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## Standardized Consent Forms for Surgical Procedures: An Intervention to Improve the Resident-led Informed Consent Process

C. Hodge  
*Abington Jefferson Health*

N. Sich  
*Abington Jefferson Health*

T. Olszewski  
*Abington Jefferson Health*

A. Rogers  
*Abington Jefferson Health*

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**Authors**

C. Hodge, N. Sich, T. Olszewski, A. Rogers, R. Josloff, and K. Noonan

## Background

The core ethical principle of patient autonomy requires the patient to develop an understanding of their disease process and agree with the treatment plan. Informed consents for surgical procedures epitomize this process. Furthermore, documented informed consents carry heavy weight of legal and ethical liability. Bagnell, et al<sup>1</sup> used a systematic review and semistructured interviews to identify the following key components of informed consent:

- Procedure description and details
- Indications for and benefits of the procedure
- General and specific risks
- Alternative treatment options and risks
- Patient concerns and expectations
- Discussion at appropriate level for the patient

While outpatient consents at Abington-Jefferson Health (AJH) are performed with printed standardized consents by each attending surgeon's practice, inpatient or ED consents are handwritten by residents, usually interns and junior residents, on a fill-in-the-blank form. This leads to several problems, including:

- Poor legibility of consent forms
- Inadequate documentation of risks and alternatives
- Inadequate description of procedure
- Having to rewrite an entire consent if a mistake is written
- Lack of resident and patient understanding of risks and benefits
- Extra time taken to handwrite consents

## Objective and Goals

To provide high quality, consistent consent forms for common surgical procedures and improve resident workflow by creating and implementing standardized printed consents for common surgical procedures.

- These consents will be used by residents consenting patients in the ED or inpatient setting.
- Consents shall include standardized procedure descriptions, risks and benefits of the procedure, and alternative treatment option descriptions, risks and benefits.

## Methods

### Creation

- Pilot – standard outpatient consents combined and agreed upon by all attendings
- Subsequent – initial consents used as a template for residents to create consents, which were then vetted by attendings performing the procedures

