Briefing Document: Patient Information, Expectations, and Consent in Medical Practice

Source: Excerpts from "04 Steve Trumble_SRT_English.txt"

Date: 26th November 2024 [Date of presentation]

Subject: The importance of effective patient information and communication in managing expectations, obtaining informed consent, and improving patient outcomes while reducing the clinician's risk.

Overview:

Steve Trumble's presentation focuses on the crucial role of patient information and communication in modern medical practice. Drawing on his extensive experience in general practice, medical education, and as chair of the EIDO International Editorial Board, Trumble argues that medical practice can be seen as "the management of disappointment." He highlights how unmet patient expectations are a significant driver of complaints and litigation. The presentation traces the evolution of the consent process, particularly in Australia and the UK, and emphasises the shift from a paternalistic, doctor-centred approach to a patient-centred, conversational model. Trumble discusses the increasing use of electronic resources for patient information but stresses that these should support, not replace, the essential consent conversation.

Key Themes and Ideas:

1. **Medical Practice as the "Management of Disappointment":** Trumble asserts that a core aspect of medical practice is dealing with situations where patient outcomes or experiences do not align with their expectations. He quotes the description of medical practice as "the management of disappointment," highlighting its inherent truth.

- **Quote:** "I can't remember where I first heard it, but medical practice has been described as 'the management of disappointment', and there is something in that."

- **Implication:** Setting realistic patient expectations is crucial for managing satisfaction and mitigating the risk of complaints.

2. **Unmet Expectations and Risk:** The presentation links unrealistic patient expectations directly to increased risk for doctors in terms of complaints, litigation, and regulatory scrutiny. Doctors who "over promise and under deliver, or if not under deliver, fail to give their patient a realistic expectation" are more likely to face such issues.

- **Examples:** Cosmetic surgery patients with unrealistic expectations about relationship improvements and high rates of dissatisfaction following total joint arthroplasties (particularly knee replacements) are cited.
- **Quote:** "It's no surprise that the frequent flyers with the medical regulators and claims departments and indemnity providers down here tend to be doctors who over promise and under deliver, or if not under deliver, fail to give their patient a realistic expectation of what their clinical skills can achieve."

3. **Patient Information Aids as a Solution:** Trumble strongly advocates for the use of patient information aids (sheets, videos, online resources) to help ensure patients are properly informed and have realistic expectations.
   - **Quote:** "This is where patient information aids can help to make sure that the patient is properly informed and gets the help that they really do need."
   - **Benefit:** Patients whose preoperative expectations are met are more likely to be satisfied with their clinical outcome.
4. **Evolution of Patient Information Delivery:** The presentation acknowledges significant developments in how patient information is being provided, moving towards online platforms, animations, live interactive information, and usage tracking.
   - **Quote:** "Big developments are coming in the way that information is provided to patients with online versions that allow easy dissemination, animations to make better sense of complex concepts, live information that allows patients and their families to dig deeper into topics about which they're particularly curious, as well as tracking of usage to make sure that the information is getting to patients, being read and most importantly, understood."
5. **The Shift from Paternalism to Patient-Centred Communication:** Trumble uses a humorous but illustrative video clip to highlight the outdated and often demeaning nature of traditional, paternalistic medical communication where patients are discussed rather than spoken to.
   - **Observation:** The "look of bewilderment on the patient's face as he was discussed and dissected in public is still quite common in some places."
   - **Critique of Automation:** Examples of colleagues using automated video viewing and quizzes to "subjugate into knowledge rather than educated" and showing graphic surgical videos leading to adverse patient reactions are used to illustrate the dangers of abdicating responsibility for person-centred communication.

- **Quote:** "We cannot abdicate responsibility for informing patients about their proposed treatment onto documents or videos or whatever. It has to be done in a person centred way."

6. **The Consent Conversation:** Trumble views the consent process as a critical conversation that educational resources should "support, not replace." He contrasts his early experience as a junior intern dispatched to obtain signatures with the modern imperative for meaningful dialogue.

- **Quote:** "Of most interest to me is the consent conversation. The educational resources can support, not replace. I must emphasise 'support'."
- **Critique of Old Method:** "Looking back, the depersonalisation caused by referring to people as their procedures was deplorable. As was sending a very junior and rather thick headed intern off to obtain a signature on a piece of paper, for a procedure he was in no way competent to explain, let alone perform."

7. **Impact of the Rogers and Whitaker Case (Australia):** Trumble identifies this 1992 High Court case as a significant legal "meteor" that disrupted entrenched behaviours and brought about major changes in how doctors inform patients.

