Informed consent

- Word onset tracking in neural responses of human basal ganglia nuclei
- Regional free-water diffusion is more strongly related to neuroinflammation than neurodegeneration
- Effect of Obese Body Mass Index on Clinical Outcomes and Inflammatory Blood Biomarkers following Sport-Related Concussion in Collegiate Athletes and Military Cadets: Findings from the NCAA-DoD CARE Consortium
- Depression after aneurysmal subarachnoid hemorrhage: development of a screening tool and discharge user interface
- Recent advances in molecular mechanisms of microRNAs in pathogenesis and resistance of treatment in glioblastoma
- Transitional haemodynamic profiles of intrauterine growth-restricted preterm infants: correlation with antenatal Doppler characteristics
- The Impact of Virtual-, Augmented- and Mixed Reality during Preoperative Informed Consent: A Systematic Review of the Literature
- Are isolated linear fractures over major dural venous sinuses a risk factor for sinus thrombosis in mild TBI?

---

see Intracranial tumor informed consent.

see Spine surgery informed consent.

Informed consent is an important part of patient care during the preoperative routine workup, especially in the light of potentially life-changing risks of spinal surgery. There is growing interest in the development of programs and interventions to improve patients' active involvement in treatment decisions, especially while being informed prior to consenting to a procedure [1)].

Guidelines around consent imply a logical, plain-speaking process with a clear endpoint, agreement, and signature yet surgeons' surveys and patient interviews suggest that surgeons' explanation is anecdotally variable and patient understanding remains poor.

The consenting process is an important communication tool that also carries medico-legal implications.

Informed consent is a process for getting permission before conducting a healthcare intervention on a person. A health care provider may ask a patient to consent to receive therapy before providing it, or a clinical researcher may ask a research participant before enrolling that person into a clinical trial. Informed consent is collected according to guidelines from the fields of medical ethics and research ethics.

An informed consent can be said to have been given based upon a clear appreciation and understanding of the facts, implications, and consequences of an action. To give informed consent, the individual concerned must have adequate reasoning faculties and be in possession of all relevant facts. Impairments to reasoning and judgment that may prevent informed consent include basic intellectual or emotional immaturity, high levels of stress such as PTSD or a severe intellectual disability, severe mental illness, intoxication, severe sleep deprivation, Alzheimer's disease, or being in a coma.

Some acts can take place because of a lack of informed consent. In cases where an individual is considered unable to give informed consent, another person is generally authorized to give consent on his behalf, e.g., parents or legal guardians of a child (though in this circumstance the child may be required to provide informed assent) and conservators for the mentally ill.

In cases where an individual is provided insufficient information to form a reasoned decision, serious ethical issues arise. Such cases in a clinical trial in medical research are anticipated and prevented by an ethics committee or Institutional Review Board.

While written consent is a pre-requisite before spinal surgery in the UK, the standard and effectiveness of the process have not been assessed previously. A study assesses standard of written consent for elective lumbar decompressive surgery for degenerative disc disease across different regions and specialties in the UK; level of patient recall of the consent content; and identifies factors which affect patient recall.

Consent forms of 153 in-patients from 4 centres a, b, c, d were reviewed. Written documentation of intended benefits, alternative treatments and operative risks was assessed. Of them, 108 patients were interviewed within 24 h before or after surgeries to assess recall.

The written documentation rates of the operative risks showed significant inter-centre variations in haemorrhage and sphincter disturbance (P = 0.000), but not for others. Analysis of pooled data showed variations in written documentation of risks (P < 0.0005), highest in infection (96.1%) and lowest in recurrence (52.3%). For patient recall of these risks, there was no inter-centre variation. Patients' recall of paralysis as a risk was highest (50.9%) and that of recurrence was lowest (6.5%). Patients <65 years old recalled risks better than those ≥65, significantly so for infection (29.9 vs 9.7%, P = 0.027). Patients consented >14 days compared to <2 days before their surgeries had higher recall for paralysis (65.2 vs 43.7%) and recurrence (17.4 vs 2.8%). Patient recall was independent of consenter grade.

Overall, the standard of written consent for elective lumbar spinal decompressive surgery was sub-optimal, which was partly reflected in the poor patient recall. While consenter seniority did not affect patient recall, younger age and longer consent-to-surgery time improved it [2].

Complications

Postoperative complications

1)
Kinnersley P, Phillips K, Savage K, et al. Interventions to promote informed consent for patients undergoing surgical and other invasive healthcare procedures. Cochrane Database Syst Rev.

2013;(7):CD009445.
2)
Lo WB, McAuley CP, Gillies MJ, Grover PJ, Pereira EAC. Consent: an event or a memory in lumbar spinal surgery? A multi-centre, multi-specialty prospective study of documentation and patient recall of consent content. Eur Spine J. 2017 May 20. doi: 10.1007/s00586-017-5107-6. [Epub ahead of print] PubMed PMID: 28528481.