The Journal of One-Day Surgery

Annual Scientific Meeting
Special Edition
Presidential Handover
Audit on Patients' Experience of Consent for Surgery
Now available from the British Association of Day Surgery

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Front Cover photograph: A panoply of Presidents: past, present and to come.
Left to right: Doug McWhinnie, Ian Smith, Anna Lipp, Mark Skues and Ian Jackson
As I was driving back to Merseyside from the Annual Scientific Meeting in Torquay, I found myself singing along to an old pop tune from the sixties.

The correct title for the song is “It’s my party and I’ll cry if I want to”.

However, I found myself singing, “It’s my body and I’ll do what I want to”.

With the health and welfare reforms now on the statute books, enshrined therein is the principle of “no decision about me without me”. Meanwhile intermittently the press highlights another case of an incapacitated patient requesting, through the courts, the ultimate right of self determination – to decide the time and place of their own death and assurance that anyone who helps them will not be prosecuted. This is to me a bemusing situation: the Suicide Act 1962 decriminalised taking ones own life unless of course one is unable to do it because of a physical handicap.

Autonomy is here to stay, straddles all elements of medicine and we must adapt from the medical paternalism of old.

I believe that a recurrent theme from many of our speakers in Torquay was the accelerating and growing requirement for patients to be actively recruited into conversations about their health needs and interventions.

Day Surgery is the big provider of interventional healthcare so this means serious work for us!

I was obviously further ensnared by both direct and subliminal messaging. Did Philip DaSilva continue my indoctrination with his exposé on variation in clinical practice? He was unquestionably an advocate for doing the right thing for our patients and with their understanding thereof.

Notably in the debate on providing acute laparoscopic cholecystectomy for the “hot gall bladder”, delegate comment from the floor was quizzical about how the patients would react to day surgery for the acutely unwell patient. How can we make it possible to assure an acutely unwell person that their interests are best served by returning home within hours of operation?

Peter “Alf” Collins recounted his experiences and directed us towards this new world of shared decision making.

He also highlighted that to deliver it we would need an abundance of what is a most costly and precious resource – that is time.

My fellow BADS council member, Claire Tickner in her talk on the Ideal Day Surgery Patient also embraced the concept of a patient who is both informed and involved in his or her own care.

One of the great privileges and duties of the Editor of the Journal of One Day Surgery is to construct the supplement of abstracts for the Annual Scientific Meeting. This year, I have been immensely impressed by the interest shown by authors in what patients think of their day services. It transcends the data collected as Patient reported outcome measures and Patient reported experience measures.

There is a real and growing appreciation that client recommendation must be earned and must never be taken for granted.

This theme is exemplified in prize winner Sarah Futcher’s work on “the Mystery Shopper”.

So how good are we at sharing the decision making with our patients. I commend the article herein by Parvizzi et al who take a cold clinical look at acquiring consent. I suspect we can all identify with their findings.

Then of course, the other great current topic for conversation in healthcare is money - tariffs, profits and cost reduction. Meanwhile, a cash strapped healthcare trust has been put into administration.

In his lecture on Hernia Repair, it was inevitable that my colleague Harmeet Khaira would mention comparative costs. I would draw your attention to an article in the British Medical Journal. In Africa, inguinal hernioplasty is accomplished using mosquito net mesh.

Things here are tight but not that tight yet!

BILL HORTON

References

1. “It’s my party and I’ll cry if I want to!”. Sung by Lesley Gore. Released by Mercury Records in April 1963.
2. The Suicide Act Chapter 60 9 and 10 Eliz 2.
4. Cash strapped NHS Trust is to be placed in administration. BMJ News 2012;3441.
Although sad to be concluding my term as President, I am also immensely proud of what has been achieved by the association in the past two years. This has only been possible through the support and hard work of council and our many associates, for which I am enormously grateful. It is fitting that the fruits of their labours are summarised here.

Our past two annual scientific meetings have provided excellent scientific content, ideal social networking opportunities and have attracted record numbers of abstract submissions. Despite the unfavourable economic climate, delegate numbers have remained high and we have enjoyed fantastic levels of trade support to help make the meetings financially viable. Thank you in particular to all of the delegates for the interest and warmth you always show our trade partners.

To supplement the annual conferences, we have held nine regional meetings in association with a wide range of partners, including the Royal College of Surgeons, the Royal College of Surgeons of Ireland, the Scottish and Irish Governments, Health Service Journal, Circle and, most recently, Healthcare Conferences. In addition, the views of BADS have been represented at 20 other meetings by a wide variety of individuals. All of these events help to disseminate the ethos of the association to a wider audience. We have also continued to run interactive courses on local anaesthetic hernia repair, preoperative assessment and laparoscopic cholecystectomy.

The association has produced a number of useful publications, not least the Day Case Surgery textbook from Oxford University Press. Anna Lipp’s team have produced six handbooks in the past two years, the latest three being “Teamwork and staffing in day surgery”, “Day case surgery under local anaesthesia” and “The pathway to success — management of the day surgical patient”. Individual council members have also contributed to a further two book chapters and a series of articles in the Bulletin of the Royal College of Anaesthetists. The BADS Directory has just been updated to the fourth edition and is now accompanied by a national dataset which highlights current performance against the targets and a revised edition of the commissioning guide which reiterates the principles of high quality care. The principles of the Directory are now used for national benchmarking through the better care, better value indicators, while the intellectual property of the directory has been licensed to a number of commercial companies. This means that the BADS Directory is now the definitive day surgery benchmark.

BADS has continued to work positively with a number of other organisations to highlight the value of day and short stay surgery. We are represented on both the Association of Anaesthetists of Great Britain [AAGBI] and Ireland and the Association of Surgeons of Great Britain and Ireland. BADS was a major contributor to AAGBI day surgery guidelines, as well as collaborating with NHS Diabetes and the NHS Atlas of Variation. We continue to be consulted by the Department of Health and are delighted that day surgery is now recognised and rewarded as best practice for several procedures.

