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ORIGINAL ARTICLE

'All by myself': interns' reports of their experiences taking consent in Irish hospitals

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Abstract

Background Obtaining patient consent is a fundamental process in surgical practice and is integral in respecting and safeguarding patient autonomy. It has been reported that the task of consenting patients frequently lies with junior doctors, who have the least experience of the procedure.

Aim To examine the role of interns in the consent process in the Irish context as well as to identify their concerns.

Methods A 12-point questionnaire, assessing interns' experience with surgical consent, was circulated to interns in three Irish university teaching hospitals based in different geographical locations. Interns who had never worked in a surgical team were excluded from the analysis.

Results Out of 104 interns, 60 interns returned questionnaires. Of these, 58 (96.7%) had consented a patient for a surgical procedure. Forty-four interns (73.3%) had never been supervised by a senior doctor. Of the 58 interns who had obtained surgical consent, six interns (10.3%) reported knowledge of 'all' the steps of the procedure. Only five interns (8.6%) reported that they were aware of all the risks of the procedures and 34 interns (58.6%) reported they knew 'most' of the risks. Twenty-five interns (43%) reported that they had, at some point, been explained the risks of the procedures by a senior colleague.

Conclusion The majority of interns reported that they had taken consent for a procedure without full knowledge of the procedure and its complications. Supervision or instruction from a senior colleague was reported by a minority.

Keywords Informed consent · Interns · Risk disclosure · Surgical consent

Introduction

Obtaining informed consent is a fundamental step prior to any medical or surgical procedure. The importance of consent is frequently emphasised by the Health Service Executive (HSE) of Ireland and Irish Medical Council (IMC) and is documented in both European and International human rights law as well as in the Irish constitution [1, 2]. For informed consent to be valid, the doctor must disclose all relevant information regarding the purpose, nature, risks, benefits and alternatives of the procedure and answer any questions posed by the patient truthfully, without concealing any of the facts. The decision to proceed with the surgery must be made without duress and the patient must possess the capacity to make this decision [1].

The IMC states that it is the responsibility of the treating doctor to obtain consent from the patient. If it is not feasible for the surgeon to do so, this may be delegated to a junior member of the team, providing the junior doctor is adequately trained and possesses a comprehensive understanding of the procedure; its risks, benefits and alternatives. The guidelines also state that, in the majority of cases, an intern should not be involved in the consent process as interns lack the relevant knowledge and experience [2].

Previous studies have demonstrated that junior doctors are frequently the primary doctors obtaining consent, with figures ranging from 62.5 to 99% of respondents surveyed [3, 4]. In one survey, 62% of doctors reported a lack of knowledge of the procedure they were consenting for [5].

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The process of consent is integral to the provision of surgical care and failure to obtain informed consent has both ethical and legal implications. While several studies have examined the process of consent in the United Kingdom (UK), there is a paucity of Irish data. In this study, we aim to examine the role of interns' in the consent process in the Irish context and assess their knowledge of the procedures they are consenting for as well as to identify their concerns.

Methods

The intern year is the first year of postgraduate medical training and allows doctors to experience a variety of medical specialties. An intern (equivalent to 'junior house officer' or 'foundation year 1 doctor') must spend 12 months working in one or more hospitals and receive a 'Certificate of Experience' upon successful completion of the year.

A 12-point questionnaire was piloted in one Irish university teaching hospital (model 3) and then circulated, without adjustments, to interns in two other university teaching hospitals (model 4) based in different geographical locations in Ireland. All questionnaires were completed anonymously. The questionnaire comprised a series of closed questions regarding interns' experience with the surgical consent process. All interns, regardless of their current post, i.e. medical or surgical, were invited to participate in the study. The questionnaires were distributed at educational seminars in the individual hospitals. Interns who had never worked in a surgical team were excluded from the analysis. The questionnaire is displayed in Fig. 1.

Statistical analysis was conducted using Microsoft Excel Software (Windows, Redmond, WA).

Results

Participants

Out of a total of 125 potential intern participants, 104 were eligible for inclusion. The remaining 21 interns had not yet worked in a surgical post and were therefore excluded. Of those eligible, 60 interns completed questionnaires, resulting in an overall 57.6% participation rate. All interns were 9 months post graduation and in their eighth month of employment. At the time of questionnaire completion, 25 interns were employed in surgical posts, 32 in medical posts and one each in anaesthetics, emergency medicine and general practice. With regard to surgical experience since commencing employment, 30 interns had spent 6 months in surgical posts, five interns had 3 months surgical experience and the 25 interns currently employed in surgical specialties were in those posts for 2 months. The interns who participated had consented both public and private patients, with theatre lists comprising more of the former than the latter.

