"You never told me that could happen!" Consent and litigation: how to avoid it

More and more negligence cases against doctors include allegations that consent was not adequately obtained. Patients claim that they were not warned about the risk of complications, the probability of a successful outcome was not discussed, or that alternative procedures were not explored.

It certainly can seem that whenever something goes wrong, patients want to sue the individual concerned. If they cannot show that the doctor was negligent in the procedure that was performed, they often claim that "you never told me that could happen". To help avoid litigation in this area, three factors should be considered:

(1) What you tell the patient;
(2) How you tell them; and
(3) What you record in the notes.

What do you tell the patient?

Whenever obtaining consent for a procedure, the following information must be given to the patient:

- Who you are;
- What you propose to do;
- Why you recommend this action;
- Who will complete the procedure;
- Who will assist with the procedure;
- What the chances of success are;
- What risks, complications, and side-effects may occur;
- What alternative treatment options there are;
- What happens if the patient says no; and
- What the costs are.

The doctor also needs to answer any specific queries that the patient may have. The area that causes most concern is that of warning the patient of risks. Do you tell the patient about the one in one hundred thousand chance of death, or the one in ten chance of transient numbness around the wound? Unfortunately, there is no formula to answer such questions.

The law currently follows what has been called the 'prudent doctor test'. Simply put, this means that a doctor is only obliged to advise of risks to an extent in keeping with that of a reasonable and responsible body of medical opinion. However, even if a doctor decides not to disclose all conceivable risks, the doctor cannot decline to do so when specifically asked about them by the patient. Secondly, when a doctor fails to disclose a substantial risk of grave adverse consequences, a court is at liberty to find the doctor in breach of the duty to advise. Thirdly, a court may reject expert medical evidence if it cannot be demonstrated to the court's satisfaction that the body of opinion relied upon is reasonable or responsible.

In a number of countries the law is tending to follow the American doctrine of informed consent and what is known as the 'prudent patient test'. This means that there is no liability on the doctors' part if a prudent person in the patient's position would have accepted the treatment even if he or she had been adequately informed of all significant risks and complications. These complications may range from commonly occurring risks of minor significance to rare risks of major significance. The emphasis is on what the patient feels would be significant and obviously differs according to the individual patient.

One practical way to determine what information should be given to the patient is to imagine that you are talking to a close relative who is undergoing the particular procedure.

How do you inform the patient?

Effective communication is essential for any successful consultation. This is even more relevant when explaining a procedure and the inherent risks involved in order to obtain consent. Here are some points to consider:

- It is not enough to simply give written or verbal information to the patient. The information must be given in a form the patient is able to understand. The procedure should be explained in non-technical terms. The patient must be given time to digest the information, and you must be available to answer any questions.
- Involving the patient in the decision-making process helps to build trust and can avoid difficulties should problems arise.
- The probability of a successful outcome should be explained in the context of what the patient believes or expects and not in terms of what the doctor believes or expects. Patient expectations are influenced by many factors and are often much higher than a doctor's. Even when a procedure has been successful in the eyes of a doctor, a complaint or claim can often be triggered if the outcome fails to meet the patient's expectations. Exploring the difference between the doctor's expectations and the patient's expectations before consent is obtained is therefore vital.
- Raising unrealistic expectations in a patient is a dangerous practice. While it is essential to instil confidence in your abilities, it is important that the prospects of success or the likelihood of complications are discussed with the patient in realistic terms.
- Patient leaflets that explain a procedure, the likely outcome, the risk of complications, and postoperative care are extremely useful as aids to obtaining consent. They are, however, no substitute for talking and listening to the patient. Patients must be given time to read such material and have an opportunity to ask any questions that arise. Involving patients in drafting information leaflets can help

to ensure the information is easily understood and addresses areas of patient concern, some of which a doctor may not have considered. Websites are also useful for providing information, but again are no substitute for patient-doctor discussion.

Other members of the health care team also assist in providing information for patients. Notwithstanding, there should always be an opportunity for the patient to discuss planned treatment directly with the doctor who will perform the procedure.

What do you record in the notes?

When a patient decides to sue a doctor, they always appear to recall what the doctor did not say. Doctors cannot and are not expected to recall all exchanges with patients; thus, medical records are essential to assist in the defence of a claim against a doctor.

Consent forms and patient records

As has been seen, valid consent is more than a signature on a consent form although the consent form is a useful piece of evidence should the patient claim that he or she did not give consent. If a patient leaflet has been used, it is helpful if the patient signs that it was received and understood and this should be documented in the medical notes. Any questions that the patient asks should also be documented along with the answer provided. If a patient raises a particular concern that the doctor considers trivial, this question and answer should nevertheless be recorded, as experience suggests that such issues form a likely future focus for a patient complaint.

The following two cases illustrate the importance of good record-keeping with respect to obtaining consent and defending a negligence case.

Case 1

A man in his 30s underwent varicose vein surgery to both legs, having previously been treated by injection sclerotherapy. The patient complained of postoperative numbness affecting part of his left foot. This symptom was reported as constant over the following two and a half years. A claim was brought against the surgeon alleging negligent and unskilful surgery, and failure to warn of the risks of the surgical procedure.

The patient denied that there had been any preoperative discussion concerning the possibility of postoperative numbness. The surgeon stated that he always warned patients that there might be damage to cutaneous nerves with this surgery and that the risks were outlined in an information leaflet given to patients.

Though an advice sheet provided by the surgeon did refer to the risk of numbness, the patient denied that he had ever seen this sheet and there was no written record to refute this contention. The medical notes in this case were very brief and there was no mention of discussion of the procedure itself or the risks involved. In addition, the consent form was not signed by the medical practitioner in question. The case was therefore indefensible, and an out-of-court settlement was negotiated.

Case 2

A middle-aged man with recurrent pain in his lower back was referred to a specialist neurosurgeon. A computed tomography scan showed a right-sided prolapsed disc at the level of L4/5 and the neurosurgeon performed a lumbar microdiscectomy. The operation proceeded uneventfully, apart from a small thecal tear that was repaired.

The patient made a good recovery, but 6 months later, the pain returned. Further investigations revealed that the patient had a recurrent prolapsed intervertebral disc. The patient sued the neurosurgeon, claiming he had failed to warn him of the possible complications associated with the operation and about the thecal tear.

An expert who examined the case could find no evidence of negligence on the part of the neurosurgeon. Preoperative counselling in which the patient had been informed of the risks associated with the procedure was clearly documented in the medical records. The Medical Protection Society denied liability on behalf of the neurosurgeon and the claim was withdrawn before the case came to court.

It is clear from review of these cases that both patients suffered from a recognised complication of the surgical procedure they underwent, which did not in itself constitute negligence. What distinguishes the second case from the first is that the neurosurgeon clearly warned the patient of the relevant risks and scrupulously documented this fact.

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