Throughout my presidency, we have been supported by our strategic alliance partners Abbott, Anetic Aid, Ethicon and Ethicon Endo-Surgery. Arizant and Storz provided support for some of this time and we have now been joined by Eido and Vanguard. All of these partners have a portfolio of non-competing products and benefit from website links and professional advice, lectures and teaching from BADS Council members.

Underpinning all of the influence and activities of BADS are you, the members of the association. In these harsh financial times, our membership remains healthy, although our aim of 500 members remains tantalisingly just out of reach. We are constantly striving to increase the value of your membership and this year for the first time offered additional member discounts during our conference. My successor, Mark Skues, has already expressed a desire for greater involvement of the membership in BADS activities and will set out how he hopes to achieve this separately. In the meantime, one obvious way is to ensure that you exercise your democratic rights by voting in the upcoming council election.
As I hand over to Mark, I am happy that BADS is a healthy, vibrant and influential organisation with a brand which is well respected and increasingly recognised as a marker of quality. This has been achieved by the hard work and dedication of many, many people, of whom Mark Skues has already made numerous valuable contributions. I am confident that he will continue to lead BADS into an even more successful future.

IAN SMITH

The British Association of Day Surgery
President’s Award

The President’s Prize is awarded each year to someone who, while not an elected member of council, has nonetheless made an outstanding contribution to day surgery and to the association. None of the activities in which BADS engages could be sustained without the association being on a firm financial footing, so this year the prize was awarded to our Exhibition Manager, Janet Mills. Despite enormous economic pressures and declining global trade support, Janet has consistently managed to fill all of the available exhibition space year on year, attracting as many exhibitors as meetings with three or four times the number of delegates. By maintaining excellent working relationships, Janet has ensured that many trade partners return regularly, but she has also worked tirelessly to attract new exhibitors into the fold, thereby helping to disseminate the day surgery ethos even further. Janet has been instrumental in developing trade relationships which have culminated in strategic alliance partnerships and additional advertising revenue and we therefore take great pleasure in awarding her the President’s Prize.

IAN SMITH
In this outgoing letter, I have highlighted in his outgoing letter. As I mentioned in my address at the Annual Scientific Meeting in June, I have a legacy of superb leadership to inherit and continue, and Ian is going to be a very hard act to follow. On behalf of the Association and Council, I’d like to thank him for the sterling work he’s done over the past two years with development and promotion of our message, our ethos, and our credo. BADS has developed its influence and its credibility under his guidance and I know, like previous Presidents, he will continue to offer his guidance and wisdom to me as the “new boy on the block”.

So, where do we want to go for the next two years? We heard some inspiring talks and presentations at Torquay, and it’s phenomenal that the Association received over 120 submissions for oral presentations and posters for this meeting. This is the highest number ever, for any Annual Scientific meeting in our 23 years of existence, so that makes me think there is a real desire out there to be more innovative, more resourceful, and seek out new ways of improving the quality of patient care for day and short stay surgery. And yet, we learned from the various presentations, that there remains continued wide variation in day surgery rates for reasons that at times, seem pretty inexplicable. At BADS, we have a message that day surgery works; sure, it involves collaborative team work from a variety of multi-disciplinary backgrounds, certainly, it involves pre-emptive planning of the integrated patient pathway, but it’s not rocket science. So, who are the people who can best deliver and develop this message? Surely, everyone of you who are members reading this are the folks who can take back this message that we believe in, and indeed know to be true... The most important people who can continue to influence and deliver change isn’t me and, it isn’t Council... It’s you.

In Torquay, nearly two thirds of the attending delegates were non members, and it was wonderful to see a significant number of these people, who obviously have an interest in Day and Short Stay Surgery, join the Association. We will be now be better able to support them by representing their views, and indeed learning a little more about the challenges, successes and tribulations that, actually, we all face and deal with on a daily basis. So, if you are one of the new readers of the Journal, welcome to the BADS team.

If you are an existing member,... you are our life blood. It is you that I and the rest of Council represent with all of the national input that has been delivered so well over the last few years. We are grateful to you for supporting us. But how can we support you? Well, to my mind, it’s about further developing some of the resources already available to you as a result of you being a member, and then perhaps, trying to empower you even more. In the Member’s section on the website, we already have a series of discounts for books and other meetings that we are involved with, there’s access to every presentation that has been given at our Annual Scientific Meetings for the last few years, and this year will be no exception. We have a literature database, downloadable articles from the Journal of One Day Surgery, and the links to comparative benchmarking for Day Surgery will be there soon. I would like to see us further enhancing educational media in this section of the website that you can then go out and use within your own working environments to influence the change that is sorely needed across the country. I would like us to be able to help you in any way that we can. But, I would like to know from you, how you feel we can do that.

So here’s an offer to you all. Our next Council meeting is scheduled for Friday 21st September. The day before, on the afternoon of Thursday 20th September, if any of you would like to come and meet with me, in London, with any bright ideas for how you would like to see the Association develop to meet your needs, then I would love to chat with you. Please e-mail me via baks@bads.co.uk, heading your mail ‘President’s Offer’. My own personal challenge, and perhaps one to you, is to ensure that you get involved, and that you feel involved with our Association. Next year, at our meeting in Southport, I would like my President’s review to include details of what you’ve achieved over 12 months, rather than what the Association has achieved; I’d
want to highlight you and your efforts as the most significant development, rather than anything I and the rest of Council have been doing . . . and, who knows . . . perhaps we should develop a series of awards for innovations and improvements that you have been able to facilitate over the next year?

So, my offer is out . . . talk to me, e-mail me, meet with me, and let’s see what we can do to support you in your job developing day and short stay services in your own hospital . . . we have a lot of work ahead to spread the message that the Association promotes, and I need your help to be able to do it.

