Briefing Document: Key Themes and Ideas from Consent Discussions

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Overview:

This briefing document summarises the main themes and important ideas discussed across the provided transcripts concerning patient consent in the healthcare setting, primarily within the NHS in the UK. It highlights the evolution of consent from a paternalistic model to a patient-centred, shared decision-making process, driven by legal precedents like the Montgomery ruling, and explores practical challenges and potential solutions, including the role of digital tools and robust processes.

1. The Evolving Understanding of Consent: From Form to Process

A central theme across multiple speakers is the shift in understanding consent from a singular event of signing a form to an ongoing, dynamic process of shared decision-making.

- **Ben Thomas** explicitly states, "10 years of experience in this space has shown that I think a lot of clinicians equate consent with a yellow form, with a consent form, whereas actually it's about decision-making..." This highlights a common misconception that needs to be overcome.
- **Simon Parsons** emphasises the ongoing nature of this dialogue, stating, "...we'll come back time and again to that meaningful dialogue and the exchange of relevant information specific to the individual patient."
- **Bryony Lovett** strongly agrees, "I disagree with consent on the day. Consent is a process. It starts with the diagnostics..." She argues that the conversation and information sharing should begin much earlier in the patient journey.

2. The Impact of the Montgomery Ruling:

The landmark Montgomery v Lanarkshire Health Board case is repeatedly referenced as a pivotal moment that significantly altered the legal and ethical landscape of consent.

- **Simon Parsons** notes that "principle four, ‘doctors must try to find out what matters to the patient.’ And this has come as a result of the Montgomery case..."
- **Amelia Newbold** explains the core of the Montgomery ruling: "So what are material risks? What does it mean? It's a two-stage approach involving both an objective and a subjective assessment... what risks should a clinician

reasonably be aware that an individual patient would be likely to attach significance to? And this is the dialogue point."

- **Bryony Lovett** underscores the shift in focus: "I think the most important thing about Montgomery is the shift in focus of consent towards the specific needs of your patient and being aware that any risk that an individual patient, not the doctor, might consider, is really important."

3. Material Risks and Individual Patient Needs:

Understanding and communicating "material risks" – those a reasonable person in the patient's position would likely attach significance to, or risks the clinician knows the particular patient would consider significant – is crucial post-Montgomery.

- **Amelia Newbold** provides examples: "...a risk, however remote might be of particular significance to somebody whose livelihood would be significantly affected if the risk materialised. So the good example that we often use in our cases, surgery where there's a small risk of damage to the vocal cords, would be a particular significance to somebody who needs to use their voice in their in their career."
- **Francis Brooks** from the insurer's perspective stresses the importance of getting to know patients: "I always say to clinicians, and it plays so crucially into Montgomery, I think, is that you really need to get to know your patients."

4. Challenges in Implementing Effective Consent:

Despite the clear principles, several challenges in achieving truly informed consent are highlighted:

- **Time Constraints: Dr. Ben Thomas** raises the tension between "a good conversation with the doctor about the decision-making process" and "the imperative of the waiting list time and the time to treatment." This pressure can hinder thorough discussions.
- **Patient Understanding and Information Format: Helena Durham** powerfully shares her personal experiences as a patient, highlighting the issue of inaccessible information: "I was given a patient information leaflet. (Holds up and waves a piece of paper) A great wodge of written paper presented information for patients... I wasn't given anything in a format that I could read." She also notes that patients often perceive the consent process as being "for the surgeon so that I don't sue them" rather than for their own benefit.
- **Competence of Clinicians:** Concerns are raised about trainees performing procedures and the level of supervision, as well as the need for consultants learning new techniques to be appropriately proctored. **Bryony Lovett** states she

only allows trainees to perform procedures "for which they've been signed off at level four," the level expected of a new consultant.

