INFORMED CONSENT: PROTECTING THE PATIENT IS PROTECTING YOURSELF

A legal background is not necessary to administer informed consent, but an overall emphasis on good communication with patients is imperative.

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Despite their differing natures, medicine and law are inextricably tied to one another, crossing over in various capacities of which perhaps too many physicians are reminded. But even those of us who are fortunate to have eluded major legal action from patients should be very aware of the legal components of medicine. That's because we all likely administer informed consent to our patients in some capacity. While there is no assurance that any medical procedure, aesthetic or otherwise, will go exactly as planned, the legal ramifications may vary greatly based on how the informed consent stage of the process unfolds. Everything from establishing patient expectations to setting the groundwork for liability comes to play a role in informed consent, which is why perhaps many clinicians are compelled to draw up very detailed informed consent paperwork and take every defensive step necessary to ensure they are protected. However, the most effective informed consent may require an altogether different and decidedly non-legal approach.

LOGISTICAL DETAILS AND PITFALLS

Informed consent serves a number of critical functions within the context of a medical procedure. Not only does it protect the physician, but more importantly it also provides an educated and pertinent disclosure to help refine choices toward meeting expectations. Some practitioners see informed consent as a matter of documentation and defensive posturing, but this is not a sustainable approach for reasons I will explain. From both a clinical and legal standpoint, informed consent is actually a nuanced and absolutely essential process in the scope of medical procedures.

Placed in perspective of today's media-saturated state, informed consent has become even more important. Currently, there is an ongoing national discussion about the role of industry in directly marketing to patients. In the aesthetic realm, patients are exposed to various advertisements in the media and come to us as a direct result of marketing and have very specific ideas about what they want. As general demand rises for certain procedures, the role of the physician becomes more nuanced. However, patients often have little awareness of whether a procedure they want is appropriate for them. That is why a physician's primary focus in the consultation stages should be on advising patients on procedures that are appropriate.

While preset media pressure often directs patients to the wrong procedures or the wrong areas to treat, it also

A CONCEPTUAL HISTORY OF INFORMED CONSENT

Informed consent firmly establishes the concept of patient autonomy, i.e., the patient has a right to exert control over decisions related to his or her health and well-being. At the same time, it reacts to "the imbalances in information and bargaining power that permit providers to exploit their patients."[1] In 1982 President Reagan's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research found, perhaps not surprisingly, more support for informed consent among patients than physicians. In the Commission survey, 72 percent of the public said that they would prefer to make decisions jointly with their physicians after treatment alternatives have been explained, while 88 percent of the physicians said they believed that patients wanted doctors to choose for them the best alternative.[1]

At the heart of informed consent is the premise that patients require sufficient knowledge—presumably communicated by the healthcare provider—about their healthcare options to make a reasoned decision to receive or forgo a treatment, test, or procedure. The goals of informed consent "cannot be achieved," Schuck observes, "unless the information about the risks associated with various treatment (and nontreatment) alternatives is reliable and is communicated in a fashion that is intelligible and meaningful to patients."[1] Whereas physician communication once focused on acquiring a biomedical history from the patient then rendering a diagnosis and treatment mandate, informed consent expanded the scope of the physician's communication to education and counseling.

The patient empowerment that developed from the ascendance of informed consent and the consumerism of medical care prompted a new trend in patient empowerment or patient-centeredness,[2] and patients began to research and learn about medical topics. Nonetheless, the notion of patient access to individual medical records remained controversial, both due to concerns about the appropriateness of access and the ideal mode for providing information. Proponents of patient-owned records maintained that when patients held their own records, it supported patient/physician trust. Researchers in the 1980s argued that patient-carried health records had the potential to, "improve continuity of care, to improve patient understanding of instructions, and to encourage patients to take a more active role in maintaining their health."[3]

—*Modern Aesthetics* staff

1. Schuck, PH. Rethinking Informed Consent. 103: 899–959.
2. Roth, MS. Enhancing Consumer Involvement in Health Care: The Dynamics of Control, Empowerment, and Trust . Journal of Public Policy & Marketing. 13: 115–132.
3. Giglio RJ and Papazian B. Acceptance and Use of Patient-Carried Health Records. Medical Care. 24 (12): 1084–1092.

places additional pressure on physicians to meet more precise demands. Patients come to us not only with a specific procedure in mind, but also a reason for having it, such as a divorce, a major life event, or perhaps having a friend that's had the procedure. However, regardless of any preconceptions that patients hold, physicians should always maintain control and only offer options that they see as confering legitimate benefit to patients. That means saying "No," if you believe the procedure is not in the patient's best interest. A patient should never consent to a negligent procedure. Apart from this, though, refusing to bow to outside pressures is just better business. When faced with a patient that you fear will not be pleased, either don't accept the patient, knowing that you can't make him or her happy, or alter the procedure, as appropriate.

Other common pitfalls with informed consent concern the documentation itself. Given the additional pressures of meeting more stringent patient expectations, physicians may be more inclined to compensate for their own uncertainties with more elaborate informed consent paperwork. However, this is a major misstep and potentially a significant source of legal action against physicians. Some clinicians may feel more protected, but denser informed consent paperwork is often an acknowledgement that you shouldn't be doing the procedure in the first place. Thus, it may have the opposite effect of protection. In addition, there is an argument that the more extensive a list, the more likely you will miss something. (On the other hand, if the process is under-thought, then all options and disclosures are omitted and should a problem arise, difficulties arise.)