As a final note, when I’d finished my new President’s address in June, Sarah Lloyd and I chaired the last session of the meeting hearing about the ‘ideal’ members of a day surgery team we’d all like to work with. It was a super ‘closure’ that was both entertaining and challenging. I remain very aware, though, that it’s you, our members, who are the most valued asset of our BADS ‘team’. So, let’s talk together, plan together and do it together, and really make a change.

MARK SKUES

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**The BADS Fellowship**

The BADS Fellowship is available to be awarded each year. However, the award will only be made when a suitable project is approved by the council of the British Association of Day Surgery. The award is for a maximum of £2,000.

The Fellowship is open to all members of the Association. It may be awarded to aid a research project or to help fund travel costs as part of a study or practice development. In all cases, the project must be aimed at improving day surgery, either within the UK or abroad. A precondition of the Fellowship is that those who receive it will attend the next BADS Annual Scientific Meeting and present the outcomes of their project.

To apply for the Fellowship, a full description of the aims, methods and costs of the proposed project must be submitted and should include ethical committee approval where this is appropriate.

Applications should be sent to: Dr. Sarah Lloyd, Honorary Secretary, British Association of Day Surgery, 35–43 Lincoln’s Inn Fields, London WC2A 3PN.
The Journal of one Day Surgery

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<td>+9 0</td>
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<tr>
<td>Previous upper abdominal surgery Yes no</td>
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<td>Pre-operative acute cholecystitis requiring hospital admission Present absent</td>
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Table 1
Risk score for conversion from laparoscopic to open cholecystectomy (RSClo) 2.

This specialist handbook is the culmination of collaboration between the British Association of Day Surgery and Oxford University Press.

The editors, Smith, McWhinnie and Jackson, have recruited experts from around the world to deliver an up-to-date and comprehensive guide to all that is best practice in Day and Short Stay Surgery.

Contents

- Origins and importance of Day and Short Stay Surgery and its benefits to health economies.
- Pre assessment and preparation for same day admission for medical intervention or surgery.
- The selection and delivery of the differing modalities of anaesthesia to facilitate surgery.
- Post operative care, complications and follow-up thereafter.
- Issues specific to the various types of surgery.
- Focussing on the patient centred clinical journey.
- Workforce issues and organisational development.
- Developing the required facilities.
- Pushing the boundaries and evolving to meet future challenges and developments.

This book has been produced as the workshop manual for all clinicians involved in the day to day delivery of shortest stay surgery.

However, it is anticipated that it will become the reference work for those who are to be intimately involved in the design and commissioning of elective interventional services.

We are pleased to announce that BADS members can now receive a 20% discount on selected Oxford University Press publications including the recently published BADS Day Surgery Handbook.

For more details and other member benefits please login to the BADS members area on the website. www.bads.co.uk
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Reports from the BADS ASM 2012, Torquay

Report of the Debate: “This house believes pre-operative assessment should be carried out by the Day Surgery Team”

BILL HORTON

Proposing the motion: Dr Mary Stocker, Consultant Anaesthetist & Director of Day Surgery, South Devon Healthcare.

Challenging the motion: Dr Anna Lipp, President Elect of BADS, Consultant Anaesthetist, Norfolk & Norwich Hospital

Chair: Vicky Hampson & Bill Horton

Before battle commenced the referee polled the audience as to their views.

The forest of hands overwhelmingly supported the motion laying down a significant challenge for Dr Lipp.

Dr Stocker delivered a solid and polished summary of the accepted and conventional wisdom that supported her stance. She referenced it with a catalogue of publications from august Anaesthetic bodies and included works to which BADS and its officers had contributed. She enhanced her argument with illustrations from her own facility in Torbay.

Not to be phased by the size of the task presented, Dr Lipp retorted with an adroit demonstration that clearly one size could not possibly fit all and provided stalwart challenges against the aforementioned conventional wisdoms.

Emergencies in the Day Case Unit

Report on presentations and round table discussion

IAN R. ARMSTRONG

The question of whether emergencies could or should be dealt with in the day case unit was one which was addressed by four of our speakers. Each approached it from the perspective of their own specialty. Jim Clark eloquently outlined the management of emergencies of early pregnancy and how he managed these within the context of the day surgery unit. Similarly, Claire Edwards, Anurag Golash and Celia Ingham-Clark described clinical scenarios within their own specialist areas of Orthopaedics, Urology and General Surgery respectively, which could be managed on a day case basis.

The first problem was distinguishing between ‘emergencies’, which need action there and then, and unplanned surgical procedures which require intervention sooner rather than later. Across the specialties there was a general consensus that operative procedures for conditions presenting for unplanned surgery could be identified which lent themselves to management along the principals of planned day case surgery.

However, there was also agreement that unlike planned day surgery, the default position may be in-patient. Indeed, in some instances there had to be rigorous patient selection before day case management. Celia Ingham-Clark outlined this issue very well in discussing the issues surrounding incision and drainage of an abscess: a simple straightforward surgical procedure which on the face of it lends itself to same day discharge from hospital. However this overlooks the important fact that this was an unplanned surgical procedure – the patient may be seriously systemically unwell before the procedure and had the potential to be seriously unwell after the procedure.

When it came do the thorny issue of actually organising theatre time and beds/trolleys, all our speakers were left adopting a ‘fit it on the end of a planned list’ philosophy which rather flew in the face of all we had heard on team working and patient safety, not to mention optimizing theatre utilization. Our speakers laid out the challenge – can we encompass unplanned urgent surgical patient admissions within the day case unit and apply the day case philosophy to their management, yet not compromise all that has been achieved in planned short stay surgery?
Free Paper Session: Theme – Orthopaedics

IAN JACKSON

Six papers were presented during this interesting session. First up was Dr Simpson from Derriford Hospital, Plymouth who looked at the barriers in their own practice as part of planning a day case microdiscectomy service. This dealt with the review the team had performed of current practice before starting this new service. It was interesting that several members of the audience commented on their own local day surgery experience in this area. Next up was Miss Razik from University College London Hospital who had worked with the coders in her hospital looking at the coding of anterior cruciate ligament reconstruction. She identified issues around recording of procedures so that they were coded appropriately which was losing the department income. I suspect this is a recurring theme in surgery and one worth checking in your own hospital.

