

## Competency of gaining consent: a Foundation trainee's perspective in the North Western Deanery

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### ABSTRACT

#### Introduction

The General Medical Council (GMC)<sup>1</sup> and the National Health Service Litigation Authority (NHSLA)<sup>2</sup> have strict guidance on how informed consent should be gained and how trainees should be supported when learning to take consent, however foundation trainees often feel vulnerable when expected to gain consent for a procedure they have little or no expertise for.

#### Objective

- (1) To examine the perceptions and confidence level of new Foundation year 1 doctors in gaining consent.
- (2) To look at the factors that favourably influenced confidence.
- (3) To outline the best method of teaching in gaining a valid consent of a procedure.

#### Method

Questionnaires were distributed in 9 hospital trusts in the North Western Deanery and completed by 203 FY1s in the first 6 months of their post.

#### Result

71% had taken written informed consent, of these 43% felt they had been put in a position in which they were unhappy to do so, 33% were supervised and 16% were formally supervised. Confidence levels were increased by: supervision (Mean confidence 7.26 vs 6.58, 2 sided P value 0.0036); and formal assessment (Mean confidence 7.26 vs 6.64, 2 sided P value 0.0277).

Respondents preferred the following modes of teaching consent: one-to-one session with supervisor (47%), organised tutorial session during induction (21%), and medical school (20%).

### **Conclusion**

Results show low levels of supervision and formal assessments in gaining consent, despite being key factors in increasing confidence. A mandatory Mini CEX or similar activity early in Foundation training could lead to better prepared doctors in gaining a valid consent.

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**Keywords:** consent, training, foundation programme.

### **Introduction**

Gaining informed consent to treatment forms one of the vital roles a doctor has to perform day to day. The General Medical Council's (GMC) Good Medical Practice states, the responsible clinician must be satisfied that they have consent or other valid authority before they undertake any examination or investigation, provide treatment or involve patients in teaching or research.<sup>1</sup>

In the revised GMC guidance, *Consent: Doctors and Patients making decision's together 2008*, it states the doctor undertaking an investigation or providing treatment, is responsible for discussing it with the patient. If this is not practical, they can delegate the responsibility to someone else, provided they make sure that the person they delegate to: a. is suitably trained and qualified, b. has sufficient knowledge of the proposed investigation or treatment, and understands the risks involved, c. understands, and agrees to act in accordance with the guidance.<sup>2</sup>

In day to day practice, it is often the most junior of doctors who are asked to obtain written informed consent. Clinicians have been aware of this for some time and have expressed concerns regarding the ethics of delegating this task to ill-prepared juniors. In a medical ethics symposium it was stated that, if informed consent is to fulfil the purpose of respecting the autonomy and dignity of patients sufficient resources are required to train young doctors to the job properly. It stated that one thing was clear: if they cannot complete the task in accordance with the guidance issued by both the GMC and Department of Health, they should not be doing it at all.<sup>3</sup>

In 1997 Houghton et al looked at the perceptions of junior doctors and patients in the consent process. They found that although 95% of patients questioned were happy with the consent procedure performed by junior doctors, 45% of patients wrongly thought the junior doctor themselves would be carrying out the procedure and of the junior doctors questioned 37% admitted to gaining consent for procedures of which they had little understanding about.<sup>4</sup>

In 2005 a study by Schildmann et al found that half of the PRHOs (FY1s) stated that they were often or always the only person involved in the consent process. The majority also seemed to be never or rarely receiving supervision.<sup>5</sup> Schildmann felt that despite extensive undergraduate training in ethics and

communication, there was a need for applied education regarding the clinical procedures for which PRHOs were obtaining consent.

In 2010 the NHS Litigation Authority published the Risk Management Standards for NHS trust in the UK. This document focused on measures to ensure patient safety. Part of the documentation focused on written consent. It stated that as a minimum NHS trust should provide generic training on consent along with procedure specific training for those authorised to obtain consent. It stated there should also be a process for monitoring compliance with GMC guidance on taking informed consent.<sup>6</sup>

Although the structure of Junior Doctor training has changed, the issue of ill-prepared juniors taking informed consent continues. Our aim was to determine whether Foundation Year One Doctors (FY1s) express the same concern regarding gaining consent as shown in Schildmann's study.

## **Material and Method**

The study took place within the North Western Deanery in England. A survey was developed using the GMC's guidance on consent as a basis. The survey was approved by the North Western Deanery and each survey was optional and anonymous. Participants were asked about their involvement in taking informed consent. They were asked about which procedures they had been asked to consent for and whether they were supervised when initially taking consent. They were also asked whether or not they felt they could refuse taking consent when they felt unknowledgeable. A total of 9 hospital trusts were recruited in to the survey and an FY1 representative from each trust was charged with distributing and collecting the surveys. The surveys were distributed to all FY1s within each trust who at the time of taking part were just over 6 months in to their first year of training.

