

Medical Education Research

'Teaching Informed Consent in Medical Training: A New Educational Paradigm'

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Background: Bioethical principles of autonomy, justice, beneficence, and non-maleficence underlie the modern practice of medicine.¹ Informed consent is the process by which physicians provide patients with the knowledge requisite to exercise autonomy. Consent is not a mere legal formality; it is a cornerstone of the physician-patient relationship.² While informed consent theory may be taught in medical school, a survey of anesthesiology residents revealed an absence of formal clinical instruction on obtaining consent. Rather, consent elements are gleaned from casual observation of colleagues or guided by prompts in the electronic consent form. Specialty- and patient- specific nuances influencing the process require accumulation of clinical experience which junior trainees lack. Scant clinical instruction represents both a medicolegal vulnerability and a disservice to patients whose autonomy depends upon a robust consent process.

Objectives: This project evaluates the effect of individualized, specialty-specific clinical education in informed consent on the quality of consent discussions by anesthesiology residents in an obstetric setting.

Methods: Review of the medical and legal literature was utilized to guide development of a detailed obstetric anesthesiology - specific metric containing elements of an ideal informed consent conversation. The metric included discussion of past medical history, discussion of the offered therapies for labor analgesia as well as alternatives, the risks, benefits, and implications of offered therapies, use of appropriate language (not medical jargon), patient-specific considerations such as use of a translator, recognition of incapacity/coercion, urgency of the situation, general demeanor, and discussion of a medical recommendation if indicated.

¹ Beauchamp TL, Childress JF. Principles of biomedical ethics. 5th. New York: Oxford University Press; 2001.

²Gillon R. Ethics needs principles - four can encompass the rest - and respect for autonomy should be first among equals. J Medl Ethics. 2003;29(5):307.

A single observer trained in both law and obstetric anesthesiology observed 23 individual anesthesiology residents of all training levels perform consent discussions with patients admitted for labor. Residents did not know the reason for observation. Discussions were scored against the written metric. Individual 1:1 multimodal education was provided, including verbal feedback, review of pertinent medical literature, didactics on legal requirements of informed consent, observation of consent discussions with a patient, and anticipatory discussions of patient-specific therapeutic considerations.

Observation was repeated after educational intervention by the same observer. 97 total observations were performed; 59 of those prior to educational intervention, and 38 observations afterwards.³

Results: Deficiencies were noted across all levels. Prior to intervention, residents failed to describe the offered procedure of a labor epidural in 79% of discussions, and failed to disclose alternative therapies in 86% of discussions. 90% of discussions omitted one or more pertinent risks. In 79% of instances when a medical recommendation was clearly indicated, the residents failed to communicate a recommendation to the patient. “Never” events included failure to recognize questionable capacity and three instances of complete omission of consent. In those 3 cases, the patients were all medical professionals. Trainees excessively prioritized the signed consent form above the process of consent. Qualitatively, pre-intervention discussions were inaccurate, sparse, and often contained inappropriate terminology that was frightening to the patient (for example: “catastrophic”, “disaster”) or undermined the perception of medical competence.

Following educational intervention, there was improvement in all assessed parameters. Most notably, in instances in which a medical recommendation was clearly indicated, residents discussed that recommendation with the patient 100% of the time. Residents described the offered procedure and alternatives 87% and 68% of the time, respectively. Residents continued to omit pertinent risks nearly 40% of the time, highlighting an important area for ongoing education. Residents were noted to project greater confidence in their discussions with patients and utilized more professional language.

³ Robert D’Angelo, Richard M. Smiley, Edward T. Riley, Scott Segal; Serious Complications Related to Obstetric Anesthesia: The Serious Complication Repository Project of the Society for Obstetric Anesthesia and Perinatology. *Anesthesiology* 2014; 120:1505–1512

As a result of this study, clinical instruction in informed consent will be formally incorporated into the curriculum for the obstetric anesthesiology rotation.

Conclusions: Respect for patient autonomy requires informed consent or refusal, and a robust consent process enhances the patient-physician relationship. Individualized specialty-specific clinical instruction improves both accuracy and breadth of consent discussions by anesthesiology trainees in an obstetric setting. Future work entails expansion of this educational model beyond the obstetric anesthesia context through development of program-wide instruction in the clinical application of informed consent.