Dr Bawa from Derriford Hospital presented on the outcome of patient telephone interviews at 48 hours following anterior cruciate ligament reconstruction. They had an admission rate of 20% with the largest factor being postoperative nausea. Overall 80% of their patients rated their experience as very good or good. The audience were surprised at the high rate of post operative nausea and vomiting though were reassured that the team are actively refining their management of these patients following this audit.

Mr Bismil presented the work of the Parkside Day Case Unit in Boston which is community based service. This was a fascinating presentation in that this is non hospital based hand surgery, performed as a one stop service and Dupuytren’s contractures were being managed under local infiltration and without a tourniquet. The potential cost saving for the NHS is considerable. Mr Bradley from Torbay Hospital presented their experience of day case unicompartmental knee replacement. This is in its early phase of implementation but they have successfully discharged 6 out of the initial 7 patients on the day of surgery.

The final presentation was from University Hospital Coventry and Warwickshire on a novel approach to the management of ankle fractures. This involved the patient being sent home after assessment and initial management with a cast and advice to keep the leg elevated. Patient were admitted six days later for fixation. The pathway appeared to work well and though the patients stayed in post operatively they are now considering fixation as a day procedure.

Poster Exhibits Torquay 2012

IAN R. ARMSTRONG

This year we had over 70 posters presented at the ASM in Torquay. The standard of all exhibits was extremely high and set our three judges, Mr Tim Rowlands (Consultant Surgeon, Derby), Ms Nikki Bennet (Matron, Day Surgery, South Devon NHS Trust) and Dr Ian Armstrong (Consultant Anaesthetist, Edinburgh) a formidable task. As always, we had no limit on the number of BADS Certificates we could award but rather judged each poster on its merits awarding points for content, innovation, presentation and conclusions. This year we awarded 15 Gold Certificates and 22 Silver Certificates.

There is a tremendous amount of work involved in putting together a poster exhibit but the results are very much appreciated. Posters form an important element of our ASM. They are an excellent way of letting others know how you solved many of the problems we all face and also of promulgating (to use our new President’s word!) the innovations you have made. Not least, they are a great way of learning! If you did not get awarded a certificate, the poster was no less appreciated by those attending the meeting. For all who did submit a poster and have extended the work, the Editor of the Journal of One Day Surgery would be more than pleased to hear from you and consider publication in the journal.
## Prizes for Posters

### Gold Certificates

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Silver Certificates

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<td>P Sinclair, J Jackson, TS Bhatti, A Riaz</td>
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<td>Musgrove Park Hospital, Taunton</td>
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<td>SG Kulkarni, RC Read, M Stocker, J Montgomery</td>
<td>Torbay Hospital South Devon Healthcare NHS Foundation Trust</td>
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<td>P36</td>
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<td>RR Thurairatnam, VR Jayaraj, JE Mongomery, ME Stocker</td>
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<td>P35</td>
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Pictorial Memories of the Annual Scientific Meeting 2012 held at The Riviera International Conference Centre in Torquay

Council Members: Amjid Riaz, Ian Armstrong and Lawrence Rowe.

Council Members: Annette Thorpe, Claire Tickner, Past President Jill Solly and Sarah Lloyd.

A Very Special Offer: Drs Ahuja, Lipp and Armstrong.

Mary Stocker thanks Harmeet Khaira for update on hernia services.

Time for Presidential Handover: Drs Smith and Skues.

New Members completing Direct Debits.
Ian Smith acknowledges Jan Jakobssen for delivering the President’s lecture.

Ian Smith and Sarah Lloyd: “Ready for Kick Off”.

Philip DaSilva on Variation in Healthcare.

A Roaring Trade: Dr Madhu Ahuja.

Ian Smith acknowledges Jan Jakobssen for delivering the President’s lecture.

“Dancing the Night Away”.
Conference Dinner, with music from the “Abba Girls.”

Amjid Raiz with speakers from the session on Surgical Process.

Session: Emergencies in Day Surgery. Liam Horgan & Ian Smith with speakers......

Sue Eve-Jones emphasises the crucial rationale for coding; thanked by Kerri Jones.

Content with post prandial conversation.

Trevor Dale receives token of appreciation from Tim Rowlands.
“No Mystery here”, as Sarah Futcher picks up a prize from Ian Smith.

Rob Schofield, Free Paper Prize Winner, with President Ian Smith.

The Admin Team: BADS Angels Catherine Horton, Veronica Hall and Alysia Wilde.

Celebrating the Eighties.

The President’s Prize is awarded to Janet Mills.

Lay Members of BADS Council, Marilyn Thirlway and James Heffron who presented on the Ideal Team.
Report of the Debate: “This house believes that acute cholecystectomy is not viable in the day case setting”

BILL HORTON

Proposing the motion: Mr Doug McWhinnie, Past President BADS and Consultant Surgeon at Milton Keynes.

Challenging the motion: Mr Amjid Riaz, Consultant Surgeon at West Hertfordshire Hospitals.

Chairs: Doctors Sarah Lloyd & Mark Skues

In time-honoured fashion, the chair polled the audience prior to commencing the war of words. This revealed a considerable majority supporting the motion.

Mr. McWhinnie began his address by acknowledging that Erich Muhe had performed the first laparoscopic cholecystectomy in Germany in 1985. He reminded us that elective surgery has a single pathway but acute cholecystitis required two – surgery immediately or allow to settle on the ward and an operation some four to six weeks later. He advocated that to deliver an acute service required consideration of four domains. The first of which is clinical outcomes. He specified the findings of the 92 published papers and concluded that although not finding great differences in outcomes from acute and interval laparoscopic cholecystectomies they did not really reflect current practice in the UK or specifically Milton Keynes. He then addressed the adaptation of the day surgery pathway and facilities.

