Informed consent - more than a signature?

It's coming to the end of morning surgery in your practice. As the senior RVN, you have been running a busy and diverse nurse clinic, and you feel a sense of relief when you see that the next patient is Karla, a beautiful black Newfoundland who was in for a routine spay last week. It is a bit early for stitch removal, but you hope it is just a routine check. Opening the door to the waiting room to see where Mr Beddow and Karla are seated, you notice that your client is looking uncharacteristically grumpy. As you call him in, he is shaking his head and muttering "Doesn't look right, it's not healing." After examining Karla's wound you agree with him. There is swelling and inflammation along the line of stitches, with some blood-tinged discharge. You empathise with both the client and the patient. After referring your client on to the next available veterinary surgeon, you think back to Karla's admission. You remember going through post-operative care with Mr Beddow, especially the need for Karla to wear a plastic cone to prevent interference with the wound.

At lunchtime, the vet who saw Karla explains that she has started Karla on antibiotic therapy, and that although Mr Beddow has been using the collar, the wound has become infected because Karla is so large and spends most of her time lying on her belly. As a throwaway remark, she jokes that it's just as well that she has such a good relationship with the client, or he may have complained about not having been offered a laparoscopic spay!

Later, you reflect on her words. Does the vet have a point? Although you realise that laparoscopic ("keyhole") spays are ideal for larger breeds, the practice neither has the equipment nor the expertise to offer them. The nearest practice that offers them is 11 miles away. Should you have discussed this with Mr Beddow when you admitted Karla? Let's unpick what has happened here, examining your practice's protocol for consent.

1. Time and timing

Like the situation many other practices, you obtain informed consent for elective surgery, such as neutering, on the day that you admit the patient for the procedure. In human medicine, this would be seen as poor practice, with medical associations advising that consent conversations should be held in advance of the procedure where possible (Royal College of Surgeons of England [RCSE], 2016, S4.8, General Medical Council [GMC], 2008, S18).

In giving clients the information that is needed to make an informed decision, it is important that they then have sufficient time to consider this information and decide whether to proceed (Berry, Unwin, Ross, Peacock & Juma, 2007). The Royal College of Veterinary Surgeons (RCVS) endorses this view, recommending that *'(f)or non-urgent procedures, the consent discussion should take place in advance of the day of the treatment/procedure where possible.'* (RCVS, 2019, S11.2).

There are additional benefits to holding the consent discussion in advance of the surgery (Gray, 2019). For example, clients are often stressed and anxious if they are leaving their pets for surgery, so may not listen carefully to the information about risks, costs, and additional procedures. There is often less time to hold a proper discussion during early morning admissions slots, with clients waiting for their animals to be admitted so that they can get off to work or school. Bringing the consent conversation forward gives the client time to consider the procedure and ask questions when there is less emotional pressure, while giving the veterinary professional time to go through all the required elements of the consent discussion without unrealistic time constraints. In an observational study of consent conversations conducted in advance of the day of surgery, all conversations fitted comfortably into the allocated 15-minute slots.

You therefore submit an item for the agenda of the next practice meeting: "For elective surgery, this practice should schedule 15-minute consultations to conduct the consent discussion several days before the surgery appointment."

2. Personnel

In your practice, registered and student veterinary nurses assume responsibility for obtaining consent for routine procedures, such as neutering. Is this acceptable?

Following the recently updated RCVS guidance on consent, either a registered or student veterinary nurse would fit with the College's recommendations on who should take consent. Interestingly, the guidance does not stipulate that the client should be informed of the role of the person to whom they are talking. The RCVS guidance has been formulated along similar lines to the GMC guidance regarding training and suitability of personnel for consent discussions:

> … the veterinary surgeon can delegate the responsibility to someone else, provided the veterinary surgeon is satisfied that the person they delegate to:
> a. Is suitably trained, and

b. Has sufficient knowledge of the proposed procedure or treatment, and understands the risks involved.
(RCVS, 2019, S11.3-11.5)

The RCVS lists those to whom the delegation would be appropriate, from veterinary surgeons, through veterinary nurses to student veterinary nurses, subject to the provisos above. It seems that your protocol in this area is acceptable, but you will suggest that the training of student nurses in obtaining consent is reviewed at your next practice meeting.

3. Content

By following the layout of your consent form, you usually structure your consent discussion to cover the procedure (clearly explaining that for a spay, the uterus or womb, and ovaries will be removed), the risks (you always mention the very small risk of death for any general anaesthetic), the costs (with an estimate clearly provided on the form) and the aftercare for the patient. So far, so good.

