscopy (Re: ANZ J. Surg. 2011; 81: 176-80). ANZ journal of surgery. 2011 Oct;81:747.
12. Bollschweiler E, Apitzsch J, Obliers R, Koerfer A, Monig SP, Metzger R, Holscher AH. Improving informed consent of surgical patients using a multimedia-based program? Results of a prospective randomized multicenter study of patients before cholecystectomy. Annals of surgery. 2008 Aug;248:205-11.
13. Ryan F, Shute J, Cedro M, Singh J, Lee E, Lee S, Lloyd TW, Robinson A, Gill D, Hunt NP, Cunningham SJ. A new style of orthognathic clinic. Journal of orthodontics. 2011 Jun;38:124-33.