What’s the best way to help patients remember information they are given during the informed consent process?

Don’t just talk to them about it—give them written information they can read and discuss.

That’s the advice of plastic surgeon Ara Samuel Makdessian, MD, FRCSC, of the West-Med Facial Cosmetic Surgery Center, Plantation, Fla. He and his colleagues studied patients’ comprehension and recall of preoperative information.

In the prospective, randomized study, they found that patients given a pamphlet in addition to a discussion with the surgeon had better recall 2 weeks later than patients who had a discussion alone.

Dr Makdessian decided to conduct the study because he noticed his patients would come back days after he discussed the risks, benefits, and possible complications of a procedure and wouldn’t remember what he had told them.

In the study, 120 patients undergoing rhinoplasty, rhytidectomy, or laser resurfacing were randomly assigned either to an oral discussion of the risks or oral and written communication about the risks, using a pamphlet (sidebar). Two weeks later, patients were surveyed to see what they recalled.

**The more information, the better**

The findings indicated that written material was key to helping the patients comprehend and recall the risks of their impending surgery.

“Patients remember more, and they can go back and review the risks and complications when they are given a pamphlet to read,” Dr Makdessian told *OR Manager*.

He has also found the pamphlet helpful if patients have complications.

“They may say they don’t remember the discussion, but when they are shown the information in the pamphlet, their usual answer is, ‘Oh, yes. I remember,’” he says.

Even the slightest complication in cosmetic surgery can upset a patient. But when patients see the complication described in the pamphlet, know it isn’t out of the ordinary, and remember they were forewarned, they appreciate that it was discussed ahead of surgery, notes Dr Makdessian. “Without the pamphlet to remind them, many just would not remember.”

The general rule is that the more information patients are given in as many formats as possible, the better they will remember it.

“It is basic adult learning theory—the more redundant the communication the better,” says Arlen D. Meyers, MD, MBA, of the University of Colorado Health Sciences Center, Denver, who wrote a commentary on the study.

**Informed consent in plastic surgery**

The fundamental concept of informed consent is that patients should receive sufficient information about risks and benefits of a procedure to make an informed decision to accept or refuse treatment. Consent is necessary because surgery is a form of battery that can be excused only when the patient has given consent.

Obtaining consent before surgery is a process, not merely having patients sign a form, Dr Meyers comments. Many people think informed consent includes only risks and complications of a procedure, but informed consent also should cover the benefits, disadvantages, alternatives, and limitations.

Elements of informed consent are no different for facial plastic surgery than for
any other surgery, Dr. Meyers told OR Manager. But because facial plastic surgery is elective and involves patients’ perceptions of themselves, surgeons need to do a good job of communicating about the expectations.

“We are not just operating on the physical part of the body, we are really affecting a person’s self-esteem and psyche, and that is difficult to get a handle on,” he says.

Defining a patient’s expectations may be more demanding in facial plastic surgery than in orthopedics, Dr. Meyers says. “You fix a knee, and you want it to work; you don’t want it to hurt. But in facial plastic surgery, there are issues about a patient’s expectations for the face lift, nose job, or blepharoplasty.”

What should patients be told?

What should patients be told about the risks and complications? Dr. Meyers suggests that surgeons consider the “reasonable patient rule” or “reasonable physician rule.” In other words, what should a reasonable person know about a complication? And what would a reasonably prudent physician disclose? For example, should the doctor tell a patient having a blepharoplasty that blindness is a recognized, though rare, complication of the procedure?

“I don’t know the answer,” says Dr. Meyers, “but personally, I think that if a complication is so significant that a reasonable person should know it, I would tell them.”

Whose responsibility is it?

The primary responsibility for informed consent rests with the surgeon, Dr. Meyers says. Though the focus tends to be on legal liability, the core concept is that the surgeon has an ethical obligation to disclose the risks of the procedure and ensure the patient is making an informed decision.

The American College of Surgeons in its Statement on Principles says, in part, “Patients should understand the indications for the operation, the risk involved, and the result that it is hoped to obtain.” Most states have legislation or legal cases that determine the standard for informed consent.

Obtaining consent is not the facility’s nor the staff’s responsibility, Dr. Makdessian says. The staff’s role is to:

- confirm that the patient has discussed the procedure with the physician
- ask if the patient has additional questions
- and if so, bring the questions to the surgeon’s attention.

Having patients sign consents in the preoperative holding area is discouraged, and some organizations do not allow it. Preferably, the surgical consent is signed in the physician’s office when the decision to have surgery is made.

Some circumstances may warrant modifying or amending the consent immediately before surgery. For example, just before a patient who will have a rhinoplasty is taken to the OR, she asks if the surgeon can remove a mole from her face. The consent can be amended to add this procedure, Dr. Meyers notes. The surgeon should sign the change and document the reason for the change, noting the patient was not under duress at the time of signing.

If the consent is modified, the staff should make sure that is done under appropriate circumstances—the patient hasn’t been sedated or isn’t under duress, and that the amendment is properly documented and witnessed.

In the future, Dr. Makdessian says there may be standard index cards that outline plastic surgery procedures, including information for informed consent, in simple and comprehensive language. Local, regional, and national plastic surgery societies are beginning to look into this project.

—Judith M. Mathias, RN, MA

Reference

Pamphlet lists rhinoplasty risks

Risks outlined in a pamphlet by plastic surgeon Ara Samuel Makdessian, MD, FRCSC:

1. Nose bleeding (epistaxis)
   There is a very low chance that you might bleed from the nose. It usually occurs 2 weeks after surgery. Avoiding heavy exercise, heavy lifting, and trauma to the nose can reduce this risk. This bleeding may require treatment.

2. Numbness of nasal tip
   You should expect numbness of the tip of the nose after the surgery. This may persist for up to 8 months. It usually resolves on its own.

3. Asymmetry of the tip and supratip
   There may be unevenness of the tip of the nose as well as the area above it. This is dependent on how you heal. If this occurs, steroid (Kenalog) injections may be required to correct it.

4. Nose not being perfectly straight
   Straightening a crooked nose is the most difficult aspect of rhinoplasty. We would do our best to straighten the nose, but we cannot guarantee a perfectly straight nose. However, the nose will be straighter.

5. Bruising and swelling
   Bruising and swelling are expected. The amount of bruising varies from patient to patient. It usually occurs around the eyes. Swelling is expected as well. Most of the swelling and bruising disappear, and you will look “socially acceptable” by the end of 2 weeks. Some swelling may last up to a year.