AUTHOR'S RESPONSE 1

doi 10.1308/003588407X155617

ROBERT WHEELER

Child Health Directorate, Wessex Regional Centre for Paediatric Surgery, Southampton General Hospital, Southampton, UK

CORRESPONDENCE TO

Robert Wheeler, Consultant Paediatric and Neonatal Surgeon, Child Health Directorate, Wessex Regional Centre for Paediatric Surgery, G Level, East Wing, Mailpoint 44, Southampton General Hospital, Tremona Road, Southampton SO16 6YD, UK
E: robert.wheeler@suht.swest.nhs.uk

The comments by Hamilton and colleagues are timely. Since the legal rules governing surgical practice are as pertinent as the physiological and pathological rules which we derive from basic sciences, there is a powerful argument for ensuring that all surgeons, at whatever level, have adequate formal training in the current law.

If difficulty is encountered, a surgeon should seek advice, and the local Clinical Ethics Committee may be an appropriate source.

The patient safety alert to which Hamilton and colleagues refer gives a rather low standard when applied to matters of consent. This is because there is no requirement that the nominated deputy should be capable of performing the procedure in question. Therefore, under such a standard, it would be possible that a patient's consent would be obtained by an individual who is ill-equipped to provide it.

It is accepted that the survey may indicate woeful ignorance amongst surgeons when it comes to the issue of consent. Nevertheless, this survey needs to be taken with some caution. Psychiatric patients may be perfectly competent to provide consent providing that their psychiatric state has no bearing on the decision of whether surgery is appropriate. In the case of *Re C [1994] 1 All ER 819*, a schizophrenic Broadmoore patient was held to be entitled to refuse to have his leg amputated. This man had an illness which caused him to believe (erroneously) that he was a world-famous surgeon; however, the court found that he understood the nature and purpose of amputation and realised that he might die of the underlying gangrene if he refused treatment. It is salutary to note that the amputation proved unnecessary and his infection was successfully treated with antibiotics.

COMMENT 2

doi 10.1308/003588407X155626

Consent

Y FONG, P LEWIS, MH LEWIS

Department of Surgery, Royal Glamorgan Hospital, Llantrisant, UK

CORRESPONDENCE TO

MH Lewis, Consultant Surgeon, Department of Surgery, Royal Glamorgan Hospital, Ynysmaerdy, Llantrisant, Rhondda Cynon Taf CF72 8XR, UK
E: caron.potter@pr-tr.wales.nhs.uk

In the climate of a flourishing medicolegal industry, where all aspect of clinical practice can, and will, be scrutinised with a fine-toothed legal comb, the burden of proof and responsibility often fall upon the medical profession which places a financial penalty on the health service. We feel that the emphasis of obtaining consent has now shifted to producing legal defence papers rather than providing information and understanding of a procedure to the patient.

One of us was recently involved with a bungee jumping event abroad. The consent for this is for an event with no intention of improving the quality of life but, in fact, puts life at risk. If the NHS employed a similar 'consent' framework, it would read like the following:

1. I accept that surgery carries with it some degree of risk, both to person and property, and of emotional trauma of friends and family. Knowing the risk I still wish to participate in surgery and so expressly agree to assume the risk.
2. I release, waive and hold harmless the NHS Trust, its officers and/or its employees from all claims, losses, damages or expenses including legal costs that may be incurred during or in conjunction with my participation in surgery.
3. I also indemnify the NHS Trust, its officers and/or its employees against all claims, losses, damages or expenses including legal costs that any of my family or their executors, administrators, heirs, next of kin, successors or assignees may have or assert against the NHS Trust as a result of my participation in surgery.
4. I hereby consent to receive further treatment deemed to be necessary by the NHS Trust in the case of injury, accident or illness during the course of surgery and also agree to indemnify the NHS Trust in respect of such treatment.