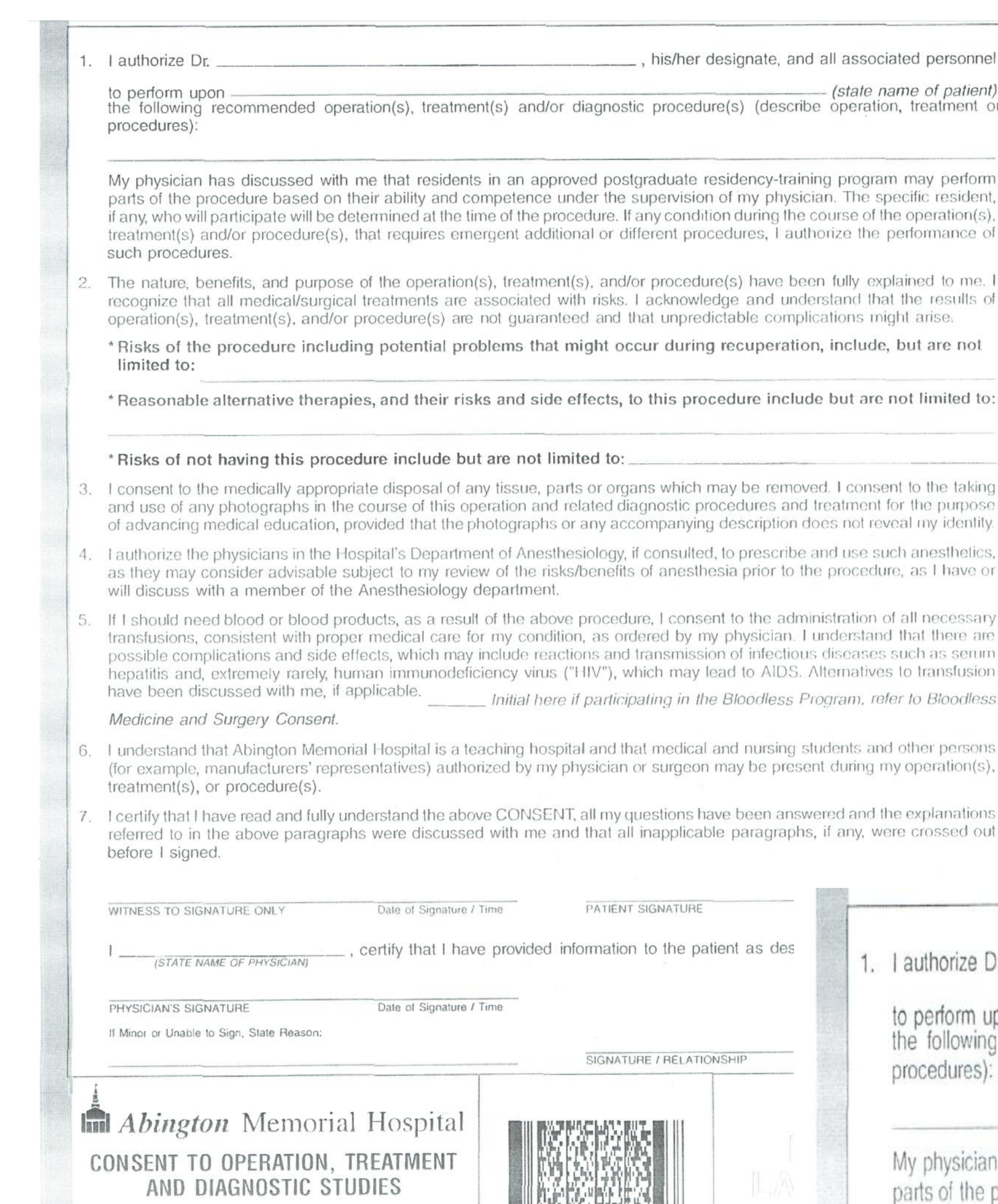
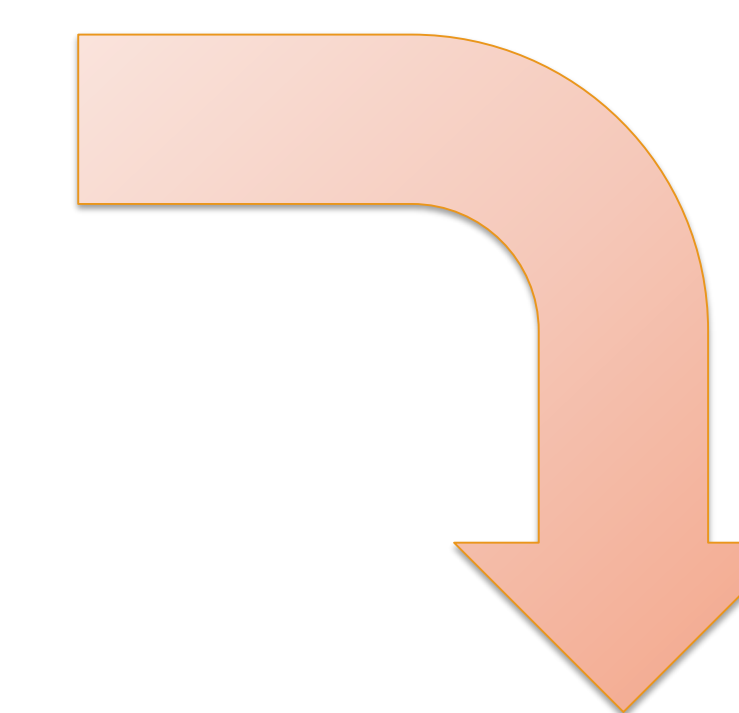
### Implementation

- Consents posted on resident shared drive
- Consents are modifiable - type in patient, attending and consenting physician name
- Residents educated about the standardized consents during weekly conference