- **Case Summary:** Marie Whitaker successfully sued ophthalmologist Chris Rogers after developing sympathetic ophthalmia in her good eye following surgery on her blind eye. She had asked questions indicating particular concern about losing sight in her good eye, but was not warned of this rare complication.
- **Rejection of Bolam Principle:** The court rejected the long-standing Bolam principle (where standard of care was dictated by the medical profession) in this context.
- **Introduction of Material Risk Test:** The ruling established the doctor's duty "to disclose to the patient any material risk inherent in the proposed treatment, with the risk being considered material if, in the circumstances of a particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it. Or if the medical practitioner is or should reasonably be aware that the particular patient, if warned, would be likely to attach significance to it."
- **Quote:** "A seminal court case made its way to the Australian High Court that has forever altered medical practice, both here and in the UK, when it comes to failure to warn and gaining informed consent for medical treatments."

8. **Connection to the Montgomery Case (UK):** Trumble explicitly links the Rogers and Whitaker ruling to the UK's own seminal case, Montgomery, which also criticised paternalism and established a similar material risk test for informed consent.

- **Case Summary:** A mother with short stature and diabetes successfully sued after her child sustained a hypoxic brain injury due to shoulder dystocia, having not been warned of this possibility or informed of the alternative of caesarean delivery.
- **Shared Principle:** Both cases led to the profession being "criticised for being paternalistic, or doctor centred, in deciding what information to pass on and what to withhold."

9. **Two Key Questions for Patient Information:** The legal changes prompted a shift towards asking two key questions when informing patients:

- "What does any person reasonably need to know about this particular treatment?" (Standard information, can be delegated to resources).
- "What would this specific person want to know about it?" (Personalised information, requires conversation).
- **Quote:** "In reality, things settled down and we were left with two, clear questions to ask ourselves when informing patients about their treatment. 'What does any person reasonably need to know about this particular treatment?' and 'what would this specific person want to know about it?'"

10. **The Importance of Asking the Patient:** Trumble stresses that determining what a specific patient needs to know is best achieved by simply asking them. This demonstrates empathy and consideration.

- **Quote:** "How would I know what the particular patient needs to know?' to which the best response seems to be, Ask them."

11. **Consent as a Conversation, Not a Procedure:** The new approach transforms consent from something done to patients into a conversation with them, focusing efficiently on what is relevant to that individual.

- **Quote:** "Most importantly, perhaps, this new approach turned medical consent from something we did to patients as a procedure, into a conversation we have with patients."
- **Efficiency:** Answering patient questions is often more efficient than delivering a lengthy, pre-prepared spiel.
- **Quote:** "We can leave the standard information to the information sheet, as I've said, and instead spend more time effectively and efficiently focusing on what's particularly important to this patient having this treatment on this occasion. I've said that so many times, but it's the nub of the whole thing."

12. **Customisation of Electronic Resources:** As electronic resources become more prevalent, Trumble argues strongly for the ability for doctors to customise the information presented (underline, circle, add notes, adjust risk percentages) to maintain a personalised "concierge approach."

- **Quote:** "The one thing I will ask though, as we move further into that realm of electronic patient information, is to always have the facility for the doctor to customise the information, to electronically underline or circle this bit, to cross out that bit, to jot a risk percentage next to the mention of an adverse event about which the patient is particularly concerned."
- **Purpose:** This is not just for legal trail but to keep the interaction personal and ensure a shared interest in the best outcome.

13. **The Ideal Conclusion to the Consent Conversation:** The conversation should end with the patient feeling fully informed.

- **Quote:** "It's a conversation that really should conclude with the doctor's question 'Is there anything further you'd like to know?' being answered by the patient saying 'no doctor, I've got all the information I need.'"

Summary of Key Facts/Information:

- Steve Trumble is a Professor of General Practice, Education and Curriculum at Deakin University, with extensive experience in medical education and as Chair of the EIDO International Editorial Board.
- Patient dissatisfaction with total knee replacement is quoted as 10-30%, potentially reduced by better preoperative preparation.
- A 2023 study suggested the use of decision aids to reduce postoperative decision regret in joint replacement patients, especially for knees.
- A systematic review from Addenbrooke's found that patients whose preoperative expectations were met were more likely to be satisfied.
- The Australian High Court case *Rogers and Whitaker* (1992) significantly changed the law on informed consent by rejecting the Bolam principle in this context and establishing the "material risk" test, considering what a reasonable person *in the patient's position* would likely attach significance to, or what the doctor knows or should know the *particular patient* would find significant.
- The UK case *Montgomery* (similar to Rogers and Whitaker) also moved away from medical paternalism in informed consent.
- Effective patient communication involves identifying both standard information needs and specific individual needs.

- Asking the patient what they want to know is key to tailoring information.
- Electronic patient information resources should support the consent conversation and ideally allow for doctor customisation.

Conclusion:

Steve Trumble's briefing underscores the fundamental shift required in medical communication and consent. Moving beyond simply providing information to engaging in a genuine conversation, tailored to individual patient needs and supported by comprehensive resources, is essential for managing expectations, improving outcomes, and navigating the legal and regulatory landscape in modern medical practice. The legacy of cases like Rogers and Whitaker and Montgomery highlights the legal imperative for this patient-centred approach.