Should junior doctors be obtaining consent?

Introduction

It's been a year since I became one of the latest additions to the medical profession and it's only now that I'm getting to grips with what to do. However, at the back of my mind throughout this year, I have never really been confident with one particular task – the issue of consent and who was expected to obtain it.

Starting as a foundation year 1 doctor in August 2005, I was bewildered with the great variety of bureaucratic tasks I was expected to perform. I took on the responsibility of gaining consent through a combination of naivety, where I did what I was told, and fear of the consultant's wrath for any delay in theatre.

Despite having recently graduated and having read the General Medical Council's (2001) *Duties of a Doctor*, I did not fully appreciate the potential consequences of what I was doing and this continued throughout my jobs in general surgery and gastroenterology. I've lost count the number of consents for gastroscopies and colonoscopies I must have gained, not to mention the numerous incision and drainages, appendicectomies and hernia operations. I even gained consent for a 'modified Hartmann's' without clear knowledge of what it involved.

It was during my last rotation in paediatric surgery, however, that I began to question why I have felt pressured in doing this, when legally I would have had to face up to the patient had anything gone wrong that wasn't discussed during consent. I was surprised to have a 'consent list' where I had to obtain consent for insertion of grommets from around ten patients every Tuesday morning. Although the insertions of grommets is a simple and straightforward procedure, I found it difficult to obtain consent as I had never seen a grommet operation let alone performed one. This happened weekly and on the third week I seriously entertained the thought of obtaining group consent, as all the patients were having the same procedure. One consultant had once told me how he, as a junior, did group consent of 22 patients for a colonoscopy in order to keep to schedule, giving me the idea. It was only when I investigated if this was a real possibility did I see the risks in what I was doing.

Not soon after, I was bleeped by a very angry consultant anaesthetist after he had had to cancel an operation because the person I had obtained consent from was not legally able to give it. The child in question had been under the care of her grandfather but as he was not her legal guardian, the consent did not stand.

I was frustrated at receiving the blame, having only obtained consent following reprimands for not doing so in the past. This frustration was compounded by knowledge that the consent should have been obtained by the person doing the operation in the first place or, at the very least, double-checked by themselves. It was then I decided that any consents I gained would be countersigned by the senior doing the operation, regardless of the simplicity of the procedure, and that I must at least have seen what the procedure involved, if not assisted with or done it myself.

Legal ramifications

Delving deeper into the legal issues surrounding consent, I realized that there was more to take into consideration. Working with children, everything you do is double- and triple-checked and consent was no different. After now asking my seniors about the subtleties of obtaining consent, I learned that unmarried fathers were unable to give consent if their child was born before 1 December 2003. Heaven knows how many junior doctors have obtained from people in this subgroup who actually weren't legally allowed to give this consent.

Furthermore, there is a separate consent form for over 16-year-olds and anyone under 16 years of age who was deemed mature enough to understand the implications. Now that I was reviewing the subject of consent, I saw a potential loophole in this form. Judging whether a child under 16 years of age was mature enough to sign the form was a subjective view and, should anything go wrong, one could argue that the doctor should have obtained consent from the parents.

I discussed my reservations with one of the more traditional consultants, who suggested that obtaining consent for procedures should continue to be a routine task of junior doctors. He claimed that it would force the junior to go into theatre to see what he/she was obtaining consent for, what it involved and what the risks were. Initially I disagreed with this but, in retrospect, he was correct. It did encourage me to see the actual procedures, so that I was able to answer patients' questions and so that I was more confident when I obtained the consent.

Hospital medicine is full of little struggles of ethics *vs* practicality and who obtains consent is just one of those that continue every day in every hospital. I believe that this problem has continued as a result of internal and external issues. Internally, many doctors consider that obtaining consent is a routine task, similar to venepuncture or rewriting drug cards, that they need not do as they become more senior. Externally, pressures of meeting targets see consultants trying to maximize the number of procedures they do or the number of people seen and hence the process of obtaining consent is shifted to junior doctors. Unless these root causes are corrected, I doubt this will change in the near future. As such, perhaps the emphasis should move onto educating doctors on the significance of obtaining consent and the legal ramifications behind it. **BJHM**

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General Medical Council (2001) *Duties of a Doctor*. General Medical Council, London

KEY POINTS

- Many junior doctors feel obliged to obtain consent for procedures for which they have little or no experience of doing.
- Few doctors realize the significance of the implications in obtaining consent with inaccurate information.
- Consent is as much a legal process as a medical one and the responsibility lies with the person obtaining it.
- Root problems within the NHS need to change for this issue to resolve.