Some clinicians also make mistakes by not carefully listening to and responding to patients' expectations. If expectations are potentially unrealistic, you have an obligation to disclaim and offer alternatives. For example, if a patient wants to go on an already-purchased cruise 10 days after a scheduled facelift, and you proceed with the procedure without mentioning the possibility of rescheduling to accommodate a long recovery time, you may have created a warranty. This is in keeping with the most common standard of informed consent, the Reasonable Patient standard, which is the duty to explain and understand information suitable to make an informed decision that a reasonable patient would want to know. Therefore, I can only recommend being mindful when it comes to predicting healing, bruising, and recovery times, as they all relate to the procedure itself.

ADMINISTERING INFORMED CONSENT

When drawing up informed consent documentation, it's important to strike a balance between comprehensive and educational. A novice might unwisely miss important information and set himself or herself up for failure. Working from

a template that's already available (such as one I authored for the American Society of Plastic Surgeons) is a good place to start. But no matter which route you opt for, do not forget that all documents should be cleared with your malpractice insurance carrier before putting them to use.

Regarding the administering stage, I view informed consent as a non-delegable duty. Some physicians feel that their time is better spent performing procedures and that nurses or staff members can handle other matters. It's worth noting, though, that if an informed consent case ever makes it to the court room, the plaintiff's lawyer is going to question that practice coordinator or nurse about her/his experience, training, and schooling regarding the performance of medical procedures, and the answers will not help the physician's case.

It undoubtedly takes more time out of the physician's day, but being there to walk the patient through the process is critical. It's legally protecting, but you're also actively developing a relationship with the patient that's integral to the whole process. With that said, staff members do serve an important function, by helping to identify patients who are good matches for your practice. Your staff has the initial interaction with patients, which makes regular interaction with staff members about patients a potentially important factor.

A PATIENT-CENTERED APPROACH

There are several ways to streamline the informed consent process for both the physician and the patient. As a broader principle, a certain amount of experience (and honesty about that experience) with the particular procedure under consideration goes a long way toward a healthy interaction with patients. Time is another essential factor, since you never want the patient to feel rushed. Ideally, the patient should review what is suggested and recommended for at least two consultations and discussions.

More important than individual tips to expedite informed consent process, however, and arguably also the cornerstone of lawsuit prevention, is your relationship with patients. A strong rapport with patients can be essential to the overall treatment process from a legal standpoint. I have long recommended that clinicians only accept patients that they like and have a good relationship with. The strained first visit and hostile defensive consultation is a hallmark of things to come.

Placing emphasis on communication with patients is the basis for my firm belief that legal training is not necessary when administering informed consent. It may be second nature for us as physicians to frame informed consent through the lens of how to legally protect ourselves, but our real focus should be on first protecting the patient. Our job is to ensure that we can offer valid and appropriate options that appear to match their goals and expectations. Thus, it is much more productive to think of the informed consent process in terms of education and interaction rather than legal protection. No matter what standard of informed consent you practice, you want the patient to have enough information to make a choice. By doing that, you're better protecting yourself.

DO THIS NOW

To facilitate a strong relationship with the patient, employ some combination of the following three forms of communication: Visual, Auditory, Kinesthetic.

A patient-first attitude leads to safer procedures, happier results, and ultimately less possibility for legal action. In addition, good communication with patients will enable them to perceive the whole process as well as the clinician in a more positive way.

The number one reason for lawsuits in medical aesthetics is failed expectations. Therefore, by explaining the process to the patient and hearing her or his goals, the clinician can match the right patient with the right procedure. This may mean spending more time with patients and less on procedures, but it could also translate to a higher conversion rate and almost certainly means a diminished likelihood of legal action.

Now, what does good communication mean? In order to better educate and communicate, you need to be on the patient's level. Always remember to whom you are speaking and what kind of dialogue you are sharing. Using thick medical jargon may not be the best approach for connecting with a majority of patients. Try instead speaking to them on their terms.

There are three primary learning styles that are especially useful when interacting with patients at the informed consent stage:

- *Visual*: Photos, schematics, diagrams, etc.
- *Auditory*: Telling the patient a story about what they may experience during the surgery, aftercare, etc.
- *Kinesthetic*: Anything that conveys how the procedure will affect the patient personally.

Importantly, the patient retains about 35 percent of what you convey within each individual style, but if you integrate all three, the patient will likely remember roughly 80 percent of what you convey.

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Do not leave room for potential misunderstandings. Speak as though your elderly, slightly-hard-of-hearing grandmother is in front of you, and use simple and clear language. Always remember that just as important as what you communicate is *how* you communicate. Don't sell, but educate and protect the patient from poor selections. The more you discuss all aspects of their care, the more patients will appreciate receiving so much information. Taking these steps will enable you to select the best procedure and reduce the potential dissatisfaction with the procedure itself. Moreover, it gives patients the impression that you care, and patients don't sue doctors they like.

GOOD PROTECTION, GOOD BUSINESS

The biggest threat facing cosmetic physicians today isn't so much the legal aspects of informed consent and malpractice as it is the commoditization of aesthetics. With the rise of medispas and "corporate" practices, patients are being led to believe that anyone can do the things that physicians have earned education and training to perform. Physicians should be less of the mindset that doctors make their money in the operating room. In order for them to retain the rightful position as experts, or the gold standard of aesthetic medicine, clinicians need to be more interactive and convey to the patient that we're not just procedure-givers.

Legal protection should be on our minds to a certain extent, but clinicians should be doing more than the minimum to protect themselves and minimize risk of lawsuits. Rather, singling ourselves out as providing a higher level of care through excellent communication and strong relationships with patients results in safer choices of procedures, better results, and happier, more loyal patients. It is good legal protection and also very good business. That is why the informed consent stage is better approached as an educational process—for both the patient and the physician—rather than a legal burden. ■

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BOTTOM LINE

Clinicians should resist the inclination to administer informed consent as a defensive posture. Rather, informed consent should be used as an opportunity to educate the patient and set appropriate expectations.