Finally, he considered cost and tariffs and ultimately concluded “day acute laparoscopic cholecystectomy – maybe but Not Yet!”

Mr. Riaz started his presentation by reminding us how common and costly gall bladder disease is as exemplified by the financial burden on American Healthcare. In the UK, of 49,000 performed annually, 14% are done as emergencies. He referred to the same cohort of publications as had his opponent but emphasised the safety and potential QUALY gains from hot cholecystectomy. Slow adoption he advocated was in denial of the confirmed potential benefits.

A retrospective review of acute cases admitted to his own hospital revealed that 63 of 85 cases could have been suitable for Day Surgery either done first on the CEPOD list or as an early start on a day theatre list. He also promoted the potential financial savings of day surgery.

Comments from the floor expressed concern about discharging an acutely unwell patient and that it had, for obvious reasons, not taken off already.

Both speakers were asked about how patients would view the process.

The session was closed with a vote: the motion was carried.
The last plenary session of the conference was the much-awaited discussion on an ideal day surgery anaesthetist, surgeon, patient and team.

Mr Doug McWhinnie opened the session with top ten qualities that he would wish his dream i.e. ideal day surgery anaesthetist not to have. They ranged from ATTITUDE as number one to INFERIORITY COMPLEX as number ten. Use of opioids, junior trainees doing unsupervised lists and poor through put due to delays from various reasons also featured in his long list of absolute no nos. We quite enjoyed his novel classification of anaesthetists as teachers, readers, coffee drinkers, stockbrokers and finally the helpers. He ended his discussion on a serious note that an ideal anaesthetist should be able to deliver reliable and reusable anaesthetic that involves minimal postoperative pain, nausea and vomiting, drowsiness and disorientation.

Dr Bill Horton followed on with an equally interesting and entertaining take on an IDEAL SURGEON. His dream surgeon would have a BENIGN personality, PLACID temperament with adequate skills in plumbing and carpentry. He would be up to date in knowledge and skills, a team player and use the same clock as the rest of us instead of a Surgeons Decimal Clock. The list continued with him being considerate, compliant, realistic and last but not the least appreciative.

Miss Clare Tickner gave a very informative talk on an IDEAL PATIENT. In order to achieve a higher rate in day surgery SURGICAL, MEDICAL and SOCIAL factors need to be considered. A robust pre operative preparation helps assess, inform and educate the patient and is key to successful day surgery.

Marilyn Thirlway and James Heffron conducted a very successful interactive session with the audience to discuss an IDEAL TEAM. They used the analogy of a football team, discussing the role of each team member. Importance of briefing and debriefing was stressed along with the need for the patient experience surveys to be actionable and patient involvement in the decision making process.

This excellent discussion delivered in a very entertaining style by the council members along with some valuable contribution by the delegates from the audience was indeed a perfect ending to a very successful scientific meeting.
Audit on Patients’ Experience of Consent for Surgery

NASSIM PARVIZI, ZIAD FARAH & TAHIR HUSSAIN

Keywords: consent, audit, patient satisfaction.

Summary: One of the fundamental principles of modern clinical practice is that valid consent is required for any intervention. The consent process is at the pinnacle of patient autonomy: it empowers patients to make informed decisions about their treatment. However, they often feel that the information they receive is not sufficient and more efforts are needed to ensure that consent is truly informed and valid.

At Northwick Park Hospital, London, UK, we conducted a complete audit loop assessing how well patients felt they were being consented for surgery. We identified ways to improve the delivery of information and the process of consent, and subsequently re-evaluated our practice to ensure an improvement in practice was achieved. Data was collected as a questionnaire-based cross-sectional analysis of current practice before and after an intervention. The intervention included an awareness campaign, mass emails, and the distribution of posters and flyers across the hospital directed at doctors, nurses, and patients encouraging better exchange of information. There was particular emphasis on providing patients with Trust approved information leaflets about the proposed procedure. A total of 100 patients were interviewed, 50 before and 50 after the intervention. A three-month period was allocated to implement the change between the two audit loops. The data was analysed using Fisher's exact test (p<0.05).

At the end of the audit loop, more patients rated their knowledge as sufficient (58% before the intervention versus 90% after, p=0.001). More patients felt that the procedure was explained to them (p=0.02) and more patients were provided with supplementary information such as leaflets (p=0.01). However, there was no statistically significant difference in the number of patients who received a copy of their consent form after the intervention (p=0.32).

It is important to audit current practice of consent in all specialties as it plays a vital role in patient-centred care in the 21st century. The implementation of change through simple measures such as an awareness campaign can lead to significant improvements in practice. Furthermore, the provision of patient information leaflets enhances patient education and aims to ensure their involvement in the shared decision-making process.

In order for consent to be valid, the patient must have the mental capacity to make that decision. This is assessed using criteria specified by the Mental Capacity Act 2005 (Table 1).

<table>
<thead>
<tr>
<th>Table 1</th>
<th>The Mental Capacity Act 2005.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A patient has capacity if he/she:</strong></td>
<td></td>
</tr>
<tr>
<td>• Understands the information</td>
<td></td>
</tr>
<tr>
<td>• Retains the information</td>
<td></td>
</tr>
<tr>
<td>• Weighs the risks and benefits</td>
<td></td>
</tr>
<tr>
<td>• Communicates an informed decision</td>
<td></td>
</tr>
</tbody>
</table>

Currently, the Department of Health is undertaking a review of consent in the National Health Service (NHS), looking at the impact of existing Department of Health (DH) guidance and forms on practice. It will be exploring...
how quality for consent can best be developed, enhanced and embedded across the NHS. The completion of a written consent form, though not a legal requirement, is part of good practice as recently published in Reference Guide to Consent by the DH. This is particularly true in the context of interventions such as surgery.\textsuperscript{5}

According to the Parliamentary and Health Service Ombudsman, a significant number of complaints regarding consent involved the patient feeling that they did not fully understand what was going to happen.\textsuperscript{6} This has been reported in a number of studies: patients felt that despite having signed a consent form, they did not feel they had fully understood the risks involved.\textsuperscript{7–9}

**Aims & Objectives**

In the midst of growing concerns both internally, within the medical profession and in the media regarding how well consent is being obtained, the first audit was conducted to evaluate how we are consenting patients for surgery at Northwick Park Hospital, North West London Hospital NHS Trust, London UK. We assessed patients’ perception of our current practice, identified ways to improve the delivery of information and process of consent, and subsequently re-evaluated our practice to ensure an improvement had occurred.