It is interesting to consider how the RCVS would define *'common and serious'* risks (RCVS 2019, S11.2.b) which are required to be discussed as part of consent, and who would decide on the risks for a particular procedure. One interpretation of this phrase suggests that the College might rely on an evidence-based approach to risk, which may mean that only those reaching a specified level of occurrence, for example 10%, would be considered as either common or serious risks. An alternative definition of 'serious' could be a risk that, even if uncommon, has devastating consequences for the animal patient and the client. For elective neutering procedures, the serious risk involved is death, but the client should be advised on the risks and benefits for the individual animal. For owners of female dogs of specific breeds, the risk of urinary incontinence subsequent to neutering (O'Neill and others 2017) should be discussed as it may negatively affect the dog-owner relationship in the future and will probably require treatment. With more evidence emerging on post-neutering complications for both sexes (Adin, 2011, McKenzie, 2010, Reichler, 2009, Torres de la Riva et al, 2013), these should be discussed and balanced with the individual and societal benefits of neutering.

This scenario, however, involves the failure to offer alternatives to a traditional midline spay. The RCVS advises that the client should be given 'a range of reasonable treatment options' (RCVS, 2019, S11.2). The definition of 'reasonable' is, of course, open to debate, but there is probably a balance between giving clients too many options and not giving them any options. Of course, the costs of each option are an essential part of the consent discussion. Reasonable treatment options would include treatments available at the practice, in view of current personnel and equipment, and the

offer of referral to another practice if an alternative treatment, unavailable at the current practice, would be in the animal's best interests. With this in mind, should clients only be offered the alternative of laparoscopic ('keyhole') surgery for neutering female dogs if this procedure is available in the practice? Or should clients be informed that it is available at the neighbouring practice if the individual patient would benefit from this procedure?

You decide that this is another topic for discussion at the forthcoming practice meeting. If the practice protocol is changed to offer referral for laparoscopic spay, you will need to find out the costs involved to enable your clients to make an informed decision.

4. Client review of information

Because the practice's current consent process is carried out at the time of admission of the patient, clients do not have a chance to take away the information given, to think about it and to formulate questions and concerns that they may have. If the practice decides to move the consent discussion to before the procedure, this would allow clients to review the information given. Alternatively, the practice could send written information to clients in advance of the conversation. For example, one practice emails tailored information to clients who have booked their animals in for surgery (Gray, 2019), thus enabling them to arrive at the practice with some prepared questions. At the very least, the client should leave the consent discussion with a copy of the consent form, signed by both parties, as is currently required for consent to research. Currently, the practice protocol is to print only one copy of the form, which is retained by the practice, and to require only the client's signature. You will add suggested changes to the agenda for the next meeting.

5. Admission – questions and affirming consent

If the consent discussion takes place in advance of the day of surgery, what happens during admissions? Can we take consent prior to surgery, and how long is it valid? To answer this, the advice given to human surgeons by the RCSE seems appropriate, especially as this guidance was produced following a landmark legal case *(Montgomery v Lanarkshire Health Board,* 2015) involving medical consent:

> There is no time limit to the validity of a patient's consent. Consent will cease to be valid only when, in the intervening period between the consent discussion and the procedure, circumstances have changed in a way that has significantly altered the patient's condition, the material risks or any other aspect of the treatment.

(RCSE, 2015, S4.9)

Consequently, on the morning of admission, you would undertake a final check that nothing has changed since the consent discussion. You would then ask if the client had any questions or concerns about the procedure, deal with any that arose, and then conduct a health check on the patient. Admissions would therefore take less time, as you would not be going through the usual description of the surgery, risks, benefits and costs, these having been covered at the consent discussion.

6. Summary of proposed consent protocol

A. The consent discussion should be scheduled to allow sufficient length of time (e.g., 15 minutes) for information to be shared. For elective procedures, it should be in advance of the day of surgery
B. The consent discussion should be scheduled to ensure the availability of an appropriate member of practice staff to conduct the conversation
C. The client should be given plenty of opportunity to ask questions or express concerns
D. For procedures requiring general anaesthesia, the risk of death should always be specified
E. The risks and benefits of neutering for the individual animal should be explained and discussed.
F. Clients should be offered alternative treatment options, where these exist
G. Clients should be offered all reasonable treatment options and given clear indications of costs for each, together with any potential future costs involved
H. Consent forms should require the signatures of both parties to the consent process, and a copy should be given to the client.
I. Clients should be provided with a copy of the information discussed, for example by including it on the consent form, in advance of the day of surgery.

To implement changes to your own protocol, it is useful to start by having a practice discussion that outlines what needs to change, and then to try changing one aspect at a time. Feedback from clients and practice staff as the changes are rolled out will help to monitor the improvement in informed consent.

In our original scenario, the client had trust in the practice and the staff who treated his dog. He therefore did not wish to pursue the matter further. Had he been a new client, or had a poor relationship with the practice, the outcome may have been quite different. However, rather than

improving your consent processes simply as a means of avoiding claims and complaints, getting consent right has other benefits. According to medical literature, aiming for shared decision-making should increase client satisfaction, improve patient care and welfare (Munthe, Sandman and Cutas, 2012) and, as a consequence, it could lead to better wellbeing amongst veterinary professionals. These provide good reasons for reflecting on current consent protocols in practice.

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