Consent for cataract surgery training: a national trainers' survey

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Abstract

Aims To evaluate current trainers' attitudes and practices for informing patients about the trainee participation in cataract surgery within the United Kingdom.

Methods An anonymous online survey was distributed to current cataract surgery trainers via all Royal College of Ophthalmologists' tutors within the United Kingdom. Trainers were asked specific questions about their current consent practice regarding trainee participation in the cataract surgery. Questions also targeted experiences of patient complaints about training.

Results One hundred and twenty-three trainers completed the survey. Ninety-three percent ($n = 114$) of responders were consultants and 7% ($n = 8$) were non-consultant career-grade doctors or other grades. A total of 34% ($n = 42$) of responders stated that consent was usually taken by themselves or the trainee assigned to the list, whereas 26% ($n = 32$) always took consent themselves. Sixty percent of responders ($n = 74$) stated that consent is taken on the day of surgery; 59% ($n = 73$) indicated consent is taken where listing takes place. Thirty-three percent ($n = 41$) of trainers indicated that they had experienced patient dissatisfaction or complaints. Surgical complications, length of surgery, and discussions during surgery were the leading causes of complaints. Thirty-nine percent ($n = 48$) would operate themselves if patients requested no trainee participation.

Conclusions There is a wide variety in the current practice of disclosure and level of information given regarding trainee participation in surgery. This will influence patients' expectations, experiences, and satisfaction.

Eye (2012) 26, 666–670; doi:10.1038/eye.2012.2; published online 3 February 2012

Keywords: informed consent; cataract surgery; training; teaching

Introduction

Informed consent is a legal requirement before elective surgical procedures. Guidance for consent is available from the General Medical Council¹ and the Royal College of Ophthalmologists (RCOphth) has produced specific guidance for consent in cataract surgery.²

The RCOphth advises that patients should be told 'whether doctors in training will be involved in the surgery.'³ Patients should be reassured that 'junior surgeons will be appropriately supervised so that they are only doing what they are capable of.'⁴ However, there are no clear recommendations about what specific information or level of detail should be given to patients regarding trainee participation in surgery. The ideal person to discuss this and the best time to do so is also uncertain.

This survey describes the current variations in consent for trainee participation in cataract surgery among trainers in the United Kingdom.

Materials and methods

An invitation to participate in an online survey, using SurveyMonkey software (Palo Alto, CA, USA), was sent to all college tutors, working in the National Health Service (NHS) in the United Kingdom, listed on the RCOphth official website.

College tutors were asked to distribute a link to the online survey to all cataract surgery trainers within their unit. Data were prospectively collected over a 2-month period (March–April, 2011). Cataract trainers were asked to anonymously respond to key questions relating to current consent practice, specifically about information given to patients about trainee participation in their cataract surgery.

The questions aimed to assess the grade of the trainer and to identify who obtains consent and when consent is taken. The trainers were asked

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Received: 12 August 2011
 Accepted in revised form: 19 December 2011
 published online: 3 February 2012

what information and discussion is given to patients when a trainee will be involved in all or part of a case. Furthermore, they were asked if they had ever experienced patient dissatisfaction or complaints related to them not being told about trainee participation in their surgery. A free text comments section was also included. The data obtained were entered into a customised spreadsheet and analysed using Microsoft Excel 2007.

Results

A total of 123 trainers completed the survey. In all, 93% ($n = 114$) of responders were consultants and 7% were non-consultant career-grade doctors or other grades ($n = 8$).

Who usually takes consent?

A total of 34% ($n = 42$) of responders stated that consent was usually taken by themselves or the trainee assigned to the list, whereas 26% ($n = 32$) always took consent themselves. In all, 25% ($n = 31$) stated that the doctor listing the patient, irrespective of grade, consented patients. Only 8% ($n = 10$) reported trainees alone obtaining consent and 7% ($n = 8$) noted nursing staff taking consent.

When is consent usually taken?

Among the responders, 60% ($n = 74$) stated that consent is taken on the day of surgery; 59% ($n = 73$) indicated consent is taken in the clinic where listing takes place; 29% ($n = 35$) reported consent also takes place in pre-assessment clinics (multiple responses were possible).

What are patients told when a trainee will be operating?

The responses to this question are detailed in Figure 1.

Experience of patient dissatisfaction or complaints related to trainee participation in the surgery

In all, 67% ($n = 82$) of trainers reported no experiences of patient dissatisfaction or complaints. The remaining 33% ($n = 41$) of responders reported that they had had such experiences. Of these, 25 trainers detailed reasons for previous patient dissatisfaction or complaints (Figure 2).

Response to patient requesting no trainee participation

Among the trainers, 39% ($n = 48$) would operate themselves and 15% ($n = 18$) said they would discuss further with the patient and proceed to operate themselves if the patient was still unhappy.

