Wednesday 25 June 10.30–11.30
Poster Session 8: Clinical Governance: Consent and Communication
Chairmen: M. Emberton and A. Turner

P071

'Will you be doing my operation doctor?' Patient attitudes to informed consent

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INTRODUCTION

Recent legal cases have indicated that for consent to be fully informed, patients should be told whether trainees will be operating on them. GMC guidance supports this but it is not routinely discussed with patients preoperatively. We set out to assess patients' attitudes to operations by trainee urologists and anaesthesia by trainee anaesthetists.

PATIENTS AND METHODS

Sixty-three completed questionnaires were received from patients (55 men and eight women, mean age 72 years, range 50–91) undergoing TURP, TURBT or cystodiathermy, on various aspects of their attitudes to operations and anaesthesia performed by junior doctors as part of training.

RESULTS

Fifty-seven patients thought that junior doctors should perform surgery as part of their training. Of the 57, only six said they would be happy for a junior doctor, competent to perform the procedure, to operate unsupervised. Of 60 patients, 50 thought they should be told if the operation was going to be performed by a junior doctor, and 52 that they should be told their name and designation. If given the choice, 34 patients said they would wait and have a consultant operate, but 38 would not mind a junior doctor operating on them unsupervised if it meant the operation could be done sooner. Similar attitudes were noted towards trainee anaesthetists.

CONCLUSIONS

For consent to be 'informed' the experience and identity of the surgeon should be made known to patients. Most patients are happy to be operated on by junior doctors under consultant supervision, but would want to be told and know their name and status.

P072

Informed consent – what patients really want to know

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INTRODUCTION

Informed consent requires surgeons to provide patients with information about proposed treatment. Patients vary in the amount of information they wish to be given or consider relevant. We examined the views of people undergoing surgery to determine what they considered important.

METHODS

Over 6 months, 300 questionnaires were distributed equally to people in outside a hospital setting and to patients undergoing inpatient or day surgery; 15 areas were examined, designed to cover relevant aspects of surgical care. Statements included a discussion of common/rare risks, alternative treatments, meeting the operating surgeon/anaesthetist, patients' legal rights, return to normal activity, length of operation and theatre details. Patients were asked to answer each question either A (definitely need to know), B (preferable to know) or C (couldn't care less).

RESULTS

The statements most frequently answered 'A' were; 'when one can return to normal activity' (78%), 'meeting the operating surgeon' (64%), 'discussion of all the common risks' (64%) and 'meeting the anaesthetist' (54%). Almost a quarter answered 'C' to knowing how many operations of that type the surgeon had done before. Overall the 'non-hospital' group marked A more often than the other groups, women scored A more often than men, and the older group (> 65 years) more often C than all other ages (all $P < 0.001$).

CONCLUSION

Individuals contemplating surgery have a preference for the information they receive before undergoing surgery. This information may differ from what the clinician considers relevant. Our results also identified a difference in the attitude between men and women, and across the age range.

P073

The level of information desired by patients before elective surgery

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INTRODUCTION

Increasingly, patients are requesting more information about their surgical procedures. Therefore, to better understand the nature and level of information that patients would generally like to receive we conducted a questionnaire-based study.

PATIENTS AND METHODS

Over a 3-month period men and women inpatients were asked eight general questions about their elective surgical procedure.

RESULTS

Of the 110 patients, 102 (93%; 81 men and 21 women) completed the questionnaire; 74% and 70% of men, and 62% and 76% of women, wanted to know who exactly would be performing the surgery and how long it would take, respectively. Furthermore, 72% and 59% of men wanted to know all the possible complications and whether blood may be needed, respectively; the opposite was the case for women, where 57% and 71% wanted to know, respectively. The vast majority of men (80% and 96%) and women (86% and 90%) were satisfied with a summary description of their intended procedure and did not object to their procedure being abbreviated in the consent form. Similarly, the vast majority of men (94% and 96%) and women (90% and 95%) wanted to know their expected length of hospital stay and advice about rehabilitation after surgery. These responses were not dependent on patient age or type of surgery experienced.

