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## WELFARE OF ANAESTHETISTS SPECIAL INTEREST GROUP

### COMMUNICATION AND CONSENT: YOUR BEST DEFENCE

#### INTRODUCTION

Recent studies, both in Australia and overseas, have confirmed that one of the prime reasons for patients seeking to make claims against their health care provider after an adverse outcome is the manner in which the provider dealt with them and communicated with them.

In other words, the way doctors and hospitals communicate with their patients after an adverse event may substantially influence whether the patient considers making a formal claim or even suing for negligence.

The doctor who is attentive, responsive and sympathetic after an adverse outcome is less likely to be sued than the doctor who is dismissive, distant or less empathetic.

It is common knowledge that there are doctors who achieve less than optimal outcomes, but whose patients would never think of taking action against them. That is because their patients “love them” as a result of the attention, empathy and friendly treatment they receive.

There are certainly occasions when doctors, despite their best efforts, and with no suggestion of legal negligence, nonetheless face claims from patients because of the perception of less than optimal outcomes, or the perception of poor care.

#### Best practice communication in healthcare occurs:

- **Before the procedure** – informing the patient in relation to realistic outcomes, risks, side effects and costs (especially out of pocket expenses). The patient’s perception of what to him or her is a “Material Risk” can be elicited.

This is both a legal obligation (“**informed consent**”) as well as ensuring that patients do not have unrealistic expectations of their care and outcomes.

- **After the procedure** – dealing with adverse outcomes (whether or not legally “negligent”).

Prompt, sensitive and frank discussions can mitigate the patient’s inclination to sue or complain

(“**Open Disclosure**”) see Resource Documents RD 05, RD 10 and RD 14).



## INFORMED CONSENT

### THE DUTY

In *Rogers v Whitaker*, the Australian High Court confirmed the existing obligations of doctors to exercise reasonable care and skill in providing advice and treatment to patients.

The standard of care and skill required is that of the ordinary skilled person exercising the particular specialist skills involved. Whilst the law has always recognised that a doctor has a duty to warn a patient of a material risk inherent in any proposed procedure or treatment, the High Court has formulated a higher standard required of doctors.

"A risk will be considered material if, in the circumstances of the particular case, a reasonable person in the position of the patient, if warned of the risk, would be likely to attach significance to it, or if the medical doctor is, or should reasonably be, aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

Thus, when considering the need to inform a patient of a particular risk, there will be two separate matters that require consideration:

- **Would a reasonable person, in the position of the patient, be likely to attach significance to the risk ?**
- **Is the doctor aware, or should the doctor be reasonably aware, that this particular patient would be likely to attach significance to that risk ?**

The High Court decision places a high burden on practitioners to ensure that all material risks are considered, and that the particular circumstances of the patient are considered.

### FACTORS TO CONSIDER

These can involve a number of factors:

- Would the risk influence the decisions of a reasonable person in the position of the patient ? The risk might be so slight that no reasonable person would be influenced by it.
- Obviously, the more drastic the intervention or procedure, the more necessary it is to inform of risks and consequences.
- The desire for information by the patient necessitates greater disclosure, even if the patient says that s/he has no desire for information, the doctor might have to carefully evaluate the patient's real wishes. In *Rogers v Whitaker*, the patient was particularly inquisitive and anxious about the procedure.
- In some cases, the temperament and health of the patient might be considered. It may be that disclosing information may be injurious to the physical or mental health of the patient in some cases. The doctor can apply reasonable judgment as to what and how to disclose.
- The existence of emergency situations, or lack of opportunity for proper counselling or discussion, can affect the obligations to disclose. Clearly, in an emergency environment where there are major time constraints, the information that can be disclosed may be minimal or not possible at all.



- Special issues arise in relation to the obtaining of consent from giving adequate information to children, teenagers, and those patients who, for whatever reason, are not competent to make a decision.

Medical defence organisations and some recent studies support the view that patients are less likely to sue their doctor if an adequate and caring explanation is given when an adverse outcome (or even negligence) occurs.