Figure 1 Responses to the question 'what are patients told when a trainee will be operating?' Trainers were asked to select one of the six listed options.

Figure 2 Reasons listed for previous patient dissatisfaction or complaints related to trainee participation in cataract surgery.

A total of 15% ($n = 19$) of trainers would emphasise the trainee's competence and guarantee that all surgery is performed under consultant supervision, 7% ($n = 9$) would say 'a member of the surgical team will operate, with no guarantee of a specific surgeon, with all cases being under consultant care.' Overall, 3% ($n = 4$) offered no surgeon choice unless there was a clinical indication and 4% ($n = 5$) of trainers stressed the need for teaching and training future surgeons. A total of 5% ($n = 6$) of responders commented they have never had such requests.

Among trainers who had experienced patient dissatisfaction or complaints, 49% would operate themselves whereas only 34% of those without such an experience would decide to operate themselves.

Free text comments

A number of comments from responders are shown in Figure 3.

Free Text Comments
"Whether a trainee or consultant, the operating surgeon should see their pre-operative cases. The patient is less likely to be unhappy if they have had an opportunity to see their surgeon beforehand and the issue of training is handled sensitively." A similar comment was "...they and I see any complications post-operatively."
"I decide which operation is to be done by my trainee only after I have seen all my patients. So it may not always be possible to tell a specific patient whether the operation is going to be performed by me or my trainee."
"Communication with patients is of vital importance. Giving a running commentary most of the times eases the patients' apprehension and increases cooperation. I have been teaching cataract surgery in reverse order for 15+ years and that makes it a lot easier for the trainees, trainers and patients with least amount of complications."
"Juniors may spot potential medical or ophthalmic difficulties but often don't pick up anxious or "difficult" personality types in patient. Some patients just can't cope with the idea of "a trainee learning on them", despite our reassurances about supervision."
"I think it is best to be as honest with patients as possible. It helps if you say the trainee will be doing part of each patient's operation (even if that is just prepping and draping). I think it is really important for the consultant to be involved in the consenting process. Most patients are very generous."

Figure 3 Interesting free text comments elicited by the survey.

Discussion

Trainee participation in cataract surgery is a sensitive subject with ethical, legal, and medical implications. There is no consensus on the best way to approach the subject with patients. Despite recommendations that patients should be made aware of the possibility of trainee involvement, with re-assurance that junior surgeons are supervised, there is no clear guideline on how much detail a patient should or needs to be told.

Nguyen *et al*⁵ have investigated patient disclosure of trainee participation in cataract surgery among 20 Canadian ophthalmologists. Of only five responses, four trainers reported that they do not consistently disclose resident participation. Gan *et al*⁶ commented that their personal experience and published cataract case numbers during residency suggest that trainee participation rates in cataract surgery are higher than

Nguyen's published 16% rate. The authors concluded that the patient consent rate is either higher and/or patients are not being told about trainee participation in their surgery. A paucity of literature showing trainers' perspectives and current practices on this topic prompted this national survey of cataract surgery trainers within the United Kingdom. To the best of our knowledge, this is the first published survey of its kind.

The survey responses clearly show that there is significant inconsistency in disclosure of trainee involvement to patients (Figure 1). The majority of responders choose not to discuss the surgeon's grade or identify an individual, preferring to refer to the 'surgical team.' The RCOphth states that 'it is reasonable that the patient should have the opportunity to know the identity and status of the operating surgeon.'⁷ This is supported by Moodie *et al*⁸ who reported 80% of patients thought they should be told the name and designation of their

operating surgeon. Only 34 (28%) responders specifically introduce the trainee as the operating surgeon, with only 26 of these also mentioning that they will be supervised in line with this guidance.

The survey shows that consent is taken at various stages of the cataract care pathway, with overlap between listing in a clinic setting or on the day of surgery. Our results show that inconsistency in disclosing trainee participation to patients occurs irrespective of the setting in which consent is taken.

Patient attitudes and consent to trainee involvement in surgery have been investigated by several authors with differing reports. In Nguyen's⁵ study 84% of patients ($n = 49$) did not consent to trainee involvement in surgery when directly told a trainee would be actively involved in the procedure. The exact wording of the consent process is not detailed by the authors.

In stark contrast, and reassuringly, Gan *et al*⁶ reported that 101/106 (95%) patients agreed to resident participation in their surgery following use of a specifically worded discussion of trainee participation in cataract surgery. Furthermore, Wisner *et al*⁹ found that most patients would accept resident involvement in surgery provided full disclosure was provided by their consultant surgeon.