CONCLUSION

This preliminary study, despite the few patients, shows that patients have questions about their surgery that may not be routinely addressed by clinicians. This is an important issue that needs addressing, as a better understanding of their concerns may result in greater satisfaction with the treatment they receive.

P074

Nationalized consent forms in urology – a customized DOH model for other specialities to follow

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OBJECTIVE

To determine the current consent for urological surgery and design a solution to prevent patients from undergoing surgery while poorly informed.

METHODS

Common urological procedures were chosen and the consent forms evaluated to see how fully written consent was obtained. Pre-typed consent forms were then produced on a CD ROM for each procedure. These included a printed record of all relevant outcomes, accompanied by tick boxes for confirming that the point had been explained to the patient. The development and use of these standardized forms will be presented.

RESULTS

There was no improvement in the completeness of surgical consent, despite distributing a booklet with guidelines about the important points to discuss before surgery. Because informed consent did not improve we have produced a standardized pre-printed consent form for all our procedures. The end result has been a credit-card sized CD containing the consent forms for over 100 urological procedures, and with the help of BAUS this has been distributed to all UK urologists.

DISCUSSION

By producing national standardized consent forms for all surgical procedures, a more consistent level of consent can be achieved across different regions and important information for patients not missed. We hope to discuss the feedback from their use in this early phase after its release.

Funding: BAUS

P075

Quality control of medical records: what has changed over the last 10 years?

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INTRODUCTION

Accurate, complete and readily accessible medical records are the foundation of medical audit. Any discrepancy has potential medical, financial, managerial and medico-legal implications. Even electronic records will be prone to this problem. We evaluated the content, quality and appropriateness of medical records, and closed a 10-year audit loop from the same institution.

METHODS

In the current study (2001) randomly selected medical records (104) from three surgical specialities (urology, general surgery and orthopaedics) were evaluated against 10 pre-set criteria divided into four groups (preoperative, operative, investigations and postoperative). Missing criteria were recorded for each medical record as appropriate. The results were then compared with a similar audit in 1991, using the chi-square test.

RESULTS

In the preoperative phase, 30% of casualty records, 10% of outpatient letters and 19% of GP letters were missing. Similar numbers of anaesthetic and operative records were missing (16% and 15%, respectively). Almost half of the X-ray and histopathology reports were missing; 58% of the relevant blood results were missing. In the postoperative phase, more than half the notes were not properly bound and 16% were missing the discharge summary. When this was compared with data from 1991, there was no improvement in note-keeping over the last 10 years ($P > 0.05$). Indeed, the filing of blood results was significantly worse ($P < 0.001$).

CONCLUSIONS

Clearly, data input seems to be a problem; the introduction of electronic patient records with a strict system of data input may improve the situation. However, an urgent re-evaluation is required to safeguard patients and hospitals.

P076

Evaluation of doctors' interpersonal and communication skills in urology

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INTRODUCTION

The interpersonal and communication skills of basic surgical trainees are assessed during the MRCS examination but there is no formal assessment during higher urological training. The Doctor's Interpersonal Skills Questionnaires (DISQ) is a validated, patient-completed questionnaire that can be used to assess these skills in doctors. The maximum score possible is 60 points. We performed a pilot study to test its applicability within urology.

METHODS

We conducted the study in outpatients over 3 weeks; all patients were asked to complete the DISQ after the consultation, and were asked to give their age, sex and the duration of the consultation. Nonparametric statistical methods were used.

RESULTS

In all, 528 questionnaires were returned (51% response rate). The mean (range) patients' age was 58 (16–92) years. Nineteen doctors were assessed (seven consultants, six SPRs, four SHOs and two Research Fellows). The principle findings were: for each doctor, a range of scores was obtained; differences were detectable between doctors. SPRs and consultants performed equally well (median 55 vs 54, $P = 0.39$) but better than the SHOs and Research Fellows (median 54 vs 48, $P < 0.001$). Junior SPRs performed less well than Senior SPRs (median 48 vs 55, $P = 0.03$).

CONCLUSION

This study shows that the DISQ can be used in a urological outpatient setting. Single assessments are unrepresentative and scores seem to improve with seniority. This is an instrument that might have value in urological training.

