Spine surgery informed consent

Spine surgery represents one of the most litigious specialties in the United States health care system. The available literature points to a consistent pattern of common allegations leading to litigation following spine surgery. While a majority of filed lawsuits end in the surgeon's favor, these cases carry high monetary and time expenditures regardless of the outcome. Furthermore, the threat of a malpractice lawsuit motivates many surgeons to practice defensive medicine by utilizing unnecessary or unindicated tests and studies.

Through the examination of trends in malpractice claims and case outcomes, surgeons may be able to adapt practices to minimize their risk of litigation. These changes can include but are not limited to, identification of those procedures that are most litigious and a more thorough discussion of the informed consent process to include operative and nonoperative treatments prior to all procedures. More important, however, spine surgeons can potentially serve as advocates for change [1)].

The tension between the ideal of informed consent and the reality of the process is under-investigated in spine surgery. 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. To obtain a more authentic reflection of practice, spine surgeons obtaining 'informed consent' for non-instrumented spine surgery were studied via video recording, and risk/benefit discussions were analyzed.

A prospective observational study was conducted at a single neurosurgical institution. Twelve video recordings involving six surgeons obtaining informed consent for non-instrumented spine surgery were transcribed verbatim and blindly analyzed using descriptive quantification and linguistic ethnography.

Ten (83%) consultations discussed surgical benefit but less than half (41%) quantified the likelihood of benefit from surgery. The most discussed risks were nerve damage or paralysis (92%), bleeding (92%), infection (92%), Cerebrospinal fluid fistula (83%) and bowel and bladder dysfunction (75%). Surgeons commonly used a quantitative statement of risk (58%) but only half of the risks were explained in words patients were likely to understand.

This study highlights inconsistencies in the way spine surgeons explain risks and obtain informed consent for 'simple' spine procedures in a real-world setting. There are wide disparities in the provision of informed consent, which may be encountered in other surgical fields. Direct observation and qualitative analysis can provide insights into the limitations of current informed consent practice and help guide future practice [2)].

Todd and Birch reported a number of legal judgments in spinal surgery where there was no criticism of the surgical procedure itself. The fault that was identified as a failure to inform the patient of alternatives too, and material risks of, surgery, or overemphasizing the benefits of surgery. In one case, there was a promise that a specific surgeon was to perform the operation, which did not ensue. All of the faults in these cases were faults purely of the consenting process. In many cases, the surgeon claimed to have explained certain risks to the patient but was unable to provide proof of

doing so. They propose a checklist that, if followed, would ensure that the surgeon would take their patients through the relevant matters but also, crucially, would act as strong evidence in any future court proceedings that the appropriate discussions had taken place. Although this article focuses on spinal surgery, the principles and messages are applicable to the whole of orthopedic surgery [3].

There is variation in the disclosure of potential adverse events during informed consent discussions for lumbar microdiscectomy among Canadian spine surgeons. Patients desire more information regarding their postoperative care. Further research should focus on developing guidelines to reduce practice variation and optimize the effectiveness of consent discussions [4].

References

1)
Jackson KL, Rumley J, Griffith M, Linkous TR, Agochukwu U, DeVine J. Medical Malpractice Claims and Mitigation Strategies Following Spine Surgery. Global Spine J. 2020 Aug 7:2192568220939524. doi: 10.1177/2192568220939524. Epub ahead of print. PMID: 32762364.
2)
Li Ching Ng A, McRobb LS, White SJ, Cartmill JA, Cyna AM, Seex K. Consent for spine surgery: an observational study. ANZ J Surg. 2020 Oct 5. doi: 10.1111/ans.16348. Epub ahead of print. PMID: 33021031.
3)
Todd NV, Birch NC. Informed consent in spinal surgery. Bone Joint J. 2019 Apr;101-B(4):355-360. doi: 10.1302/0301-620X.101B4.BJJ-2018-1045.R2. PMID: 30929482.
4)
Zahrai A, Bhanot K, Mei XY, Crawford E, Tan Z, Yee A, Palda V. Surgeon clinical practice variation and patient preferences during the informed consent discussion: a mixed-methods analysis in lumbar spine surgery. Can J Surg. 2020 May 21;63(3):E284-E291. doi: 10.1503/cjs.005619. PMID: 32437095.

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