**Standards**

The standard against which our practice was audited was based on British Law, the General Medical Council (GMC), and Royal College of Surgeons guidance.\textsuperscript{10} According to these, all patients who have consented to a procedure should:

- Know what procedure they have had done and what it involved.
- Know the risks and complications of the procedure undertaken, as evidence that their consent was informed.
- Feel satisfied that the information they received was adequate to provide the informed consent.
- Be given a copy of their signed consent form.

**Methods**

A cross-sectional survey was carried out at a district general hospital from December 2010 to June 2011. Patients over the age of 18 years were prospectively and randomly selected from those who had undergone elective or emergency operations. They were interviewed by trained personnel using a questionnaire. All patients were interviewed on their latest procedure and underwent an initial cognitive assessment using an abbreviated mental test score (AMTS) (Appendix 1). Exclusion criteria included patients under the care of obstetrics and gynaecology, maxillofacial surgery and otolaryngology. Patients were also excluded if they did not have a copy of their signed consent form in their notes, had an AMTS of <8/10 or were more than 8 days post operation.\textsuperscript{11}

The results of the first audit loop were presented at a departmental governance meeting and recommendations for improvement were made as we identified the largest gap in information provided to patients which could potentially influence their informed consent. These recommendations were implemented by two junior doctors between January and March 2011. This intervention involved an awareness campaign of current practice standards. Mass emails, posters, and circulars were disseminated across the hospital to encourage the use of Trust approved patient information leaflets. The awareness campaign was directed at both doctors and nurses on the wards, in pre-operative assessment clinic and in the outpatients department. We emphasised the importance of patient education in the consent process and we were able to reinforce the need for it to be undertaken at multiple points during patient care from the time the decision for surgery was made, to the time of the pre-operative assessment, to the day of surgery. We further raised the need to use more diagrams to explain procedures, an increased awareness among surgeons to dedicate time to explain the possible need for additional procedures and after discussing complications, ask the patients to repeat these to ensure these have been retained. This would be further supported through the provision of patients with a copy of their signed consent forms.

The second audit loop surveyed another cohort of patients in June 2011 to explore the effect of the intervention outlined above. All data was analysed using Fisher’s exact test. The data was further analysed looking at the subset of elective cases only. Differences were considered to be statistically significant at a p-value <0.05.

**Results**

105 surgical patients were randomly selected for this study. A total of 100 were analysed further [5 were excluded]. Demographic data of these patients is given in Table 2.

The original data has been summarised in Table 3 and Figures 1–4. This shows that after the intervention, patients were more likely to know what their procedure was and also more likely to have had it explained correctly. All patients after the intervention knew what the procedure was compared to only 86% before (p=0.01). After the intervention patients were also more likely to have been given the opportunity to ask questions, with 94% feeling that they could ask questions, compared to only 76% before (p=0.02). Patients’ knowledge of their procedure was also increased when assessed on a 4-point, or a reduced 2-point scale. Post intervention 90% felt that they had sufficient knowledge, compared to only 58%
Diary Date

Advance Notice of 2013 BADS ASM

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Southport

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- Enhanced Recovery after Surgery
- Patient Warming in Day Surgery
- Managing Patients with Diabetes for Day and Short Stay Surgery

Available from the BADS online shop at www.bads.co.uk
### Table 2: Patient Demographics.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Before N (%)</th>
<th>After N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Male</td>
<td>29 (58%)</td>
<td>31 (62%)</td>
</tr>
<tr>
<td>• Female</td>
<td>21 (42%)</td>
<td>19 (38%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mean (Range) Male</td>
<td>57.8 years</td>
<td>58 years</td>
</tr>
<tr>
<td>• Mean (Range) Female</td>
<td>72 years</td>
<td>62 years</td>
</tr>
<tr>
<td></td>
<td>(16–91)</td>
<td>(18–88)</td>
</tr>
<tr>
<td></td>
<td>(37–94)</td>
<td>(21–90)</td>
</tr>
<tr>
<td><strong>Abbreviated Mental Test Score (AMTS)</strong></td>
<td>9.68/10</td>
<td>9.42/10</td>
</tr>
<tr>
<td><strong>Type of Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• General Surgery</td>
<td>18 (36%)</td>
<td>19 (38%)</td>
</tr>
<tr>
<td>• Orthopaedics</td>
<td>15 (30%)</td>
<td>9 (18%)</td>
</tr>
<tr>
<td>• Urology</td>
<td>4 (8%)</td>
<td>9 (18%)</td>
</tr>
<tr>
<td>• Vascular</td>
<td>12 (24%)</td>
<td>12 (24%)</td>
</tr>
<tr>
<td>• Breast</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td><strong>Nature of Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Elective</td>
<td>29 (58%)</td>
<td>36 (72%)</td>
</tr>
<tr>
<td>• Emergency</td>
<td>21 (42%)</td>
<td>14 (28%)</td>
</tr>
</tbody>
</table>

**Figure 1** Results of all patients in audit regarding explanation of complications, provision of supplementary information and receipt of a signed copy of the consent form.

**Figure 2** Results of all patients in audit regarding knowledge of procedure undergone and a clear explanation of the procedure.

**Figure 3** Results of all patients in audit regarding being given the opportunity to ask questions and aware of the possible need for additional procedures.