Information and education for patients is one way doctors can reduce their risk of litigation.

Part of the problem of recent times is that patients, encouraged by some doctors, have come to expect perfection - and they are disappointed, even angry, when less than perfect results are obtained.

## **THE PROBLEM FOR THE MEDICAL PROFESSION**

The decision in *Rogers v Whitaker* ignores the fact that practitioners do not operate in a perfect world, and that, in many cases, all of the requirements of proper "informed consent" may be very difficult to achieve.

These difficulties include:

- Informed consent may require detailed and time consuming discussions with the patient. The Medical Benefits Schedule does not necessarily recognise or reward such endeavour.
- Communication skills of doctors, and indeed patients, vary considerably. Training courses for doctors on communications skills are now available.
- Patients themselves have different abilities or willingness to take in information, or make decisions about their treatment. There will be reactions ranging from fear or aggression, to meek compliance. This will affect the type of communication involved with the patient.
- Cultural factors may complicate the consent procedure in patients from different cultures. For those from non-English speaking backgrounds, the availability of interpreters becomes an issue. Children should not act as interpreters, since there may be differing abilities in adequately communicating the message.
- The circumstances in which practitioners have an opportunity to convey information is never perfect. The ability to have one, two or even three meetings with a patient to discuss the issue is difficult in most cases. In an emergency, it may be impossible.
- For anaesthetists, radiologists and others with limited contact with a patient, it becomes very difficult to obtain appropriate consent. In hospital situations, where hospital administration controls most of the patient contact, the opportunities for the surgeon to gain consent may also be limited.

## **DELEGATION**

Of course, doctors in busy hospitals cannot act as in a perfect world, and do not have unlimited time in which to properly consider all of the issues and risks, no matter how remote, that may affect the patient's decision.



Many doctors, unwisely, sometimes delegate the task of explaining the risks to patients to assisting doctors, trainees, or other hospital staff. Doctors are entitled to delegate this responsibility to others. Doctors who leave "informed consent" to assisting or junior doctors run the risk that the other doctors do not do the job properly, or do not have the skills to do so; they may bear the liability if the others do not properly advise patients.

It is clearly the responsibility of the treating doctor or proceduralist to obtain informed consent from the patient, and to advise the patient of all material risks. If this is not done properly, the treating doctor bears the legal responsibility.

Doctors who rely simply on consent forms, hospital administration, or other bureaucratic processes, run a substantial risk.

"Consent should be obtained by the person who will touch the patient. The doctor who delegates his responsibility to a hospital employee, such as a nurse, takes the risk that the consent obtained may be inadequate" (Picard. *Legal Liability of Doctors and Hospitals in Canada* (1994) pages 66-67.)

## **STANDARD CONSENT AND INFORMATION SHEETS**

It has been suggested that the use of standard consent forms and information sheets will be sufficient to maintain "informed consent". As has now been noted in a number of journals and guidelines, standard information forms can have some use, but are no substitute for proper information given to a patient.

Under the requirements of the Australian High Court decision, the information to be given to a patient must be tailor-made to the particular patient. It must take into account the particular circumstances of the patient, the particular requirements of the patient, and what that particular patient considers to be a "material risk".

Similarly, a simple form signed by a patient is not conclusive proof that valid consent has been obtained. Indeed, in many other legal cases involving guarantees and contracts, the simple signature of the party involved has never been a deterrent to action being taken to contest the guarantee or contract, or to the courts accepting that the plaintiff should not be bound.

Prepared consent forms and prepared information sheets certainly have their place, and can be used as a prompt or checklist for the discussion that must take place between doctor and patient.

They are also useful for the patient to take away after the discussion as a reminder of some of the issues that had been considered. However, they are not, in themselves, adequate to ensure that informed consent has been obtained.

