¹ 12 King's Bench Walk, London, UK

² Chelsea and Westminster Hospital, London, UK

Sokol@12kbw.co.uk

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How should surgeons obtain consent during the covid-19 pandemic?

Now that hospitals are resuming elective surgery, what should surgeons tell patients about the perioperative risks of covid-19?

Daniel Sokol,¹ Rupen Dattani²

The 70 year old patient has been waiting months for his elective surgery. A few days before the operation, he has a swab test to detect any active covid-19 infection. It's negative. Before the operation, the surgeon reminds the patient about the risks and benefits of the procedure, as well as the reasonable alternatives. The patient agrees and signs the consent form.

The operation, which is performed under general anaesthetic, is uneventful but postoperatively the patient develops severe respiratory complications that require admission to the intensive care unit. Retesting reveals covid-19. The patient, who has sustained serious harm from the complications, sues the trust for failure to obtain valid consent. He claims that the surgeon should have discussed risks related to covid-19 and that, had he known, he would have waited until the pandemic had passed.

Many surgeons are now resuming elective work, yet we are aware that some make no mention of the additional risks related to covid-19. Although the British Association of Spine Surgeons and some private hospitals have produced information sheets for patients undergoing surgery during the pandemic, to our knowledge no formal guidance has been published by the General Medical Council or the Royal College of Surgeons on obtaining consent in such circumstances. The surgical community remains unclear as to what to tell patients about to undergo elective surgery.

Following the landmark case of *Montgomery v Lanarkshire Health Board* (2015) UKSC 11, doctors must take reasonable care to ensure that patients are aware of any material risks involved in the recommended treatment and any reasonable alternative treatments.

A material risk is one to which a reasonable person in the patient's position would be likely to attach significance, or a risk that a doctor knows—or should reasonably know—this particular patient would probably consider significant.

A recent international cohort study in the *Lancet* analysed the outcomes of 1128 patients who had surgery between 1 January and 31 March 2020.¹ Some 74% had emergency surgery and about 25% had elective surgery. Covid-19 infection was confirmed preoperatively in about 26% of patients. The study showed a 30 day mortality of nearly 24%, with pulmonary complications occurring in 51% of all patients. The mortality was associated with various factors, including sex (higher for males), age (higher for 70 and older), and type of surgery (higher for major surgery and emergency operations).

Although limited to a single study at an earlier point in the pandemic's progression, these are worrying figures. We believe a reasonable person about to undergo elective surgery would attach significance to the risk of complications and serious harm from covid-19.

Given that a minuscule risk of death by anaesthetic is commonly shared with patients, we argue that patients who undergo elective surgery should be told that, despite measures to limit the risk of infection, there remains a risk of contracting covid-19 in hospital, whether before, during, or after the operation. The surgeon should explain that, if the risk eventuates, the impact on the patient's health is currently unknown but could at worst lead to complications that require intensive care admission and, in a minority of cases, death (or, to use a euphemism, "loss of life").

Along with a verbal explanation, we recommend that doctors expressly state on the consent form "covid-19 related complications" as a risk to any surgery. As well as reminding the patient of the risk, this practice should afford the surgeon a degree of legal protection as it is evidence that the matter was raised with the patient. This should continue until the pandemic recedes and the risk becomes so negligible that no reasonable person in the patient's position would deem it worthy of mention.

A leaflet on the risks related to covid-19, though desirable, should be no substitute for a verbal discussion. It is well known that some patients do not read leaflets or booklets, or do not understand them. We also have concerns about those surgeons who indiscriminately send their patients copies of the *Lancet* article. However well intentioned, this may confuse rather than clarify.

As part of the discussion on alternatives to imminent surgery, surgeons should explore the option of waiting until the pandemic further subsides. For many patients, there will be risks associated with delay, so a balancing exercise will be necessary.

Finally, the consent discussion should take place some days or weeks before the surgery and not, as is still too often the case, on the day of surgery.

In the present state of knowledge, it is our view that the failure of surgeons to raise the perioperative risks of covid-19 during the consent process is ethically and legally troubling. It would be helpful for the Royal College of Surgeons to give specific guidance on the matter, with updates as new evidence becomes available.

The article does not constitute legal advice. Specialist legal advice should be obtained in relation to specific circumstances.

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- 1 COVIDSurg Collaborative. Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-Co-2 infection: an international cohort study. *Lancet* 2020. doi: 10.1016/S0140-6736(20)31182-X.

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