**Figure 4** Results of all patients in audit and ratings of their knowledge.
before (p<0.001). Finally, patients were more likely to have had potential complications explained to them after the intervention. They were also more likely to have been given supplementary material (p=0.01). There was however, no statistically significant difference between the two groups in terms of the number of patients receiving a copy of their signed consent form.

A sub-group was further analysed looking solely at the elective patients. Their data is displayed in Table 4 and Figures 5–8. A total of 65 patients were included in this group [29 patients before and 36 patients after the intervention]. This showed that despite discounting the emergency patients, there was still an overall improvement in all our results. The explanation of the procedure improved, with 86% explaining the procedure correctly compared to 66% before the intervention. Patients were provided with more supplementary information (p=0.02) and this was reflected in more patients being able to explain the possible complications correctly: 69% of patients after compared to 38% before the intervention (p=0.03). There was an improvement in the knowledge of what procedure the patient underwent and patients being given the opportunity to ask questions though not statistically significant.

### Table 3 Summary of results from before and after the intervention with their analysis using Fisher's exact test and their respective p-values.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Before N (%)</th>
<th>After N (%)</th>
<th>Fisher's exact test p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you know what procedure you underwent?</td>
<td>Yes</td>
<td>43 (86%)</td>
<td>50 (100%)</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>7 (14%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>Was the procedure explained to you?</td>
<td>Yes + Correct</td>
<td>32 (64%)</td>
<td>43 (86%)</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>Yes + Incorrect</td>
<td>15 (30%)</td>
<td>5 (10%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>3 (6%)</td>
<td>2 (4%)</td>
<td></td>
</tr>
<tr>
<td>Were you given the opportunity to ask any questions?</td>
<td>Yes</td>
<td>38 (76%)</td>
<td>47 (94%)</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>12 (24%)</td>
<td>3 (6%)</td>
<td></td>
</tr>
<tr>
<td>Were you made aware of the need for additional procedures?</td>
<td>Yes</td>
<td>32 (64%)</td>
<td>36 (72%)</td>
<td>0.52</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>18 (36%)</td>
<td>14 (28%)</td>
<td></td>
</tr>
<tr>
<td>Rating of knowledge (4-point scale)</td>
<td>Sufficient, I need a little more information</td>
<td>7 (14%)</td>
<td>9 (18%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>Sufficient, I do not need more information</td>
<td>22 (44%)</td>
<td>36 (72%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Insufficient, I need some more information</td>
<td>11 (22%)</td>
<td>5 (10%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Insufficient, I need a lot more information</td>
<td>10 (20%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>Rating of knowledge (2-point scale)</td>
<td>Sufficient</td>
<td>29 (58%)</td>
<td>45 (90%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>Insufficient</td>
<td>21 (42%)</td>
<td>5 (10%)</td>
<td></td>
</tr>
<tr>
<td>Were the complications explained to you?</td>
<td>Yes</td>
<td>19 (38%)</td>
<td>34 (68%)</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>Yes +Incorrect</td>
<td>14 (28%)</td>
<td>7 (14%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>17 (34%)</td>
<td>9 (18%)</td>
<td></td>
</tr>
<tr>
<td>Were you provided supplementary information?</td>
<td>Yes</td>
<td>10 (20%)</td>
<td>27 (54%)</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>40 (80%)</td>
<td>23 (46%)</td>
<td></td>
</tr>
<tr>
<td>Were you given a copy of your consent form?</td>
<td>Yes</td>
<td>3 (6%)</td>
<td>7 (14%)</td>
<td>0.32</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>47 (94%)</td>
<td>43 (86%)</td>
<td></td>
</tr>
</tbody>
</table>
Discussion

In modern clinical practice, informed consent from patients is both a medico-legal and ethical requirement. The process involves the active participation of patients. They will require accurate, unbiased information and signposts to sources of relevant advice.

The results of our audit concur with the results from three international studies in the literature whereby the perceived poor quality of the information provided to patients produced a lower than desired standard of consent. 7–9 A similar audit was performed by Siddiqui et al in which only 38% of patients understood the information imparted to them. 12 A greater proportion of our patients understood what their procedure was before the intervention at 64% (86% in elective patients). It is clear that the need for more patient information is indeed a universal one regardless of the health system or surgical subspecialty. Our results may be applied to other hospitals in other countries. This is particularly true when considering the moral right of a patient to give informed consent to treatment they receive becoming a vital component of modern day medicine, transcending different health services and legal systems.

This audit should not only encourage other departments to assess the quality of gaining consent, but it clearly demonstrates that simple measures can result in significant improvements in practice. We set up a number of

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Summary of elective patients results from before and after the intervention with their analysis using Fisher's exact test and their respective p-values.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
<td>Response</td>
</tr>
<tr>
<td>Do you know what procedure you underwent?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Was the procedure explained to you?</td>
<td>Yes + Correct</td>
</tr>
<tr>
<td></td>
<td>Yes + Incorrect</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Were you given the opportunity to ask any questions?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Were you made aware of the need for additional procedures?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Rating of knowledge (4-point scale)</td>
<td>Sufficient, I need a little more information</td>
</tr>
<tr>
<td></td>
<td>Sufficient, I do not need more information</td>
</tr>
<tr>
<td></td>
<td>Insufficient, I need some more information</td>
</tr>
<tr>
<td></td>
<td>Insufficient, I need a lot more information</td>
</tr>
<tr>
<td>Rating of knowledge (2-point scale)</td>
<td>Sufficient</td>
</tr>
<tr>
<td></td>
<td>Insufficient</td>
</tr>
<tr>
<td>Were the complications explained to you?</td>
<td>Yes + Correct</td>
</tr>
<tr>
<td></td>
<td>Yes + Incorrect</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Were you provided supplementary information?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Were you given a copy of your consent form?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>
interventions including an awareness campaign and the need to provide patients with appropriate patient information leaflets. This resulted in improved overall patient rating of their knowledge. The importance of providing written material to supplement verbal explanations has been well established in several studies.\textsuperscript{13–14} We also presented the original data to the surgical teams, and were therefore able to reinforce the need for repetition of procedure information both in outpatient's clinic, pre-operative assessment and on the day of the procedure. However, further work needs to be done to determine the optimal timing for providing patients with this information.