## **6 OPEN DISCLOSURE**

As part of the response by governments, both Australian Federal and State, to the medical indemnity crises in the 1990's, legislation was introduced into most states to permit "Open Disclosure" after an unanticipated outcome of treatment. That is, the legislation now permits doctors to have a frank discussion with their patients, without there being any adverse legal implications or an admission of legal liability.

The legislation fosters the concept of openness, and a frank discussion with patients or relatives after an adverse outcome (whether or not there has been negligence). There can be an open



acknowledgment of an adverse outcome, and even an apology (to express regret for the fact that the patient has not had an optimal outcome).

It may not be “trendy” in Australia to give an apology. However, in the case of adverse events, an apology may well be a critical factor as to whether a patient or relative sues a doctor or not.

Legislation in Australia now allows doctors to deal with adverse outcomes, without there being any admission of liability, by:

- expressing regret or apologising for an adverse outcome;
- expressing sorrow or sympathy;
- reducing fees; or
- waiving fees entirely.

Such events will also not constitute an admission of professional misconduct, or otherwise expose the doctors to civil liability for carelessness, incompetence, or unsatisfactory performance.

In addition to these legislative changes, the Australian Council for Safety and Quality Health Care (now a Commission) has undertaken a major project to draft standards or guidelines to assist doctors and hospitals in discussing these issues frankly with patients.

The standards address the following issues:

- openness and timeliness of communication;
- acknowledgment of the adverse event;
- apology or expression of regret;
- recognition of the reasonable expectations of patients;
- support for staff throughout the process;
- processes for risk management and systems improvement;
- governance frameworks to ensure appropriate clinical risk management;
- confidentiality.

The standard is designed to assist doctors, nursing staff and administrators in dealing with the issues raised by “Open Disclosure”.

Once an adverse event has occurred, it is important that the patient/relative is kept informed, as appropriate. The clinical team members should ensure that they:-

- establish the basic clinical and other facts relevant;
- assess the event and the level of response required;
- identify who will take responsibility for advising the patient;
- consider whether additional patients report is required;
- identify other support and needs;
- ensure that all appropriate staff are sufficiently informed and ensure a consistent response to the patient.

Clearly, as matters develop, patients/relatives should be provided with sufficient and up to date information, so that they feel appropriately informed. Recommendations for further remedial care should be made as soon as possible. Follow up is an essential part of the process.

Nonetheless, the process should ensure:

- confidentiality, privacy and professional privilege;



- responses to any negligent or criminal or unsafe acts (if any) including coronial investigations;
- any disclosure consideration of whether might further harm the patient;
- consideration of any other insurance or contractual arrangements.

These statutory reforms are helpful. They should give confidence to doctors and medical administrators to deal with adverse outcomes (whether negligence or not) in a caring and humane way.

It is, after all, human nature to be able to express regret and sympathy where a patient has had an adverse outcome to treatment or procedure, without such concern being considered an admission of legal liability.

### **Thanks to Mr Michael Gorton AM for this document**

### **Further reading**

Australian and New Zealand College of Anaesthetists (ANZCA) Professional Documents  
PD 26 Guidelines on consent for anaesthesia or sedation

Cyna A, Andrew M, Tan SGM, Smith A (eds)  
2010. Handbook of Communication in Anaesthesia and Critical Care. A Practical Guide to Exploring the Art, ISBN 978-0-19-957728-6

Australian Council for Safety and Quality in Health Care.  
2003. Open Disclosure Standard: A National Standard for Open Communication in Public and Private hospitals, July 2003, [www.safetyandquality.org/articles/Action/opendisclfact.pdf](http://www.safetyandquality.org/articles/Action/opendisclfact.pdf)  
Hospitals, July 2003, [www.safetyandquality.org/articles/Action/opendisclfact.pdf](http://www.safetyandquality.org/articles/Action/opendisclfact.pdf)

Welfare of Anaesthetists Special Interest Group Resource Documents  
RD 05 Critical Incident Support  
RD 10 Breaking Bad News  
RD 11 After a major mishap  
RD 14 Medico-legal Issues

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