Moodie *et al*⁸ also reported 70% (126/180) of first eye cataract surgery patients accepted the need for trainee surgeons to operate as part of their training. However, only 81% of these (57% of total) would be happy to be operated themselves by a supervised trainee surgeon. In all, 78% objected to being operated on by an unsupervised trainee. Wisner *et al*⁹ reported the majority of patients felt they should be asked in advance if a trainee may assist (83%) or perform (96%) their surgery. The majority indicated they would be upset if a resident

assisted (45%) or performed (74%) their surgery without their prior permission.

Within the NHS patients do not have the right to choose the name or designation of their surgeon.⁷ Patients can, however, expect the surgeon has the adequate experience and skill to perform their surgery. The response to a patient requesting not having a trainee participate in their surgery varied widely between different trainers with majority of trainers (39%) choosing to do the surgery themselves. Among this group, reasons for this included: reducing patient anxiety, increasing peri-operative co-operation, respecting patient choice, avoid trainee stress, and prevent complaints. Trainers were more inclined to operate themselves if they had received previous complaints related to trainee participation.

The majority of responders reported no experience of patient dissatisfaction or complaints related to trainee participation. Those who reported they had received complaints generally commented that such experiences were very infrequent. A common reason for complaints related to discussions between trainer and trainee during surgery. The RCOphth recommends there should be an 'agreement about specific phraseology' used during the surgery.⁴ Both trainees and trainers must be alert to patient awareness of discussion, particularly with most surgery being performed under local anaesthesia.

The leading cause of patient complaint was related to surgical complication. Understandably, patients may be concerned about higher complication rates with trainees and potentially attribute complications to trainee involvement. This raises the difficult issue of discussing specific complication rates of trainees *vs* consultant operating surgeons. Trainee risks will

Recommendations
<ul style="list-style-type: none">• Patients should be informed that surgery is always performed under appropriate consultant supervision.• Consistent disclosure to all patients that training takes place within the unit. This should ideally happen before the day of surgery, perhaps at the pre-operative clinic, as patients may not meet the operating team until the day of their operation.• The authors believe the trainer and trainee should see all patients pre-operatively to allow the patient to meet their operating team and allow selection of suitable training cases.• The use of pre-established specific terms and phraseology between trainer, trainee and nursing staff during the operation to avoid undue patient anxiety.

Figure 4 Recommendations for informed consent for cataract surgery training.

vary with grade and experience. Importantly, the risks of complication must always be specific for each patient taking account of an individual's risk factors. This highlights the importance of careful case selection for training. A methodology for risk adjustment of posterior capsule rupture rates for individual surgeons is now available.¹⁰

Patient recall of information given during the consent process is highly variable and has been demonstrated to be poor irrespective of technique of consent.¹¹ Vallance *et al*¹² specifically demonstrated that recall of a discussion about trainee participation was poor immediately post consent and postoperatively. Many of these patients were very unhappy irrespective of surgical outcome if they did not remember such a discussion. The discussion of training therefore needs to be performed in the best environment and with appropriate timing to aid patient understanding and recall.

Following analysis of the responses received and our personal experiences, we propose several recommendations regarding informed consent for cataract surgery training (Figure 4).

The authors acknowledge difficulties in contacting all college tutors because of an incomplete list of college tutor email addresses on the RCOphth website. The methodology relied on college tutors distributing the survey to fellow trainers in their unit; the invitation to participate may not have been forwarded to all trainers. Consequently, the actual response rate is unknown.

Conclusion

This survey demonstrates a wide variety in current practice of disclosure of trainee participation in cataract surgery. There are many issues that need to be considered when dealing with this topic. These vary within patient's individual attitudes towards training, their ability to recall information, their desire for information, method and timing of consent, trainers' choice on disclosure of the surgeon's identity or experience, and trainer willingness to accept a patient's request for no trainee involvement in their surgery. As a consequence clinicians must tailor the language and details given to each patient individually.

Increased emphasis on patient centred care is likely to stimulate further discussion on disclosure of trainee participation in surgery to patients. In the future, if patients have greater choice in their care, including the option of specifying an individual surgeon, there may be a significant impact on future training opportunities.

Summary

What was known before

- Evidence suggests patients accept the need for surgical training and the majority will agree to trainee involvement following specific discussion.
- The Royal College of Ophthalmologists (RCOphth) Cataract Surgery Guidelines advises that patients should be told if trainees will be involved in the surgery, although the required level of detail is not clear.

What this study adds

- This is the first national survey of cataract surgery trainers evaluating practices for informed consent for training.
- The study shows a wide variety in current practice of disclosure and level of information given to patients. Some consent practices reported are not in accordance with RCOphth recommendations.

Conflict of interest

The authors declare no conflict of interest.

Acknowledgements

We would like to thank all the trainers who participated in this survey.

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