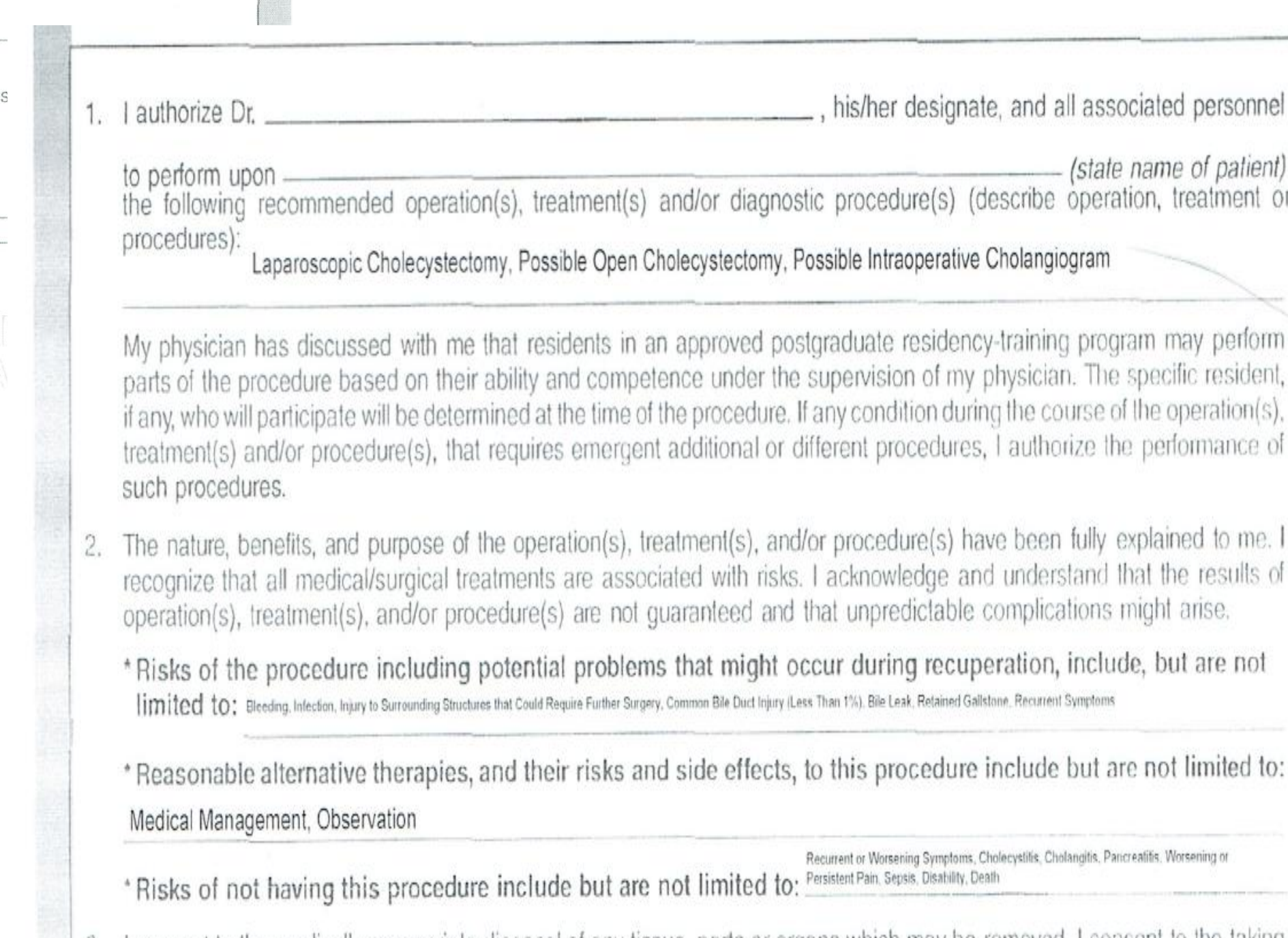
### Metrics

- Surveys of attending physicians, OR staff and residents
- Comparison of handwritten vs typed consents on legibility, correctness, completeness, errors, and resident and attending comfort with adequacy of consent now and at 1 year
- Audit of consents
- Compare selection of consents for 3 most common procedures (laparoscopic appendectomy, laparoscopic cholecystectomy, and triple-lumen catheter placements) over 3 months prior to and 3 months after intervention for documentation of: standard risks, specific risks, alternatives, risks of not having procedure

### “Fill-in-the-blank” Consent

### Standardized Consent for Laparoscopic Cholecystectomy



## Future Directions

- Future projects could implement a resident training program to improve consent discussions, such as that created by Thompson, et al<sup>2</sup>.
- Another area for possible improvement would be to incorporate audio-visual aids into the consent process, which has been shown to improve patient recall<sup>3</sup>.

## References

1. Bagnall NM, et al. Informing the process of consent for surgery: identification of key constructs and quality factors. J Surg Res. 2017 Mar; 209:86-92.
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3. Farrell EH, et al. Systematic review and meta-analysis of audio-visual information aids for informed consent for invasive healthcare procedures in clinical practice. Patient Educ Couns. 2014 Jan; 94(1):20-32.