Let’s stop consenting patients

The term negatively affects how clinicians perceive consent

A patient who underwent an unsuccessful operation claimed that the surgeon did not obtain valid consent—that he booked her in for surgery without mentioning the less invasive alternatives. In another consent case, Birch v University College Hospital, the patient was informed of the risks of the catheter angiography that led to her stroke but not the comparative risks of magnetic resonance imaging. The clinicians were found negligent for failing to do so. I have elsewhere mentioned the usefulness of a consent acronym popular in some US hospitals: PARQ. It stands for “procedure” (what it entails), “alternatives” (including doing nothing), “risks” (of the procedure and the alternatives), and “questions” (invite the patient to ask questions). In these hospitals clinicians write “PARQ” in the notes to show that they have considered each element.

In the first case above the medical notes suggested that the surgeon did mention the alternatives. The patient said otherwise. She was adamant that if she had been offered less invasive options she would have chosen one. This belief was necessary to show “causation” between the lack of consent and the harm she suffered from the operation. If she would have opted for the operation anyway, she has suffered no loss and the claim will fail.

It was during my research into this case that I came across the report of Ian Kennedy, published in December 2013, on the Heart of England NHS Foundation Trust’s handling of a poorly performing breast surgeon. One of the elements that struck me was Kennedy’s indignation at the phrase “consenting a patient.” To hospital doctors this is a phrase so common that it would not raise the slightest concern. Yet, Kennedy wrote in paragraph 6.12 of the report: “The objections to this awful phrase are not merely linguistic. They go to the heart of a proper understanding of the relationship between patients and clinicians.”

At paragraph 6.25 he wrote, “Talk of ‘consenting’ patients has no place in the care of patients.” Finally, at paragraph 14.61, he remarked, “A growing practice has emerged of talking in terms of ‘consenting’ patients. This is wrong. It trivialises what is a central feature of the relationship between patients and healthcare professionals. It completely undermines the respect that patients are due.”

The phrase “to consent a patient” is shorthand for “to obtain a patient’s consent,” but it is true that this linguistic economy comes at a cost. The risk is that clinicians will start to see consent as something they do to a patient, just like taking a history or giving an injection. In fact, consent is better seen as a cherished object belonging to the patient, like a unique gold coin passed on from generation to generation, which the patient is invited to relinquish to the clinician. The clinician should not snatch it away, abruptly, deceptively, or without careful explanation. He or she should explain why the patient may wish to hand over the coin. What will the patient get in return? What if the patient wishes to keep it? Explaining all this can take time and skill. It is a two way process, but ultimately the decision remains with the patient.

It is well known that the way in which something is expressed can affect how it is perceived. An example in medicine is the change of name of “Do not resuscitate” orders to the softer “Do not attempt resuscitation” or the serene “Allow natural death.” A few decades ago (and still in some parts of the world) clinicians avoided the word “cancer,” preferring terms such as neoplastic disease. Clinicians today continue to use expressions that are less likely to alarm patients (and less likely to be understood by them). These euphemisms mainly affect how patients view their condition. Yet “consenting a patient” is a phrase that can influence how clinicians perceive consent, with adverse effects on the manner in which they obtain it.

The phrase “consenting a patient” should be consigned to the history books, replaced by the expression “to obtain consent from a patient.” The burden of two extra words is outweighed by the benefits of a more accurate and respectful phrase. To help abolish the phrase, a “consent” jar should be placed on every nurses’ station, and a pound inserted by any clinician who talks of “consenting a patient.”

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