Obtaining surgical consent

Of the 60 interns who had worked on surgical teams, 58 (96.7%) had consented a patient for a surgical procedure. Twenty-eight interns (46.7%) reported that the responsibility of consent always lay with them while 30 interns (50%) occasionally obtained surgical consent. Forty-four interns (73.3%) had never been supervised by a senior doctor while consenting a patient. Fourteen interns (23.3%) reported occasional supervision while no intern was constantly supervised. Thirty-eight interns (63.3%) had sought assistance from a senior colleague while consenting surgical patients, with one third of interns ($N = 20$) reporting that they had never done so. One intern reported never feeling comfortable while obtaining consent from a patient. Forty-six (76.7%) of the interns were occasionally comfortable while only nine interns (15%) were always comfortable conducting the consent process.

Knowledge of surgical procedures

The 58 interns who had obtained surgical consent were asked three questions regarding their knowledge of the procedures they consented for. The responses are displayed in Fig. 2.

Twenty-five interns (43%) had, at some point, had the risks of the procedures explained to them by a senior colleague compared to 57% ($N = 33$) who had never received such an explanation.

Who should be consenting the patients?

All interns who completed the questionnaire were asked who they felt should be obtaining consent from patients. Table 1 displays the distribution of responses.

Discussion

The process of consenting a patient for a surgical procedure is a crucial step that should begin long before the day of surgery in order to allow the patient to consider all relevant information. Logically, the person who will be performing the procedure is in the best position to discuss the indication for and the risks, benefits and alternatives to the procedure with the patient. While this is a process that is anecdotally performed to varying degrees in the outpatient setting, the results of our study indicate that interns are the primary physicians obtaining patient consent.

Similar studies from the UK have reported that junior doctors' involvement in this process ranges from 62.5 to 99% [3, 4]. Ninety-six per cent of the interns surveyed in our study

Fig. 1 Consent questionnaire

Junior Doctors and the Consent Process

Please circle answers

1. **Please specify time since graduation**

   0-3 months 3-6 months 6-12 months >12 months

2. **Areas worked in since graduation (Please specify specialty)**

   Current Position:_____

   Previous Position:_____

3. **Have you ever consented for a surgical procedure?**

   Yes No

4. **How often do you consent for surgical procedures?**

   Always Occasionally Never

5. **Are you comfortable consenting for surgical procedures?**

   Always Occasionally Never

6. **Are you ever supervised while consenting patients?**

   Always Occasionally Never

7. **Do you know the steps of procedures you are consenting for?**

   All of them Most of them Some of them None of them

8. **Do you know the risks of the procedures you are consenting for?**

   All of them Most of them Some of them None of them

9. **Have you ever seen the procedures you are consenting for?**

   All of them Most of them Some of them None of them

10. **Have you ever been explained the risks by a senior performing the operation?**

    Yes No

11. **Have you ever had to call another doctor to help explain the procedure?**

    Always Occasionally Never

12. **Who do you think should consent the patient?**

    Intern SHO Reg Consultant Person performing procedure

reported that they had consented a patient for a surgical procedure with 46.7% stating that consenting patients was always their responsibility. The IMC recognises that it may not always be possible for the operating surgeon to consent a patient for surgery, and while delegation of the task to another, adequately trained member of the team is a feasible alternative, an intern is deemed to be an unsuitable delegate [2]. Considering the high numbers of interns involved in consenting patients in our study, alarmingly, only 43% reported that they had the steps, risks and/or benefits of the procedures explained to them by a senior colleague. Even more disconcerting is the high percentage of interns (73.3%) who had never been supervised while consenting a patient. Unsurprisingly, 63.3% of interns had sought assistance from a senior colleague during the consent process and only nine interns (15%) reported that they were fully comfortable when consenting patients for surgical procedures. Consideration must be given to the fact that 25 of the intern participants were working in a surgical role for only 2 months at the time of the survey. Therefore, it is possible that confidence in their ability to obtain patient consent at this early stage was low and that different answers may have been provided if the survey was completed 6 months into their role.

Concerns regarding junior doctors' lack of knowledge of the steps and complications of procedures were first identified in the literature in the early 1990s [6]. Since then, several