- **Patient Recall and Engagement: Charles Ranaboldo** poses the common scenario where a patient on the day of surgery hasn't read or understood the provided information: "Mrs. Jones sits there all in her dressing gown and you ask her, have you read the leaflet? Did you understand it? Have you got any questions? And she goes, ‘oh no, dear, I didn't do that’. Where are you then, in terms of proceeding?"
- **Standardised vs. Individualised Information:** While standard leaflets like EIDO are valuable, there's a need for individualisation. **Francis Brooks** points out a case in Australia where a "very basic consent template" was used, lacking patient-specific details, which is contrary to the principles of Montgomery.

5. The Role of Digital Tools and Resources:

Several speakers advocate for and describe the use of digital tools to enhance the consent process.

- **Jonathan Webb** highlights the Welsh Risk Pool's support for "the EIDO consent information leaflets now for 15 years" and their availability in Welsh, with plans for locally produced leaflets to be uploaded. He also mentions the digital work being undertaken in Wales.
- **Simon Parsons** champions "digital consent," describing the use of questionnaires (like the Otago gallstones questionnaire and SF-36 via Isla Health) to gather patient information pre-operatively, leading to more meaningful consent consultations: "And that really did make the consent consultation, not that single meaningful consultation much more meaningful because I understood what was important to them." He also mentions the potential for radar systems to interface with governance applications.
- **Bryony Lovett** details her trust's implementation of electronic consent in breast units using their new electronic patient record (Cerner/Nova), allowing patients to "confirm your consent prior to surgery on the electronic platform, ask questions."

6. Importance of Documentation and Communication:

Accurate and comprehensive documentation of the consent process is repeatedly emphasised as crucial for both patient safety and mitigating legal risks.

- **Bryony Lovett** mentions that the Royal College of Surgeons' ten principles of consent include "making a decision-making record" (10A) and the importance of

"documenting the whole process of consent and writing it down, and putting it in the letter to the GP."

- **Simon Hammond** from a claims perspective highlights that "good quality notes... can be invaluable in justifying your actions, but it can also help the patient in understanding what the nature of the conversations were that they had at that specific moment in time." The Australian GP case discussed by **Francis Brooks** also underscores the disaster of not making contemporaneous notes.

7. The Significance of Bedside Manner and Emotional Intelligence:

The human element of consent is highlighted, with emphasis on empathy and communication skills.

- **Francis Brooks** states, "Your bedside manner is so important with this stuff. So patients don't sue people they like, or they try not to." He also stresses the importance of emotional intelligence and self-awareness for clinicians.
- **Bryony Lovett** emphasises engagement with patients to ensure they understand their condition and how to mitigate their own risks, even describing doing "stand to sit" exercises with patients during the consent process.

8. Collaboration and Shared Resources:

The importance of collaboration among clinicians, legal experts, patient representatives, and organisations like EIDO is evident in the discussions. The Welsh Risk Pool's "All Wales model consent policy" and the collaborative development of EIDO leaflets (as mentioned by **Julie Smith** and **Sophie Randall**) are examples of this.

9. Ongoing Evolution and Future Directions:

The discussion acknowledges that the understanding and implementation of consent are still evolving. **Simon Hammond** suggests that the legal interpretation of Montgomery is "probably not" settled and will continue to be tested in court. The development of digital tools, standardised guidance, and educational resources (like the e-learning module mentioned by **Anne Davidson** and **Jonathan Webb**) are ongoing efforts to improve the consent process. **Bryony Lovett** highlights the Royal College of Surgeons' work on consent checklists and a consent process map as further developments.

In conclusion, these sources collectively paint a picture of a healthcare landscape increasingly focused on patient autonomy and informed consent, driven by legal changes and a growing recognition of patients' rights. While significant progress has been made, challenges remain in ensuring consistent and meaningful shared decision-making. Digital tools, clear guidelines, ongoing education, and a focus on the individual patient's needs and understanding are identified as key elements in continuing to

improve the consent process for the benefit of both patients and healthcare professionals.