Transatlantic Consensus of Vascular Surgery Consent

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Introduction

The World Health Organization has stated that *"documentation and record keeping is a fundamental part of clinical practice"*. Optimization of patient consent in the hospital environment remains vital for patient safety and wellbeing. The UK General Medical Council has also emphasised the importance of adequately trained and qualified personnel to obtain clinical consent.

Houghton *et al* reported that 37% of junior doctors admitted to gaining consent for procedures of which they had little understanding.

Clin Otolaryngol Allied Sci 1997; 22: 515-8.

Carter *et al* suggested that the implementation of clinical audit improved informed consent when assessed in New Zealand vascular surgery patients.

NZ Med J 2008; 121: 57-63.

Black *et al* identified significant improvement in consent performance in staff surgeons compared to trainees for carotid endarterectomy.

Eur J Vasc Endovasc Surg 2009; 37: 1334-139

Objectives

Currently, there are no explicit guidelines for informed consent for vascular surgical interventions. This study evaluated the patient consent process for five main vascular procedures:

- Abdominal aortic aneurysm (AAA) repair
- Carotid endarterectomy (CEA)
- Peripheral arterial reconstruction
- Amputation
- Varicose vein interventions

Primary study objectives included an assessment of vascular consent completion demographics.

Secondary study objectives were to collate and compare expert opinion for vascular procedural complications from members of the Society for Clinical Vascular Surgery in the United States (SCVS) and the Vascular Surgery Society of Great Britain and Ireland (VSS).

Methods

A prospective anonymous online survey was administered to members of the SCVS and VSS. Each member evaluated general and procedural specific complications for both arterial and venous interventions which should be discussed with patients during the informed consent process.

Greater than 75% reporting for a specific complication was deemed the threshold for consensus opinion. Chi-squared analyses were used to compare responses between the SCVS and the VSS.

Results

Completion Demographics
The overall response rate was 24.8%. The majority of respondents were staff surgeons (81.5% SCVS vs. 85.2% VSS). Both societies considered senior trainees competent to obtain consent.

The majority of patients were consented primarily by the attending (67.6% SCVS vs. 90.6% VSS, p<0.01) on a pre-printed consent form (95.1% SCVS vs. 98.7% VSS). Consent was obtained on the day of surgery in the office (35.4%-SCVS) or the day before surgery in the hospital ward (35.1%-VSS) with the provision of additional written documentation (59.2% SCVS vs. 85.4% VSS, p<0.01).

General Vascular Surgery Complications
With incorporation of the 75% threshold for consensus opinion, **figures 1-2** delineate key complications for inclusion in vascular consent for general arterial and venous procedures.

Procedural Specific Vascular Surgery Complications
The 75% threshold for consensus opinion was also incorporated for procedural specific complications for each of the five main vascular surgery procedures with a comparison of SCVS vs. VSS respondents' opinions **(Figures 5-10)**.

Post-Operative Documentation
81.7% of respondents provided post-operative recovery information to their patients **(Figure 3)**. 59.2% of respondents provided additional documentation to the patient following their procedure which included hospital leaflets (68.9%), professional society cards (50.9%) or charity foundation advice (7.6%).

Consent Training
Although the VSS reported a significantly higher consent training rate (14.1% SCVS vs. 40.8% VSS, p<0.01), both societies stated this mainly involved ad-hoc informal training **(Figure 4)**.

Figure 1: General Arterial Complications

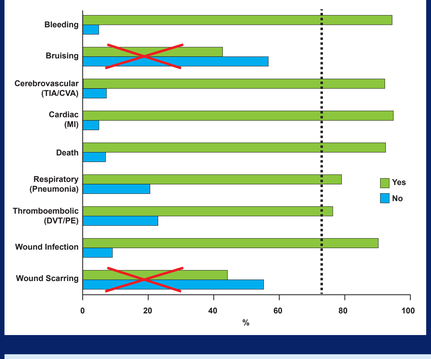


Figure 2: General Venous Complications

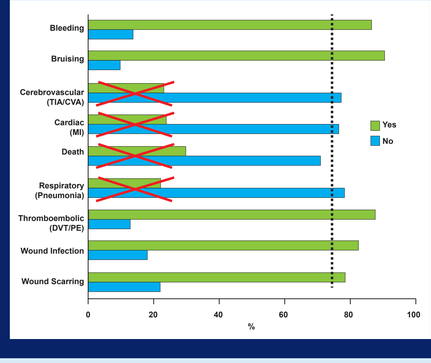


Figure 3: Post-Operative Documentation

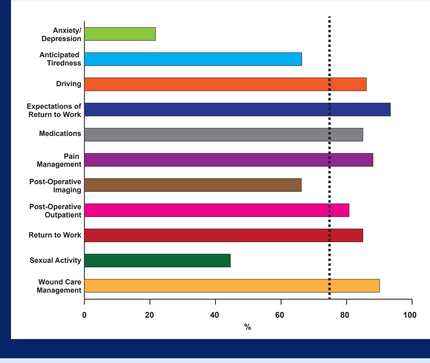
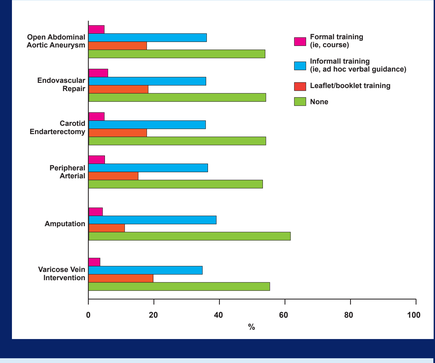