## **Results**

Nine hospital trusts within the North Western Deanery were represented with 203 FY1's taking part in the survey. The participants involved were graduates from 25 different Universities, with the University of Manchester having the greatest representation (49%). Of the 203 representatives, 71% admitted to taking informed consent as an FY1. Of those that said they had taken consent 61% said they felt suitably trained to take informed consent and 43% of participants felt that they had been put in a position to take consent which they were unhappy to do.

When asked where they had learnt to take informed consent, 94 respondents were trained during their medical school years, 136 respondents were trained by a senior colleague on the job. 17 respondents denied being taught how to take consent in their medical training.

33% of respondents who experienced gaining consent were supervised and 16% of respondents were formally assessed during gaining consent.

All respondents were asked to rate their confidence level in taking consent from 1-10 (score 1, being least confident to 10, most confident (Table 1).

The mean confidence level measured for respondents who gained consent with and without supervision is 7.26 and 6.58 respectively. There is a statistical significance when comparing these two groups (Critical values for 2 tailed T test 1.98, 2 sided P value 0.0036). We also measured the mean confidence level for those who were formally assessed and those who were not whilst taking consent. These were 7.26 and 6.64 respectively. There is also a statistical significance when comparing these two groups. (Critical values for 2 tailed T test 1.98, 2 sided P value 0.0277). (Table 2).

We also asked the survey respondents' perception on what is the preferred mode of teaching informed consent. The majority, 47% felt that a one to one tutorial session by their supervisor would be the preferred mode. 21% of the respondents felt that an organised tutorial session during their induction would be best and 20% felt that it should be best taught at Medical School.

## **Discussion**

The North Western Deanery discourages FY1s from taking informed written consent, yet 144 did so in their first 6 months of training. Only 61% of this number felt suitable trained to take informed consent and it was clear a large number of doctors were regularly being put in to a position in which they felt uncomfortable at carrying out this task.

One aim for this survey was to sample junior doctors from a range of different medical schools. Where previous studies have been held back by a cohort of junior doctors sampled from the same medical school, our respondents came from 25 different medical schools, eliminating the educational profile of one medical school as a bias.

Although previous studies had called for further investment in to teaching medical students and junior doctors in taking consent, juniors are still expressing the same concerns. Despite NHSLA<sup>6</sup> guidance on the training of taking consent there still seems to be a lack of clear structure to educational programmes and supervision of foundation trainees when taking consent.

Supervision when consenting happened for only 33% of FY1s, and formal assessment of this for only 19%. Formal assessment and supervision itself was highlighted as the preferred method of teaching and of the two, formal assessment allowed respondents to be significantly more confident in their practice.

When we talk about formal assessment we mean a work-based assessment. The Foundation Training Programme in the UK is competency-based and individuals are routinely assessed through workplace-based assessments. This formative system can identify deficiencies, problems, and gaps in training<sup>7</sup> whilst also allowing for positive observational feedback. Formal assessment of gaining consent could be done using a Mini CEX or CBD.

As an FY2, the expectation to take informed consent will be higher and there is little to suggest that an FY2 will be more knowledgeable and prepared than an FY1. Junior doctors need education and assessment during the first year of Foundation training before being allowed to practice independently in taking informed consent.

## Conclusion

FY1s are taking informed consent despite the associated problems. They report they are breaking the GMC guidance on consent<sup>2</sup> by taking consent when not possessing sufficient knowledge of the procedure and often not being supervised.

Those who have been formally assessed and supervised when taking informed consent, have a significantly higher level of confidence than those who have not.

We recommend greater clarity regarding who can and cannot take informed consent. We believe all FY1s should be supervised and formally assessed during the initial stages of gaining consent. A mandatory Mini CEX in the first year of foundation training could lead to better prepared doctors when they become FY2s.

*Abbreviations: Mini CEX (Mini-clinical evaluation exercise), DOPs (Direct Observation of Procedure), CBD (Case Based Discussion), FY1 (Foundation Year 1 Trainee Doctor), FY2 (Foundation Trainee Year 2 Doctor)*

**Conflict of Interest:** None declared. (Or mention here if any)

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Table 1: Measurement of Confidence



**Competency of Gaining Consent: A Foundation Trainee's Perspective**

**CONFIDENCE LEVEL:**

- How confident are you at this stage of your training do you feel you are able to obtain a valid consent?

Please circle appropriately.

☹									☺
1	2	3	4	5	6	7	8	9	10

Table 2: Factors that Increase Confidence

	% of respondents who gained consent with this method	Means of confidence scored, when assessed with:		Critical T two tail	2 sided P value
		Yes	No		
Supervision	33%	7.26	6.58	1.98	0.0036
Formal assessment ( e.g. mini CEX, CBDs etc)	16%	7.26	6.64	1.98	0.0277