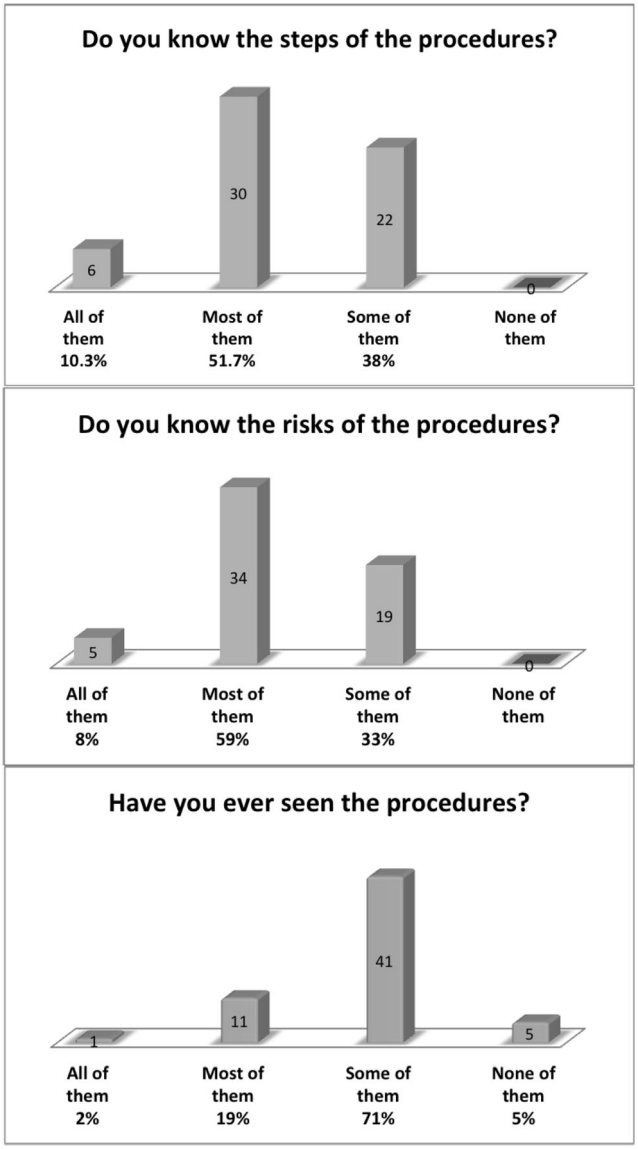

Fig. 2 Interns' knowledge of procedures for which they take consent

studies have highlighted the disparity in the risks disclosed by junior doctors and while a range of potential complications tends to be discussed with patients, wide variations in the frequency of discussion have been noted [4, 7, 8]. Our study has yielded similar findings. Only six interns reported knowledge of all the steps of the procedures they were consenting for. The majority claimed to know most of the steps and only five interns reported that they were aware of all the risks of the procedures. Approximately half reported they knew most of the risks. Only one intern had observed all of the procedures they had consented for with five interns reporting they had never seen any of the procedures.

Table 1 Interns' opinions regarding what grade of doctor should obtain patient consent

Hospital doctor	*N*	Percentage
Intern	2	3.2
Senior House Officer (SHO)	10	17.7
Registrar	23	38.8
Consultant	3	4.8
Person performing the procedure	22	35.5

The lack of understanding of the steps and risks of surgical procedures demonstrates a need for better training of Irish interns and raises the question whether they should be involved in the consent process at all.

Only two interns felt that they should continue to consent patients. The registrar or the individual performing the procedure was identified as the person who should be obtaining consent. Patients are likely to assume that the person explaining the procedure to them is the one to carry out the procedure and several studies from the literature support this. Houghton et al. found that 50% of the patients in their study assumed that the doctor obtaining consent was the operating surgeon and all but a small minority thought that, not only should this be the case, but that completion of consent by anyone other than the surgeon was unsatisfactory [3]. In a survey of 210 patients over a 5-week period, Cawich et al. found that 48% of patients did not know the grade of doctor who was consenting them for their procedure [9]. Regardless of which grade of doctor continues to complete the surgical consent process in Ireland, it is evident that clearer introductions to our patients are required.

If interns are to continue to be involved in the consent process, many options for improving the process have been proposed. The introduction of standardised consent forms (introduced in the United Kingdom in 2002) and 'sticky labels' could potentially create a more uniform consent process [10–12]. Sticky labels are pre-prepared adhesive labels, each containing procedure-specific risks, that can be applied to the patient's consent form to prompt the intern to discuss each of the documented risks. Many junior doctors in the UK agree that booklets containing relevant information for doctors (overview, steps, risks and benefits) on the common procedures would be beneficial [13–16]. Certain publications have suggested that increasing junior doctors' exposure to the operating theatre would result in improved knowledge of surgical procedures and that junior doctors should be initially supervised by senior colleagues while consenting patients [14, 17]. Finally, formal education and training in consent, both at undergraduate [14, 18] and postgraduate [5, 10, 19, 20] levels, would improve junior doctor's knowledge and confidence and their ability to obtain informed consent. Ultimately, however, the introduction of a system where the grade of doctor consenting the patient is based on the complexity of the procedure, with more complex procedures requiring more experienced doctors, is likely to be the only satisfactory solution.

We recognise that our data was collected over a short period of time from three hospitals in Ireland which could potentially limit generalisability and we acknowledge that the overall participation rate was low. The low participation rate is partially attributable to intern absences for annual leave, shift work, etc. It is also possible that only interns who were dissatisfied with their role in the consent process completed the questionnaire thus creating a selection bias. However, the study has many strengths. It is the first study to examine both the attitudes to and the involvement of interns in the consent process in Irish hospitals and consistent themes emerged with little variation between the hospitals. The suboptimal level of surgical knowledge of interns as well as the relative lack of supervision identified by this study creates goals for postgraduate education and restructuring of surgical teams.

Conclusion

The current process of surgical consent in Ireland is inadequate and is primarily completed by interns who report a relative lack of knowledge for the procedures they are consenting for. Lack of supervision and senior guidance are recurring issues. In an effort to enhance patient care and experience, several suggestions to improve the current consent process have been made. Ultimately, however, it is likely that the involvement of more senior doctors in the consent process will be required.

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