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Informed consent-'da Vinci code' for our safety in empowered patient's safety

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Respect for patient safety and quality of care improvement in laparoscopic surgery drives us to better ourselves perpetually. The same concerns, however, are becoming powerful bargaining tools in the hands of politicians, lawyers, insurance companies, and business tycoons [1]. We face unhappy patients, reluctant payers, and the stick of shifting regulations, with safety and quality concerns dangled like a carrot. We need to ponder why we have allowed ourselves to be boxed in by such a situation?

Society's yardstick for our performance and hence our reward is the outcome of the operation we perform [2]. The outcomes of our operations are at times unpredictable, causing personal regret despite heart and soul put into the care [3]. Also we lack consistency in reporting outcomes, and fail to practice what is preached [4]. We have been seen as reluctant to adopt critical incident reporting systems that have been advocated much earlier [2, 5].

A systems-based approach is not only a requirement imposed on us by an informed society but also a safeguard for us when things go wrong. The practice of evidence-based medicine is a basic tenet of such systems, informed consent being the very beginning of this systematic journey. Any hiccup in this journey is a potential stick in the hands of regulators. It prompts the financial fat cows to get us sign on a dotted line, exhorting us to be content in remembering that surgery is a calling with personal satisfaction of a job well done [1]. They envy our profession, the only one that has all three ingredients of the good life: learning, earning and yearning.

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The article by Neary et al. [6] addresses the issue of informed consent in a basic manner, raising some very pertinent and disturbing questions that demand a response. It reminds us that "informed consent" is not truly informative, participative, and voluntary from the patient's perspective, or why would a significant number of them view it as a "disclaimer"? Why would they see it as a protective mechanism for the provider only? Why would these perceptions cut across levels of maturity and gender? And why should such a perception be at cross purposes with the "patient questionnaire" and "staff questionnaire"?

The last question is an answer in itself and answers the preceding questions. Differing perceptions indicate either vested interest or failure of the communication process. Either way it contradicts the spirit of informed consent.

This study holds a mirror to us. Our intentions are always pure and our dealings precise. In fact, surgery is the highest adjective used for anything done precisely. Our care, knowledge, judgment, and technical capability are hallmarks of precise clinical care. Probably, we should accept in 'letter and spirit' that informed consent is not merely getting a patient to sign a form.

We need to give credence to the perceived vulnerability and helplessness of patients and avoid any coercive moments. We need to be holistically conscious of the social, cultural, economic, and educational plurality of society and increasingly less fiduciary in our dealings. We should not use the jargon of "reasonable physician standard," "reasonable patient standard," or "subjective standard." We should rather empathize with the patient and try to harmonize our thinking process with his or her intellectual and mental frame. We should not hypothesize much about the quantum of information being sufficient or

scary. We should disclose all the facts available to us from the evidence available in both our profession and our own practice. We should not shy away from confessing the unknown and deal systematically with scientific ignorance and informed bewilderment. This will provide a definite quantum of solace to our patients.

At times, we make morally perplexing decisions with the aim of achieving the best for our patients given the plurality of the health care structure. What Socrates said about the necessity of a dialogue for any good to emerge must be true as well for informed consent. We should accept the fact that clinicians are seldom in full control of events [7]. We should remember not to use our social pedestal for coercing or influencing the patient. This is emphasized in a self-deprecating article noting "the sins of expertness and a proposal for redemption," by the father of evidence-based medicine, Dr. D. L. Sackett [7]. We should forsake "therapeutic privilege" as far as possible and put aside the deontological/teleological/Kantian bioethical debates. We need only to be enlightened to be seen as precise in knowledge, care, and communication, as well as honest in confessing the unknown while giving the best of our competence, realizing that competence is an ever-moving target [7]. "The essence of knowledge is having it, to apply it; not having it, to confess your ignorance" thus spake Confucius.

Informed consent should be an honest and true indicator of surgical outcomes, including uncertainties. Communicating risk is something doctors are not good at doing. It deserves much more effort from us than we think [8]. This should help in alleviating many of the uncomfortable questions raised in the study [6]. This should help the society come out of an impression of George Bernard Shaw's "The Doctor's Dilemma". Shaw's eloquence was decorated with an Oscar as well as a Nobel prize. This 'socio-scientific' marriage can be a guide for our profession's social discourse as well. A proper informed consent may further innovations in a perpetually evolving field trying its best to adhere to evidence-based surgery.