It is made clear from the consent form for the voluntary act of jumping off a bridge for momentary exhilaration, that the participant has to assume all risks. An assumption is made that all safety procedures have been followed and all

equipment checked prior to the event. Similarly, the above clauses can be adapted to existing consent forms for surgery to remind patients that they are undergoing surgery voluntarily, and surgery is never risk-free. As long as all parties and equipment involved in the surgery are qualified and safety procedures are followed, barring significant deviation from normal surgical procedures, surgeons and health trusts would, in our opinion, have a stronger legal standpoint. We must stress that this does not take away a patient's right to litigation in cases of negligence or incompetence. It will at least discourage any opportunistic legal actions in which the aim is more likely to be financially motivated.

AUTHOR'S RESPONSE 2

doi 10.1308/003588407X155635

ROBERT WHEELER

Child Health Directorate, Wessex Regional Centre for Paediatric Surgery, Southampton General Hospital, Southampton, UK

CORRESPONDENCE TO

Robert Wheeler, Consultant Paediatric and Neonatal Surgeon, Child Health Directorate, Wessex Regional Centre for Paediatric Surgery, G Level, East Wing, Mailpoint 44, Southampton General Hospital, Tremona Road, Southampton SO16 6YD, UK
E: robert.wheeler@suht.swest.nhs.uk

Our society places great importance on a citizen's right of self-determination. One of the most obvious opportunities to exercise autonomy is when a person is able to make an informed choice concerning their medical treatment.

The legal doctrine of consent ensures that people are put into a position where they can make an informed choice. Choices can be informed only if the chooser has a clear and accurate understanding of what the 'procedure' entails, together with its benefits, risks, complications and alternatives.

In a bungee jump, the 'procedure' entails the opposition of gravity by an elastic band. The benefit is that the jumper may have enjoyed the experience. The risks include a rebound into the bridge from which he was suspended, or hitting the ground. The complications are, therefore, self-evident. Given the simplicity of both the procedure and its potential outcomes, there is unlikely to be a significant gap in the knowledge base between the jumper and the purveyor of the jump.

The bungee jump can be distinguished from the consent for surgery. The relationship between jumper and purveyor is quite different than between patient and surgeon. Additionally, there is significant inequality between the knowledge of the patient and surgeon, and the matters to be communicated and understood by the patient are infinitely more complex.

Unlike the jumper, the patient who consults a surgeon acquired their problem involuntarily, and it is one that may fundamentally affect their health. The problem may be serious, possibly endangering life. If he or she wishes to remain healthy, the patient must, therefore, acquiesce to surgery – there is effectively no choice in the matter; however, the jumper can simply walk away, and decide upon an alternative entertainment. The inevitability of the need for treatment gives the surgeon a degree of control over the patient far removed from that enjoyed by a purveyor of bungee jumps, yet Fong and colleagues try and persuade us that we should act in the manner of the latter.

I am honestly unable to decide whether Fong and colleagues are simply pulling my leg. The point of my article was to point out that good consent is simply good medicine, and that the lawyers are merely peripheral players. Litigation is clearly deeply unpleasant, and something that all surgeons wish to avoid. But litigation is still only a sideshow; our main purpose is to treat our patients properly, and the law provides some, albeit incomplete, guidance on how this may be achieved.

The reader will decide whether I have over-reacted to Fong *et al.* If they were suggesting that it is acceptable merely to place a conditional offer in front of the patient in a take-it-or-leave-it manner, then I would strongly disagree. This is incompatible with our moral duty to do the best for our patients.

COMMENTS ON

doi 10.1308/003588406X114712

M Newey, M Clarke, T Green, C Kershaw, P Pathak. Nurse-led management of carpal tunnel syndrome: an audit of outcomes and impact on waiting times. *Ann R Coll Surg Engl* 2006; **88**: 399–401

COMMENT 1

doi 10.1308/003588407X155644

Carpal tunnel syndrome

FRANK D BURKE

Pulvertaft Hand Centre, Derbyshire Royal Infirmary, Derby, UK

CORRESPONDENCE TO

FD Burke, Professor of Hand Surgery, Pulvertaft Hand Centre, Derbyshire Royal Infirmary, London Road, Derby DE1 2QY, UK
E: frank.burke@virgin.net

The authors' discussion touches on the matter of economic justification. They mention that when the project was set up the cost-effectiveness of the alteration in practice was not considered. Indeed, I recall when the Trent Regional Audit for Surgery of the Hand visited Leicester, the Orthopaedic Business