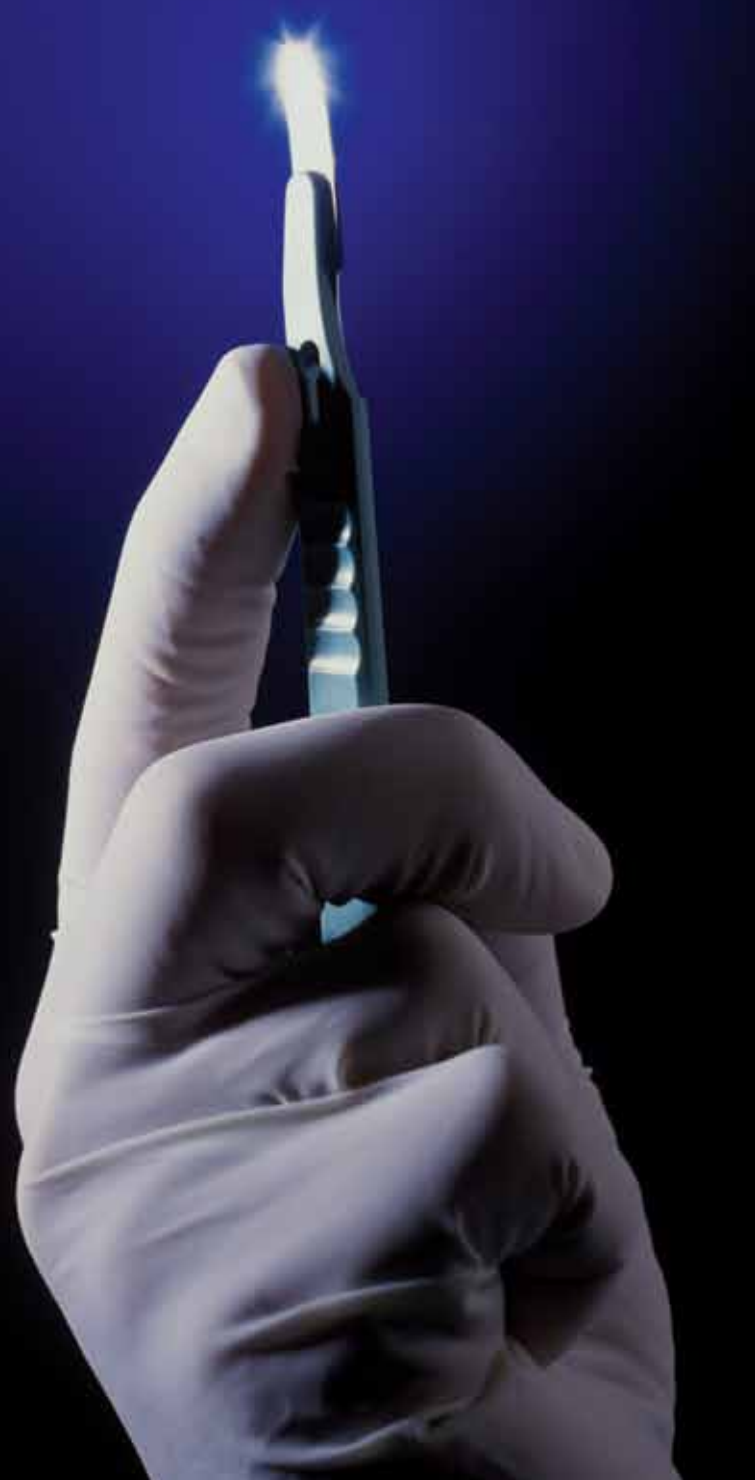
I SAID,

I had coffee with my colleagues the other day and we had a heated debate on one of the hottest topics of the day. The hot potato in question was the issue of informed consent.

This all started with a recent Court of Appeal decision on a case that had put the medical fraternity on notice. In short the case that was appealed had been about a staple haemorrhoidectomy. The patient had a postoperative complication of infection and complained that he was not informed of this during the consent taking process. The situation was compounded by the fact that this had happened some years ago and essentially boiled down to an "I said, you said" scenario. This was similarly alluded to in the news reporting on the Dominique Strauss Kahn affair.

The Singapore Medical Council (SMC) Disciplinary Committee had to decide whom to believe, and in the final analysis, believed the testimony of the patient and not that of the surgeon and his three nurses. The incident happened in the public sector and there was belief in the community that the administrative procedures in the hospital had contributed to the situation of an uninformed consent. An appeal was mounted but in the end, even if the court had wanted to, it could not, in all honesty, overturn a verdict of a committee that was based on belief.

