The forgotten part of informed consent
By Frederic W. Platt, MD

Be sure to discuss what a good outcome looks like

Three months after his total knee replacement, Mr. Patient returns to see his orthopaedic surgeon. Dr. Surgeon examines him and finds much to be happy about.

Surgeon: “Wonderful! Mr. Patient, this looks great. The knee is no longer red or warm or swollen. You are no longer in constant pain. You’re walking 8 blocks a day, when before you couldn’t walk a block. The knee bends to 120 degrees, the maximum allowed by this particular prosthesis. I’m really pleased!”

But Mr. Patient is not so happy.

Patient: “But I can’t get in and out of a bathtub without help. And I can’t get into the back seat of my son-in-law’s new convertible car.”

You might be tempted to suggest that this ungrateful patient take showers and ride in the front seat. But Dr. Surgeon is a kind man and his assessment is pretty simple.

Surgeon: “We never discussed what a good outcome of this surgery would look like. We talked a lot about all the terrible things that might happen, but we never really talked about what you should hope for, what a good outcome looks like.”
What is informed consent?

Informed consent sets up expectations and is the first part of a process that includes planning the procedure, ensuring that the patient understands the planned procedure, performing the procedure, and finally determining if the patient’s expectations were met. When those expectations are not met, the patient may view the outcome as negative and may suspect a withholding of information. The patient may even become angry. What the surgeon may view as a good outcome becomes troublesome in the patient’s eyes and may lead to complaints, even to lawsuits.

Studies of the informed consent process divide the tasks into the following six components:

1. Discussing the clinical issues and the nature of the clinical decision
2. Discussing the alternatives, including doing nothing
3. Discussing the pros and cons of all these alternatives
4. Discussing the uncertainties associated with the decision
5. Assessing the patient’s understanding
6. Exploring the patient’s preferences

Do surgeons actually do all these steps? Hardly. And it appears that even these six might leave out the step Dr. Surgeon has defined—discussing the features of a good outcome, what we might anticipate and rejoice in—and what will not happen despite our good wishes.

In these studies, no surgeon accomplished all six defined tasks with any patient. In fact, the disease was named or the clinical decision stated only about 80 percent of the time. Almost no surgeon ever checked to see what the patient understood of his or her explanation (step 5). Exploring the patient’s preferences tended to be limited to a two-word dialogue: “Okay?” “Okay.”

The missing piece

In clinical informed consent conversations, doctors often parse the segments over several discrete periods and do not hold the entire complex conversation at one time. But the above
example suggests that surgeons would do better if, at some time, they inserted a bit about what they hope for, what the patient can expect if everything turns out well. Such a conversation might sound like this:

**Surgeon:** "Mr. Patient, I want to be sure that we’ve thought about what a good result of this operation would look like before we take you off to the operating room."

**Patient:** "Okay, Doc. Shoot."

**Surgeon:** "We’re hoping to get rid of the pain or at least most of it. We aren’t going to give you a brand new knee like you had when you were 20 years old. For example, it won’t bend as fully as before and you won’t be able to get down on the floor and up again so easily."

**Patient:** "I see. Well, I don’t have to get down on the floor all that often, Doc."

**Surgeon:** "No, but you might find it hard to get into the bathtub without a helping hand."

**Patient:** "I see. Well, my wife can help me there. She’s strong and eager to help."

**Surgeon:** "Sounds like we understand each other."

Then, doctors could ask patients for their understanding, perhaps by admitting that they haven’t explained everything as clearly as they would like, using language along the lines of “Mr. Patient, when you go home today, your family is going to ask you what I said. So tell me what you’re going to tell them” or “Mr. Patient, I just want to make sure that I’ve explained this clearly. Would you tell me what you heard so I can correct myself if I’ve gone astray?”

**What happens now?**

Meanwhile, Dr. Surgeon has a puzzled, dissatisfied patient. If he doesn’t handle the conversation well, the patient may never be satisfied—even though the doctor knows that the clinical outcome was every bit as good as could be expected.

Patients experience two sorts of disappointments: the clinical outcome itself, and the way doctors behave afterward. They tend to forgive the first, but not the second. So if the doctor loses his or her temper or patience, he or she may never satisfy this patient. One way to deal with this situation is through a therapeutic conversation.

**Surgeon:** "Mr. Patient, I see that we have two rather different views of your condition right now. It might seem puzzling to you that you think something went wrong and at the same time I’m so very happy and proud of your results. You must wonder if we are on the same page at all."

**Patient:** "That’s true, Doctor. I am puzzled."

**Surgeon:** "Well, I think I should apologize for not having talked very much before surgery about what a really good outcome would look like. I should have reminded you that we were trying to get rid of most of or all of the pain and that you wouldn’t have a knee that bends as well as it did when you were 20."

**Patient:** "Well it was hardly bending at all before surgery. I guess I should be happy with how it is now."

**Surgeon:** "I appreciate your seeing that, Mr. Patient. If all knee replacements turned out as
well as yours has, I would be very pleased indeed.”

**Patient:** “Okay, Doc. Thanks for explaining. And I don’t know if I ever heard a doctor apologize for not explaining everything before. I think that’s pretty special of you.”

**Surgeon:** “Thanks, Mr. Patient. I’m glad we were able to work this out.”

**Here’s the take-away**

Be sure to talk with your patients before surgery about what a good outcome would look like. Don’t omit your usual chat about terrible things that can happen, but don’t forget the good outcome picture too. After the procedure, do ask whether the patient’s expectations were met. If they weren’t, your conversation must be empathetic, not defensive.

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AAOS Now
May 2009 Issue