P077

Patient information video for prostatic TRUS and biopsy: the way forward?

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INTRODUCTION

Informed consent is a legal and ethical requirement for all invasive procedures. As part of its 'good practice in consent' initiative, the DoH recently issued new guidance on consent, which states that the provision of information is central to the consent process and that appropriate sources of information should be readily available to patients. Although printed information leaflets are commonly used, not all patients find such information particularly accessible.

PATIENTS AND METHODS

A patient information video on TRUS biopsy of the prostate was recorded by a Consultant Urologist and Nurse Specialist. The video included a clip of a patient undergoing the procedure. The video was given to 25 randomly selected patients awaiting TRUS biopsy, to watch before their procedure. It was also distributed retrospectively to 25 patients after TRUS biopsy. Patients also received a printed information leaflet and were requested to complete a questionnaire.

RESULTS

In the prospective group, all the patients returned completed questionnaires, compared with 76% in the retrospective group. The mean (range) age of the participants was 65.5 (45–82) years. Only two patients did not have easy access to a video recorder to watch the video; 90% of the patients found the video useful/very useful and easy to understand, whilst 88% felt that the video should be given to all patients undergoing TRUS and biopsy.

CONCLUSION

Patients undergoing TRUS biopsy of the prostate benefit from an information video before the procedure. Such videos are particularly useful if combined with conventional information leaflets. The development of information videos for other common diagnostic and therapeutic procedures can ensure good practice when seeking informed consent.

P078

'Hospital To Home' – a new service to reduce hospital stay

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INTRODUCTION

'Hospital To Home' is a new service for patients having endoscopic bladder outlet surgery, with the aim of reducing hospital stay, optimizing the use of limited inpatient beds. We reviewed our initial experience.

PATIENTS AND METHOD

Following a strict protocol, patients who had TURP were discharged home with a catheter 2 days after surgery. A urology nurse visited them at home the following day to remove the catheter 1 h after giving oral antibiotics. The patient had a portable ultrasonography scan 6 h later and was re-catheterized if the residual volume was >300 mL. Otherwise, the patient was rescanned the next day and either discharged or re-catheterized. Patients who underwent bladder neck incision (BNI) followed the same protocol.

RESULTS

Over an 8-month period, 50 patients who had TURP and six who had BNI agreed to use the service. Of these, 53 patients (95%) voided successfully and required no further intervention. Of the remaining three patients, one voided successfully after a further trial without catheter and two required further endoscopic procedures, and subsequently voided successfully. The mean hospital stay was 4.4 days, compared with 5.5 days from a previous audit, saving one hospital bed-day per patient.

CONCLUSION

'Hospital To Home' is safe and well tolerated by patients, with a very low re-admission rate, and saves at least one hospital bed-day per patient. This pilot study shows an enormous potential to save hospital bed-days and we have expanded this service to include other patients requiring a trial without catheter at home.

P079

Who cares for the acute urological patient?

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INTRODUCTION

The requirements of the new deal for junior doctors' hours has meant many smaller Trusts are unable to provide adequate urological cover on-call. The care of the acute urological patient has therefore shifted to the general surgical teams in many Trusts. We assessed what impact this had upon the outcome of acute urological cases in our district general hospital, and surveyed the provision of services in other regional hospitals.

METHODS

Acute admissions with renal colic were prospectively monitored over a 12-month period. Urology registrars at 10 regional hospitals took part in a telephone survey of acute urological services.

RESULTS

In this 12-month period, 73 patients were admitted with renal colic; most (93%) were admitted under the general surgeons, with the surgical SHO the most senior admitting doctor in 79%. The delay to urological review was 0.95 days for weekday and 1.82 days for weekend admissions. Ten cases were complicated by sepsis after delayed urological review, with two cases requiring intensive treatment unit admission. Six of the 10 regional hospitals provided an acute junior doctor urological service, although only two routinely contacted the registrars about urological admissions.

CONCLUSION

The shift in care of the acute urological patient was associated with considerable morbidity for patients admitted in our hospital. The additional financial burden was estimated to be £33 000/year. The implementation of the new deal must be achieved without the clinical and financial costs of withdrawing an acute urological service.