Now all this is history and water under the bridge, but the ramifications are here to stay. To say that we received lots of feedback from the community is an understatement. We have received waves of dismay and anxiety not unlike those of a tsunami. This translated into feedback to SMC on its review of the Ethical Code and Ethical Guidelines. We published the letter in *SMA News*, and the media, in a pique of serendipity, picked it up. We also partnered our colleagues in the Medical Protection Society, who swiftly organised two seminars that were held in Mount Elizabeth Hospital and the Health Promotion Board.



YOU SAID

By Dr Chong Yeh Woei

I attended both seminars and the lessons that I have drawn from them are numerous. Firstly, the world has changed and the focus of the practice of Medicine is more patient-centric as opposed to physician-centric. What this means is that the patient is the centre of the universe and excuses such as "a busy clinic" or "bureaucracy" do not hold water.

We also learnt that of all medical mishaps that occur, the vast majority does not end up in a court of law. Even those that do, may not mean a victory for the plaintiffs. To this end, a defensive stance may not be useful as it will push us down the slippery slope. Some societies have embarked on this course of defensive medicine and have paid the price. We should not relearn these costly and expensive lessons. We must not penalise all patients to avoid the one who may take us to court. This will surely erode all the goodwill and trust that we have built up collectively with our patients and society at large.

On the other hand, we can certainly do a few good things. Firstly, we must return to the basics and make sure that patients understand the various options, including surgical and non-surgical ones. There must be choices put on the table that include the surgery, other surgical options, medical treatment, or even no treatment at all, in certain situations.

Furthermore, the patient must acknowledge the risks; this does not mean a 20-page list of all complications that have ever occurred for the procedure. These lists merely push us into the realm of defensive medicine, and from what I can gather, if there is a missing complication from the massive list, it is regarded as an omission. These legal disclaimer-types of lists do not offer blanket protection from litigation or complaints. I would venture an analogy in our recent financial crisis, where investors signed massive tomes, but the banks were still held responsible for the investors' actions. In any case, a 20-page list of complications would quickly evaporate any goodwill between surgeon and patient.

The risks acknowledged by the patient should include those that are expected in surgery, and should also include those that are known but significant, in that such a complication would cause substantial loss to the patient. An example would be a complication where a telephone operator or teacher loses her voice and cannot work.

To back up the twin strategies of all options discussed and risk acknowledgment, documentation of such a discussion is paramount. This can be done in the outpatient notes at length and reinforced in the inpatient notes. The consent form is really just a formality. The pertinent fact is that consent taking is a process and not a form.

In the public sector, a junior member of the team may ultimately conduct the consent form sign-off but the responsibility is borne by the senior members. Hence, it is important for consultants to make appropriate documentation in the outpatient notes.

Some other scenarios that cropped up include ensuring consent was taken in an appropriate setting and not on the operating table. Consent should also be taken when the patient is alert and lucid, and not under the influence of preoperative sedatives. Anaesthetists should work with their surgical partners and ensure that the consent process by the surgeons included anaesthetic risks. Ideally, anaesthetists should see their elective patients in the wards, and not meet them for the first time on the operating table.

At this point, we must acknowledge that there are areas of difficulties. Some of my surgical colleagues had echoed that it was hard to decide how much to tell patients in terms of complications. They felt that emphasising a great deal on complications would cause much anxiety and was at odds with the mantra of "to relieve sometimes and to comfort always". On the other hand, to de-emphasise the complications would run the risk of trivialising the pain and suffering one would suffer as a result of a complication.

There are no panaceas or magic bullets for this difficult area of consent. The final question is: what can we do as a community? To this end, the professional bodies must come together and rally the community to a common position. If the profession decides on certain unified code of practice on informed consent, this would certainly be the standard of practice in our society and accepted by all bodies including the courts. In the final analysis, we should not wring our hands in despair but must adapt to the situation like the well trained, sensible and rational medical professionals that we are. I have faith that my profession and all my colleagues from both the public and private sectors will not let society down in its hour of need. SMA

Dr Chong is the President of the 52nd SMA Council. He has been in private practice since 1993 and has seen his fair share of the human condition. He pines for a good pinot noir, loves the FT Weekend *and of course, wishes for world peace...*