

Consent in cardiac practice

The issue of consent has a particular bearing on cardiac practice. Cardiac disease is common, has serious consequences, and frequently requires invasive investigations and treatments. In this issue there are several articles relating to the issue of consent. These range from the concise legal perspective¹ to the actual data from studies assessing the patient's perspective.^{2–4} The issue of consent must be considered in the wider context.⁵ There is an ongoing social shift with a greater focus on the "individual" and away from the "community". This has transformed many other spheres of society and is altering the doctor–patient relationship. Individuals wish to be more in control of their lives, or perhaps more importantly perceive to be in control of their lives, and that their individual needs are paramount. Although the individual's (or patient's) autonomy has long been recognised, in the past it has not been so strongly emphasised. This in part has been the result of the attitude of the medical professions, but cash constrained health care resources, with the implicit priority of achieving the greatest benefit for the greatest number of people with the least cost, has also played a pivotal role. Recently this change has occurred in accelerated phases after a number of high profile cases such as Bristol. Although at the time the reaction to these cases has not necessarily been considered, the reaction has strongly influenced the change process. There have been changes in interpretation of the law, which indirectly have had a bearing on how consent is obtained. A combination of "no win no fee" and Lord Woolf's reform of the civil justice procedure,⁶ which encouraged out of court no blame settlements, may result in more complaints and possibly litigation.

Informed consent

The underlying principle has been cited as informed consent. However, it is only recently that we have started to move towards a clear legal definition.¹ In simple terms, the doctor delineates the benefits and risks of the different available courses of action and the patient chooses his or her preferred course of action. Unfortunately, the reality is more complex. If patients are to be given information about risks it is unclear how much is "required". The recent General Medical Council guidance on seeking consent provides a list of items, which patients should know before consenting to treatment or investigation. These include the purpose of the investigation, details of what the patient might experience during or after the procedure, and common and serious side effects. The legal standard of disclosure is defined with respect to the Bolam test,⁷ namely information of the amount and quality that "a reasonable body" of medical opinion would consider appropriate. The Medical Defence Union has proposed the standard of the "reasonable person", although the courts are less specific as to the applicability of an objective test. It is also the case that patients themselves are not uniform in their need for information, and Beresford and colleagues³ show that there is variation in

the patient's wish for information, from those who want to know everything to those who do not want to know anything.

It was perhaps put best by Lord Bridge in the *Sidaway v Governors of the Bethlem Royal and Maudsley Hospitals* case⁸ who said: "From the ethical point of view the issue is more about how best to inform than whether to inform. If a patient asks for particular information they be very unusual circumstances that would justify not being open and honest with a patient."

Individualising risk

An important step towards providing informed consent is to provide individualised risk (and benefit). The principal determinants of this are the clinical setting (emergency *v* elective), patient clinical characteristics, and institutional (and possibly operator) variables. There are extensive data from both observational and randomised studies that can give accurate figures on the first two determinants. More data are starting to become available on the performance of institutions. It is likely that in future much of this information will be in the public domain. However, the data are based on populations, and translating these results to an individual is difficult. Patients want to know individualised data—that is, what is likely to happen to them. What doctors can offer, at best, is based on groups of (ideally) similar patients.

Communicating the information

It is important that information is presented in a manner that patients can understand. Risk is often presented in the form of probabilities or by the use of qualifying adjectives such as low or high risk. However, research has shown that patients find it difficult to comprehend magnitude or risk and that the definition of high and low risk may vary between different patients.⁹ Another major hurdle to communicating risk is the lack of a common language in which to describe risk.¹⁰ Various verbal and visual scales to represent risk have been proposed. A risk of 1 in 100 or more would be high whereas a risk of 1 in 1000 or less would be low. However, these magnitudes cannot readily be translated by everybody into meaningful concepts upon which to base decisions. In order to provide meaningful comparators other investigators have suggested using easily understood contexts to describe the scale of risk, such as the National Lottery.¹¹ These examples should have relevance to the patient's life. Patients feel more comfortable getting information from a visual medium such as television than a booklet. Avenues such as giving patients videos to take home may be a possibility.

Perhaps the most important aspect to consent is the development of trust within the doctor–patient relationship, based upon open communication. In the paper by Ågard and colleagues⁴ patients feel that actual demand of written informed consent is not necessary. They put their trust in doctors. If a trusting relationship has developed

between doctor and patient the whole process, including the problems which inevitably will occur from time to time, will be easier to deal with.

Consent should not be seen in isolation, but rather as a component of communication between doctor and patient. Explaining to the patient what is going on should start at the very first consultation and should be an ongoing process. It is difficult to justify obtaining consent from a patient for an elective procedure as the house officer is about to insert an intravenous line and the catheter laboratory are looking on, anxious to proceed. Consent must be seen as an integral part of the process that does not begin and end with the signing of the form just before the procedure. It is not acceptable to say that there is an ever increasing demand to increase workload and so consent has been compromised; additional time and money will need to be spent. We need to decide whether it is optimal and/or appropriate for all the consent issues to be discussed with the operating doctor. There are good arguments for the use of specialist clinics where patients have more time to discuss and understand their disease, the proposed investigations, and treatment. Oldroyd and Docherty² describe the use of preadmission clinics where in addition to assessing the patient the procedure is explained along with the benefits and risks. These clinics will also have an important role in the training of junior staff. Their own understanding of the risks and benefits of their practice will improve. In an emergency the time for lengthy explanation and discussion is limited. Even in these situations an explanation may enable the patient to feel more in control about a procedure which they find frightening.

Evolving practice

We are only at the start of the debate on consent. It is clear that patients want greater individualised information on which to base their decisions. Where this change is leading

to is less clear.¹² In order for us to have a greater role in the changes we need to be more proactive. We need more studies looking at issues such as consent. The information obtained will provide a better basis for changing practice than the present haphazard manner in which the subject is evolving.

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STAMPS IN CARDIOLOGY

Thoracic CT



On 27 September the Royal Mail released a set of four postage stamps celebrating the role UK scientists have played in medical technological advances. The stamps feature ultrasonic imaging (fetal), scanning electron microscopy, magnetic resonance imaging (head), and the 41p stamp depicts thoracic computed tomographic (CT) scanning. The image for this stamp was provided by the radiology department of the Royal Victoria Infirmary. A small variety of different first day covers were produced in conjunction with this set. These included covers featuring the Royal College of Surgeons, the Lancet, and the British Medical Association which is illustrated. The stamps were designed by Pierre Vermeir and printed in the Netherlands.

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