This effort was more than evident in the scientific debate (Evidence-Based Surgery Is for Those Willing to Follow Behind—New Advances Can't Wait) steered by Dr. Bruce MacFadyen Jr and Dr. Richard Satava at the Society of American Gastrointestinal and Endoscopic Surgeons 2008 meeting. I have personally felt partisaned by the lack of honesty and uniformity in obtaining an informed consent. Because I do not use energy sources in laparoscopic cholecystectomy, ethics mandate that I explain the risk of hemorrhage and mortality specifically in the context of my deviation from the norm. Yet conventionalist colleagues are allowed to continue with the routine printed standardized consent form without having to explain about already known and experienced 'energy sources' technology-related concerns. This lacks secularism and is guided by convenient physician standard protocol. It is appalling considering the forewarnings about technology-related concerns [9], which continue to be emphasized time and again [10].

The holistic responsibility of the surgeon requires sensitivity to the emergence of groups sensitive to climate change [11]. Fur-shunning animal lovers, lacto vegetarians, and Jehovah's Witnesses have earned special sensitivities from the medical society. Why then should we not inform about the environmental impact in our surgery? We do not have the time, energy, or resources to wish these concerns away and wait for eco-activists to chase and chastise us. We have underreported adverse events by a factor exceeding 400 [2]. Our surgery remains at least 100 times riskier than the aviation/nuclear industry [2]. We have been procrastinators about critical incidence reporting systems [5] and the like.

We pray to have the very best outcomes for our patients and ourselves, and we do not want honest conscientious colleagues to harm or come to harm [3]. But the overall atmosphere seems to be hostile [1]. We must not rely on the politicolegal system to wring accountability [12]. To err may be human, but it is not acceptable to fellow human beings, not so divine [2].

With increasing awareness in this age of the informed, adverse outcomes are subject to the subjectivity of social negotiation and barter [12]. The distinction between human errors, negligence, and surgical crime is liable to be legally blunted and exploited by administrators and lawyers that see us as milch cows. An informed consent will become a powerful tool in our hands to help reconciliation of balance between concerns of quality/safety and surgical accountability that already is being used as a bargaining tool by the financial fat cows [1].

Like a silver lining to every cloud, the study by Neary et al. [6] shows that women see "informed consent" as an empowering tool. The very fact that the fair half of humanity sees it as such and believes in it with so much faith indicates the potency of this instrument for us, provided its contents reflect our honesty. It is a great source of reassurance for us because it may be our very own divine feminine "da Vinci code" in search of safety for ourselves in the safety of our patients.

References

1. Lerner E (2008) Learning the landscape: medicine in the political arena. Surg Endosc 22:2335–2337
2. Cuschieri A (2006) Nature of human error: implications for surgical practice. Ann Surg 244:642–648
3. Cuschieri A (2005) Surgical errors and their prevention. Surg Endosc 19:1013

4. Satava RM (2003) Scientific inquiry: why don't surgeons practice what they preach? Surg Endosc 17:1513
5. Zingg U, Zala-Mezoe E, Kuenzle B, Licht A, Metzger U, Grote G, Platz A (2008) Evaluation of critical incidents in general surgery. Br J Surg 95:1420–1425
6. Neary P, Cahill RA, Kirwan WO, Kiely E, Redmond HP (2008) What a signature adds to the consent process. Surg Endosc 22:2698–2704
7. Michel LA (2007) The epistemology of evidence-based medicine. Surg Endosc 21:145–151
8. Smith R (2003) Communicating risk: the main work of doctors. BMJ 327:doi: 10.1136/bmj.327.7417.0-f
9. Cuschieri A, Terblanche J (1990) Laparoscopic cholecystectomy: evolution, not revolution. Surg Endosc 4:125–126
10. Cuschieri A (2005) Reducing errors in the operating room: surgical proficiency and quality assurance of execution. Surg Endosc 19:1022–1027
11. Agarwal BB (2008) Journey of the carbon-literate and climate-conscious endosurgeon having a head, heart, hands, and holistic sense of responsibility. Surg Endosc 22:2539–2540
12. Dekker SW (2007) Criminalization of medical error: who draws the line? ANZ J Surg 77:831–837