Austin Journal of Surgery

Open Access

Austin Publishing Group

Editorial

Informed Consent for Surgery in Ontario Canada

Dennis F. Pitt*
Division of General Surgery, The Ottawa Hospital, Canada

***Corresponding author:** Dennis F. Pitt, Division of General Surgery, The Ottawa Hospital – General Campus, Box 202, 501 Smyth Rd., Ottawa, ON, K1H 8L6, Canada

Received: August 06, 2015; **Accepted:** September 28, 2015; **Published:** September 29, 2015

Editorial

Informed consent for surgery is of increasing importance in the practice of surgery and is a major issue in many complaints to regulatory bodies and in medical legal actions against surgeons. The Canadian Medical Protective Association reports that 65 percent of malpractice cases involving informed consent are surgical and only 21 percent of these cases are decided in favor of the surgeon [1]. The consent to treatment policy of the regulatory body in Ontario Canada, the College of Physicians and Surgeons of Ontario was updated in May 2015 and is the impetus for this article [2].

Surgeons have a legal and professional obligation to obtain informed consent from patients before providing treatment. This is based on patient autonomy and respect for their personal dignity. Our patients have the moral and legal right to make decisions about their treatment when they are capable or by their substitute decision maker when they are incapable.

The essence of informed consent is about what physicians should tell their patients. In the era of Hippocrates, patients were told very little because the doctor knew best and directed the patient's treatment. Some of this concept persists today and we do not give every patient a formal postgraduate level seminar on their disease. Henri de Mondeville in the 14th century advocated to always tell patients they would get better to keep their spirits up and to improve the likelihood of a good result. This was an early version of the power of positive thinking. Although we certainly inform patients of the material risks of surgery, we do it a manner that gives them hope of a successful outcome and does not terrify them. Surgery is stressful enough. Benjamin Rush, Thomas Percival and the American Medical Association in the 1800's began the practice of being truthful with patients and American physician, Worthington Hooker is credited with being the first to strongly advocated for never lying to a patient in his 1849 book, Physician and Patient [3,4].

Regulation of surgeons by the profession can be traced back almost 5000 years to the Code of Hammurabi on the black stella that sits in the basement of the Louvre. Law #218 in cuneiform writing states that a surgeon will have his hands amputated for bungling an operation. The term "informed consent" arose from a malpractice case in the courts of the United States in 1957. Legislation of the provincial government, the Health Care Consent Act of 1996 is the basis of policy set by the regulatory agency, the College of Physicians and Surgeons of Ontario [5].

The basic elements of valid consent are:

1. It is obtained from the patient if they are capable or if incapable, from their substitute decision make.
2. It is relevant to the proposed treatment
3. It is informed
4. It is given voluntarily
5. It is not obtained through misrepresentation or fraud

The information provided must include

1. The nature of the treatment.
2. The expected benefit.
3. The material risks and side effects.
4. Any alternate treatments
5. The consequences of not having the treatment.
6. In addition to the information that a reasonable person would require to make a decision, any specific circumstance of the patient have to be taken into account.

The court precedent of the specific circumstance provision was a patient who had a disabling CVA after elective carotid endarterectomy. If his surgery had of been delayed 18 months, he would have qualified for full pension benefits [6]. Another example is a patient with breast carcinoma who has to be advised of the risk of a complication of immediate breast reconstruction after mastectomy delaying her chemotherapy. Her situation is different than the patient having a prophylactic mastectomy and reconstruction.

There are hundreds of potential complications for most operations if we include everything possible but a patient does not have to be informed about every conceivable material risk. A surgeon has to use judgement to individualize the content of the discussion with the patient. If a patient would have had the surgery even if a risk was known, there is court precedent that the surgeon is not at fault. The onus is on the patient to show material risks not discussed (or the patient does not remember being discussed) would have caused the patient to refuse treatment. Causation is required to demonstrate liability [7]. The emphasis is on material risks that would directly affect the patient's decision regarding the proposed treatment. An example is the risk to the fetus of vaginal delivery after a Caesarean section. The percentage risk to the fetus of both procedures is essential information for the patient to decide between another Cesarean section or a vaginal delivery [8].

Reasonable steps must be taken to facilitate the comprehension of the information. Care is required when a family member is translating. We have all had the experience of giving a detailed explanation about the proposed surgery to patient who does not comprehend our language and the relative translating it into one word. Professional translators should be employed whenever feasible.

Citation: Pitt DF. Informed Consent for Surgery in Ontario Canada. Austin J Surg. 2015; 2(6): 1073.

Consent can be expressing (oral or written) or implied by actions or gestures. For surgical procedures, written consent is always necessary except in emergency situations.

No consent is required from a capable patient if there is a communication barrier due to language or disability, reasonable steps have been taken to obtain to obtain consent, delay would prolong suffering or increases the operative risk and the surgeon has no reason to believe the patient does not want treatment. Similar requirements apply to obtaining consent from the substitute decision maker for an incapable patient. If the patient is incapable and the substitute decision maker is not available, no consent is required if delay to obtain consent will prolong suffering or put patient at risk of serious bodily harm [4].

The following list is the priority for substitute decision makers [4,9]:

1. Guardian, if authorized
2. Attorney for personal care, if authorized
3. Person appointed by the Consent and Capacity Board, if authorized
4. Spouse or partner
5. Child or parent or individual/agency entitled to give or refuse consent instead of a parent
6. Parent with right of access only
7. Brother or sister
8. Any other relative by blood, marriage or adoption
9. Public guardian or trustee

Surgeons need to be alert for separated or divorced couples who do not have their former partners best interests at heart and occasionally the prudent surgeon will seek legal advice before embarking on the informed consent process.

A surgeon's prime defence in a medical legal action involving informed consent is a legible, understandable and contemporaneous note in the patient's record. Absence of documentation can be the major factor in a decision against the surgeon [8]. Patients memories of their conversation with a surgeon is not improved by the passage of time and the potential for large monetary awards. The recommendations for documentation are:

1. The date of the dialogue.
2. Who was involved in the dialogue?
3. The specific material risks that were communicated.
4. Any unique material risks related to the specific circumstances of the patient that were communicated.
5. The risks of not treating the condition that were communicated.
6. Whether consent was given or refused and by whom.
7. Any findings of incapacity and the identity of any substitute decision maker.

The elements of informed consent for surgery are constantly evolving as patient expectations of surgeons expand and we must adapt to these changes.

References

1. CMPA Risk Fact Sheet. 2013; 8.
2. Consent to Treatment. College of Physicians and Surgeons of Ontario. Policy 3-15. Updated May 2015.
3. Capron AM. (Almost) everything you ever wanted to know about informed consent. [Review of: Faden, RR and Beauchamp, TL. A history and theory of informed concsent. New York and Oxford: Oxford University Press, 1986]. Med Humanit Rev. 1987; 1: 78-82.
4. Bums CR. Legacies in Ethics and Medicine. New York, Science History Publications. 1977.
5. Health Care Consent Act. Current version 2010. Statutes and Regulations of Ontario. 1996.
6. Hughes RV. SCC 880 CanLII. 1980.
7. Smith AV. SSC 360 CanLII. 1997.
8. Cojocaru V. British Columbia Women's Hospital and Health Centre. SCC 30 CanLII. 2013.
9. Substitute Decisions Act. 1992; 30.

Austin J Surg - Volume 2 Issue 6 - 2015
ISSN : 2381-9030 | www.austinpublishinggroup.com

Citation: Pitt DF. Informed Consent for Surgery in Ontario Canada. Austin J Surg. 2015; 2(6): 1073.