Informed consent and junior house officers

Sir,

I enjoyed the report of Arumugam et al (vol 64(2), 2003, p. 108) in which the efficacy of an educational package concerning informed consent and index surgical procedures was demonstrated. They cited a study of ours (Huntley et al, 1998), documenting the unfortunate ignorance of junior house officers with respect to consent – using colonoscopy as an index procedure. We proposed an educational induction package similar to that instigated by Arumagam et al, and somewhat surprisingly provoked some critical reactions (Hole, 1998; Jeffery, 1998; Richardson and Jones, 1998). Broadly these centred on:

1. The junior house officer being too inexperienced
2. Some question as to whether it was correct to mention a 'remote risk' such as perforation for a colonoscopy (Hole, 1998; Richardson and Jones, 1998)
3. The induction package not being the correct mode in which to impart such information (Jeffery, 1998).

With regard to:

1. The junior house officer being too inexperienced: education is obviously the key. It is fair to add that junior house officers are doctors, have undergone some training years at medical school, and should not be 'dumbed-down'. This in no way negates a role for more senior doctors to be involved in the consenting process.
2. The communication of risk: this is necessarily complex (Calman, 2002), but material risks must be discussed. 'Material' is not merely a function of likelihood but also of severity (Skene and Smallwood, 2002). This is inceasingly important as courts adopt a standard of what a 'prudent patient' can expect, rather than what a 'reasonable doctor' might do (Skene and Smallwood, 2002).
3. The 'induction package': it is clearly good practice that the junior doctor has the educational information available before commencing the job in which it is relevant.

Pressures of litigation and risk management, together with the change in emphasis promoting patient autonomy, mean we cannot afford to get consent wrong. It is, in addition, too good a learning opportunity for junior doctors to miss.

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Antibiotic prescribing must improve

Sir,

I wholeheartedly support the call for improved national surveillance of hospital-acquired infections (HAI) by Andrew Swann in the January issue of *Hospital Medicine* (vol 64(1), 2003, p. 4). However, this is only part of the solution to the growing morbidity and mortality caused by HAIs. More appropriate treatment of these infections is also needed. Traditional approaches to management are inadequate in many patients, resulting in around 30% of patients receiving inappropriate antibiotic treatment with a resulting mortality of up to 90% (Kollef et al, 1999; Ibrahim et al, 2000; Kollef, 2000).

A worldwide educational initiative to optimize antibiotic prescribing for hospital acquired infections has recently been launched, with the aim of reducing mortality by promoting early treatment with appropriate empiric antibiotics. The initiative – the Academy for Infection Management (AIM) – has agreed key principles designed to improve the treatment of HAIs: recommending the use of appropriate empiric antibiotics early in patients with suspected nosocomial infections and giving the right dose for the appropriate duration. The antibiotic dosage or therapy should then be changed if required, when pathogen and resistance information is available. It is hoped that this treatment strategy will improve survival and reduce hospital stays associated with HAIs.

Research has clearly shown that early empiric treatment reduces mortality associated with HAIs. An intensive care unit study of one of the most vulnerable groups of patients with which we deal found that 29.9% of patients received inadequate antimicrobial treatment for their bloodstream infections. The mortality rate of this group of patients was 61.9% and was statistically significantly greater than the death rate among patients with a bloodstream infection but who received adequate antimicrobial treatment (28.4%) (Ibrahim et al, 2000).

To reach as many doctors as possible, AIM will be running meetings and providing educational materials on its website at www.infectionacademy.org. The project is being supported by an educational grant from AstraZeneca as part of its ongoing programme to improve the use of antibiotics, which includes a global antibiotic resistance surveillance system, MYSTIC (Meropenem Yearly Susceptibility Test Information Collection).

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