In 2011, Schenker et al reviewed the concern that patient understanding in clinical informed consent is often poor and that encouraging a wide range of communication interventions can improve understanding.\textsuperscript{15} This study addresses such communication interventions including particular emphasis by the surgeon to the possibility of additional procedures to take place such as switching from a laparoscopic to an open procedure. Also, asking the patient to repeat the risks and benefits of the procedure and giving them a signed copy of the consent form further reinforces the information discussed during the consenting process.

However, this study shows that encouraging these practices resulted in patients feeling better informed.\textsuperscript{16} Further studies are required to assess whether these different interventions result in patients being more informed.

Furthermore, the differences between consent in the context of emergency versus elective procedures have been a topic of great interest in the literature. Akkad et al in 2004 demonstrated that emergency operations tend to have lower standards of consent.\textsuperscript{17} In our study, the proportion of patients undergoing emergency operations in the first loop was slightly greater than in the second. Nevertheless on excluding patients undergoing emergency operations, there was still a marked improvement in all our results. The proportion of patients being able to correctly explain the procedure as well as its complications improved (p=0.03). Also, there was a significant increase in the proportion of patients receiving supplementary information (p=0.02). From this subgroup analysis, there were a lower number of patients which could explain why there were fewer statistically significant improvements in other areas such as the patients’ overall rating of their knowledge, awareness of their procedure or feeling that they had the opportunity to ask questions.
It is arguable that one limitation to the results of our study is that no information was available on the mental state of the patients at the time of consent being sought. Excluding patients who do not speak English automatically creates a selection bias. We tried to minimize inter and intra observer bias by running a control survey initially to standardise the interview process. There was also an element of recall bias which we tried to minimise by only interviewing patients <8 days postoperatively and through selecting patients with AMT scores of 8 and above.  

When analysing results from a questionnaire, it is important to consider the degree of patient autonomy. While conducting the interviews, a number of patients expressed that they were satisfied to sign the consent form with the minimal provision of details relating to their procedure. The amount of information given to each individual is variable as each patient will request differing amounts of information relating to their procedure and yet may respond the same to a particular question. For example, the same patient who might have answered that they did not receive additional information such as leaflets or diagrams while being consented may have refused such information. This same patient may also have rated their overall knowledge as sufficient. The degree of consent being fully informed will vary for each patient in different settings posing a dilemma for the overall amount of information to be provided.

A final remark relates to the quote by Lord Bingham in the case of Chester versus Afshar: ‘A surgeon owes a general duty to a patient to warn him or her . . . of possible serious risks involved in the procedure . . . there may be exceptional cases where objectively in the best interests of the patient the surgeon may be excused . . .’.  

This reflects the important legal and ethical nature of consent and ensuring patients are aware of the intended benefits and complications of the procedure they are to undergo. This is a ubiquitous part of medical practice and being fully informed will vary for each patient in different settings posing a dilemma for the overall amount of information to be provided.

It is important to audit current practice of consent in all specialties as it is a topical issue and plays a vital role in patient centred care in the 21st century. The implementation of change through simple measures such as an awareness campaign can lead to improvements in practice. Furthermore, the provision of patient information leaflets enhances patient education and ensures their involvement in the shared decision making of their care, encouraging patient autonomy.

**Disclaimer**

The results have been compiled with consideration given to the implications of the Human Rights Act 1998 and the Data Protection Act 1998.

**References**

### Appendix I

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your age?</td>
<td></td>
</tr>
<tr>
<td>What is the time to the nearest hour?</td>
<td></td>
</tr>
<tr>
<td>Give address ‘42 West Street’ and ask patient to repeat at the end of the test.</td>
<td></td>
</tr>
<tr>
<td>What is the year?</td>
<td></td>
</tr>
<tr>
<td>What is the name of the hospital?</td>
<td></td>
</tr>
<tr>
<td>Recognition of two persons e.g. doctor and nurse.</td>
<td></td>
</tr>
<tr>
<td>What is your date of birth?</td>
<td></td>
</tr>
<tr>
<td>In what year did World War 1 begin?</td>
<td></td>
</tr>
<tr>
<td>Name the current monarch/prime minister.</td>
<td></td>
</tr>
<tr>
<td>Count backwards from 20 down to 1.</td>
<td></td>
</tr>
<tr>
<td>Recall address</td>
<td></td>
</tr>
</tbody>
</table>

Age ................. AMT ....................../10 Specialty .....................

<table>
<thead>
<tr>
<th>Procedure .........................................</th>
<th>Pre-op</th>
<th>Post-op</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent form in notes?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you know why you are in hospital?</td>
<td>Yes + correct</td>
<td>Yes + incorrect</td>
</tr>
<tr>
<td>Do you know what procedure you are having/have done?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Was the procedure explained to you?</td>
<td>Yes + correct</td>
<td>Yes + incorrect</td>
</tr>
<tr>
<td>Were you given the opportunity to ask questions about the procedure/address your concerns?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Were you made aware of the possibility of additional procedures or alterations to the stated procedure?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Were the possible complications of the procedure explained to you?</td>
<td>Yes + correct</td>
<td>Yes + incorrect</td>
</tr>
<tr>
<td>Were you given supplementary material (e.g. leaflets, diagrams etc)?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

How do you rate your knowledge of the procedure you are having/have had?

- Insufficient, I need a lot more information
- Insufficient, I need a little more information
- Sufficient, but I need a little more information
- Sufficient, I do not need more information

If you signed a consent form, were you given a copy of it?  Yes No N/A
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<th>Two</th>
<th>Three</th>
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<td>3,600</td>
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<td>4,500</td>
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<td>2,375</td>
<td>3,450</td>
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<tr>
<td>Centre pages <em>(2 x A4)</em></td>
<td>2,500</td>
<td>4,750</td>
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