greater the number identified the more likely the occurrence of postoperative hypocalcaemia. As a result, we do not actively seek out the parathyroid glands during surgery and advocate a subcapsular dissection to try and preserve the glands as well as the blood supply which are both extra-capsular except in cases where the parathyroids are intrathyroidal.

COMMENT ON

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Procedure-specific consent forms

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The authors invoke the use of procedure-specific consent forms (PSCFs) without any evidence to support this from the data analysis published. PSCFs lack:

1. The space to express adequately the nature of, the benefits of, the risks of, the discomforts of, the alternatives to and the consequences of not having a procedure which complies with 2008 General Medical Council guidance *Consent Patients and Doctors Making Decision Together*, paragraph 9.
2. Further compliance with UK Department of Health guidance restricts information to risk and benefits only.
3. A vignette. A patient had severe chronic obstructive pulmonary disease (COPD) and developed bronchial carcinoma. The respiratory reserve was such that only a partial lobectomy was physiologically feasible. The patient was sent to a centre. The trainee used a preprinted consent form for the surgical management of bronchial carcinoma, *i.e.* lobectomy. The side was not documented nor the consequences of a lobectomy in the individual patient. The patient had this surgery, returned to the originating trust and died with severe and deteriorating pulmonary reserve as a direct consequence.

It is apparent that death and any consequences of surgery are unique to an individual patient who has the right to curtail or expand upon information they have received on which to form their decision. PSCFs deny individual autonomy for the sake of generic risk which may be below an

acceptable threshold of the individual. However, this can be circumvented by quality patient information sheets (PISs) and extra or lesser information recorded in the individual case notes. A copy of the PIS should be dated, signed by the clinician and filed in the record. The generic consent form can be used still and reference made to the annotations in the case record.

This method allows for detail that is unique and pertinent to an individual patient rather than relying on pre-printed consent forms that may exclude pertinent and relevant information for that patient.

Generic pre-printed consent forms equate to generic thought and the risk of involuntary automatism with its potentially lethal sequelae: a risk too far for social convenience.

AUTHORS' RESPONSE

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Procedure-specific consent forms in surgery: more than 'sign on the dotted line'

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We read with interest and disagree with the letter of Mr McIlwain on the potential disadvantages of the use of procedure-specific consent forms (PSCFs) in surgery.

There is increasing evidence highlighting both the benefits of PSCFs and the weaknesses of conventional consent forms (CCFs) in consenting practice. In a recent randomised-controlled trial, Finch *et al.*¹ revealed that patients consented for transurethral prostate resection by use of PSCFs recalled more accurately the predicted risk of re-operation than patients who signed the CCFs. Similarly, Kondziolka *et al.*,² using PSCFs, demonstrated high postoperative recall rates (ranging between 97–100%) regarding diagnosis, planned treatment, alternatives and relevant risks of specific neurosurgical procedures. On the other hand, various studies have evaluated the current conventional consenting process and emphasised the high variation in the quality of obtained consent for common general surgery procedures such as inguinal hernia repair.³

The British Orthopaedic Association has endorsed a website allowing surgeons free access to PSCFs (<www.