Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the instructions to authors at <http://www.rcseng.ac.uk/publications/submissions/authorinstructions.html>. Tables and figures should only be included if absolutely essential and no more than five references should be given. The editor reserves the right to shorten letters and subedit contributions to ensure clarity.

Informed consent

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COMMENT ON

Shokrollahi K. Request for treatment: the evolution of consent. *Ann R Coll Surg Engl* 2010; **92**: 93–100

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We read with interest the article by Shokrollahi and Wheeler's response.¹ There is no doubt that the process of informed consent should be one of the most important aspects of patient-centred surgical care and something that we hope we all strive to achieve. However, in this era of the EWTB, non-specialty specific junior surgical trainees and the added time pressure of having to consult more patients in clinic to meet the 18-week target, when are we expected to find the extra time required for this ideal standard of care? In our experience, pre-assessment clinics are now often being run by specialist nurses, who, although trained in possible surgical complications, are not the actual surgeons performing the procedures. Additionally, if there are no contra-indications to general anaesthesia, some pre-assessment clinics are now conducted entirely over the telephone. Furthermore, we now have pooled lists, when the surgeon who initially listed a patient for a given procedure is not the one who ends up performing the surgery. Patient 'ownership', the continuation of surgical care under a single surgical consultant, along with more time to see patients in clinic would surely improve the process of informed consent, perhaps even more than RFT forms.²

References

1. Wheeler R. The evolution of consent. *Ann R Coll Surg Engl* 2010; **92**: 91–2.
2. <www.rft.org.uk>.

AUTHOR'S RESPONSES

Highlighting advantages of implementing request for treatment (RFT) as a method of consent

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RESPONSE 1

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Wheeler's comments¹ relating to my Hunterian paper² are welcome, highlighting persuasive arguments in favour of a request-based system of consent and allowing some clarifications.

His suggestion of 'special arrangements' aiding non-English speakers is most welcome; indeed, the fact that procedures are not universally in place for these patients at present is a critical legal, ethical and clinical omission of the current process of written consent. It is just too easy to acquire simply a signature from any patient and proceed to surgery (without truly valid consent). The 'all-you-need-is-a-signature' process of current consent facilitates this negligent practice. Wheeler, therefore, puts into sharp focus how consent using RFT does not allow a patient to undergo treatment without first giving truly informed consent. Thus, the issue is not that RFT can in some circumstances be difficult to implement, it is that RFT will not allow a non-informed patient to proceed to surgery, which, after all, is the primary aim of a written document of consent. In any circumstance where a patient can sign a consent form but cannot accurately complete an RFT form, I would challenge the validity of that consent.

Wheeler suggests that comparative data could help in seeing whether RFT might be better than standard written consent in the assessment of capacity. This is simple to