Figure 4: Consent Training



Procedural Specfic Vascular Surgery Complications

Figure 5: Abdominal Aortic Aneurysm (AAA)

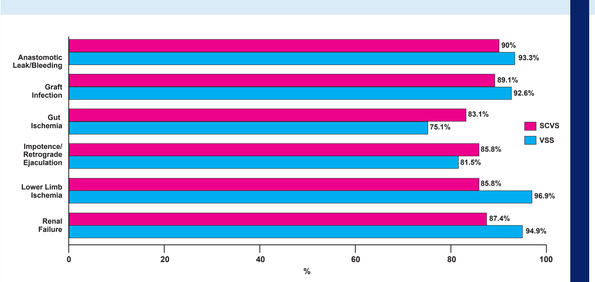


Figure 6: Endovascular AAA Repair

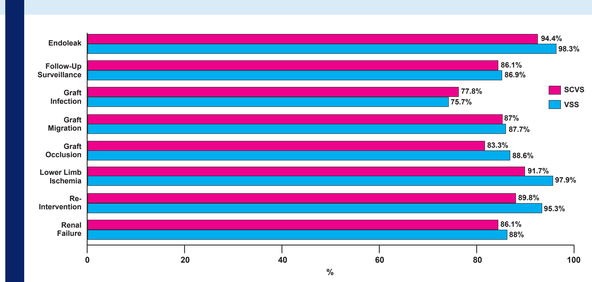


Figure 7: Carotid Endarterectomy

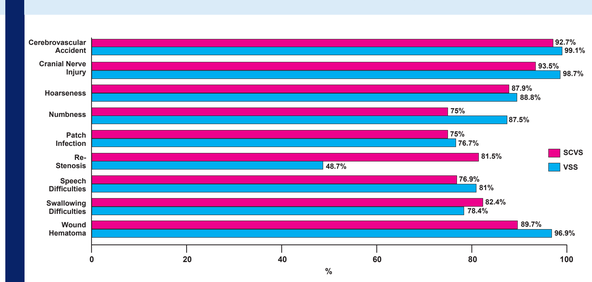


Figure 8: Peripheral Arterial Reconstruction

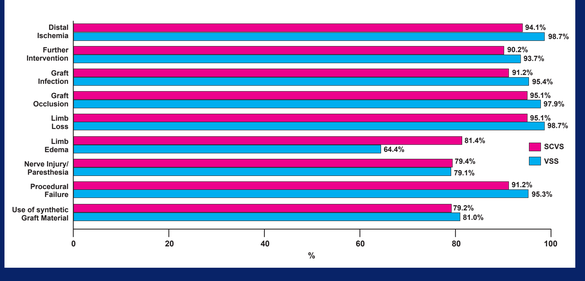


Figure 9: Amputation

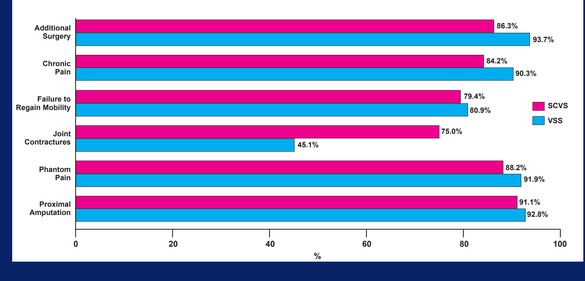
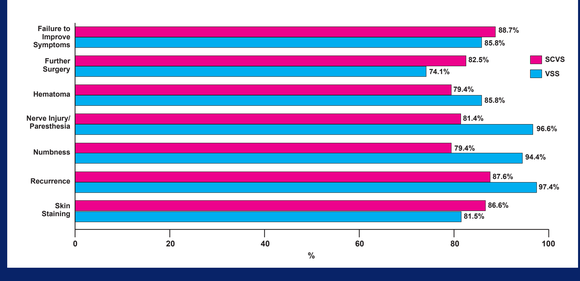


Figure 10: Varicose Vein Intervention



Study Limitations

Response rate of 24.8% may not be truly representative of both societies.

Survey too expansive and time-consuming to complete.

Was the 75% threshold limit appropriate for consensus opinion?

Conclusions

This transatlantic study represents a significant opportunity for vascular surgeons to standardize and enhance the informed consent process for their patients.

Whilst completion logistics of vascular consent vary, both SCVS and VSS members concur on the majority of complications necessary for inclusion in informed vascular consent.

However, significant deficiencies in consent training for junior doctors still remain in the United States, Great Britain and Ireland.

Belfast Health and Social Care Trust

The Vascular Society of Great Britain & Ireland

SOCIETY FOR CLINICAL VASCULAR SURGERY