Taking informed consent for Doctors in Training Policy

Including marking of an operating site

Approved by the Oxford Deanery Executive Team
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Introduction

In the “12 key points on consent: the law in England” it states that “It is always best for the person actually treating the patient to seek the patient’s consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure. (1)

A number of national bodies have issued guidance on taking consent (2-6). These do not make a distinction between different healthcare workers, applying to those in training as well as nursing staff. Adherence to national recommendations varies and there is variable quality assurance of process.

Doctors in training are particularly vulnerable in taking consent as they may be expected to take consent for a procedure of which they have little or no expertise. If they have knowledge of the procedure they may still not have been taught the principles of taking consent for that particular intervention. Also they may be at risk of coercion or pressure from senior staff.

a) Purpose

The purpose of this policy is to outline a rational approach which will enhance patient safety and provide a training opportunity for developing communication and other professional skills.

This policy has been written:

1. “to develop a systematic approach to taking consent (to include the cessation of obtaining consent by inadequately trained junior doctors outside the individual’s field of experience) (2)

There is evidence from trainee surveys and Trust quality control visits indicates that doctors in training may be taking consent when they have not been equipped to do so. Current national guidance does not address this aspect, rather concentrating on the foundation for good practice (see references 2 – 6).

Adherence to national guidance is variable, unpredictable and in the worst case when ignored could lead to putting a patient’s life at risk, or at least serious error and patient complaint.

2. “to provide clarity about who should mark a patient’s operating site”.

Surgical site marking is a pivotal component of the consenting process with the patient, and sign-posting for the operating practitioner, usually a surgeon.

b) Scope

This policy relates specifically to all doctors in training, including those undertaking locum positions.
c) Exclusions

It excludes non-consultant career grades and consultants and also dentists. This does not mean that there is no need to review guidance for these groups but this should be done as a separate exercise. In addition it is acknowledged that Nurse Practitioners take consent regularly with the confidence of the operator, typically for endoscopic procedures. However this group is far more likely to have completed a clearly defined and detailed training programme than doctors in training. In addition they are working in a narrower area of clinical practice for longer.

It is unlikely that foundation doctors will gain sufficient depth of understanding in a 2 to 4 month attachment. Nevertheless the Foundation Programme provides the ideal opportunity to set the basis for good consent practice.

d) Definitions

Directly Observed Procedural Skill (DOPS) for consent provides evidence that the trainee:-
- Understands the legal aspects of consent
- Understands ethical issues of consent
- Chooses appropriate environment and time for taking consent
- Explains clearly to patient purpose of consent process
- Explains clearly the planned procedure to patient in an understandable fashion
- Explains risks of procedure to patient
- Is able to answer any questions raised clearly and accurately

Correct site surgery (CSS) refers to operating on the correct side of the patient and/or the correct anatomical location or level (such as the correct finger on the correct hand).” (see reference 6)

e) Responsibilities and duties

Doctors taking consent
Any doctor taking consent must:-

i) Have sufficient knowledge of the proposed investigation or treatment and understand the risks involved

ii) Understand and agree to act in accordance with the General Medical Council and Department of Health guidance on consent (see references 3 and 4)

Foundation trainees
Foundation trainees taking consent must:-

(1) Not take consent for an invasive procedure unless observed by the doctor responsible for undertaking the procedure. In the first instance Oxford Deanery strongly advises that the trainee is shown how to take consent by observing their trainer as part of their training experience.

(2) Have attended a course or session on consent (either undergraduate course or session within induction)
(3) Have been observed on at least three occasions while taking consent for non-invasive procedures and have been deemed as competent by their trainer, using an assessment tool such as DOPS.

In summary: Foundation year doctors should only take consent as part of a structured training opportunity. They should not take consent for any invasive procedure without direct supervision.

Post Foundation: Core and Specialist Trainees
Core and Specialist Trainees must:-

i) Be encouraged to be involved with the consenting process
ii) Have been formally delegated with the responsibility of taking consent by the senior operator for the procedure
iii) Have demonstrated competence to take consent by having completed the tasks and experience set out above in points i, ii and iii for Foundation trainees, and be familiar with the operative procedure and its potential complications.

In summary: Specialty grades should have a clearly defined step by step approach for training in taking consent. This should be performed as a Directly Observed Procedural Skill (DOPS) whereby the early stages are formative and build incrementally to result in a combined assessment of the entire process.

The marking of an operating site should only be done by an operating surgeon who is deemed competent in the consent process for that particular operation. This may include a trainee surgeon providing they are guaranteed to be an active part of the operating team. Ideally however this should be done by the most senior surgeon involved with the operation.

Individual Trusts
Individual trusts will consider national guidance to create a clear clinical policy regarding the taking of consent and surgical site marking. (see reference 2)

Education providers
Oxford Deanery expects that those education providers responsible for trainees will incorporate this guidance into their local policy documents and develop effective audit to ensure compliance.
References

(2) NHSLA guidance 2008
(3) Reference guide to consent for examination or treatment DH 6April 2001
(4) Consent: Patients and Doctors making decisions together GMC (2008)

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