

components of the curriculum are, little clinically applied consent teaching takes place². As a result when junior medical staff hit the ward they are often silently overwhelmed by the task of consenting patients when they have little experience in the proposed procedure. This may cause increased levels of stress for both the patient and junior doctor and may lead to the provision of uninformative or even incorrect answers to patient's questions^{3,4}.

The purpose of this study was to assess the effect of teaching sessions in improving the validity of consent for tonsillectomy and to develop more efficient and standardised ways to obtain consent.

A retrospective analysis of 70 sets of patient notes was carried out at three ENT centres in Northern Ireland. Consent forms were scrutinised for complications outlined by ENT UK⁵. Several other components of the consent form including the timing of consent and the grade of those taking consent was noted. A teaching session on consent was provided at each centre and a repeat analysis on a further 70 sets of notes performed.

Initial analysis showed 48%, 56% and 66% of consent forms to have been completed to the standards set out by ENT UK at the three centres respectively. Following the teaching session the three centres improved their consent taking standard by an average of 9%. There was considerable variation in the grade of doctor taking consent across the three centres with consent being taken almost exclusively by the SHO grade at one centre. Consent was obtained at the clinic 83% of the time with the remaining consent being taken on the ward prior to the procedure. Consent was not documented in any of the patient notes reviewed.

Consent practices across ENT centres in Northern Ireland are variable often reflecting the constitution of staff in the department. Consent teaching sessions led to improvements across all centres and it would be reasonable to include consent teaching for common procedures as part of an induction program for junior staff. We also recommend the use of prefabricated consent stickers to improve the standardization and efficiency of consenting across all grades, we reiterate both the need for doctors to document consent in both the notes and the consent form and for consent to be taken at the clinic to allow adequate time for patients to weigh up the risks and benefits prior to the procedure.

These recommendations serve not to "dumb down" or allow for outsourcing the process of consenting patients to other healthcare professionals but to create an environment where junior staff can safely be an integral part of the process despite time constraints and legal pitfalls.

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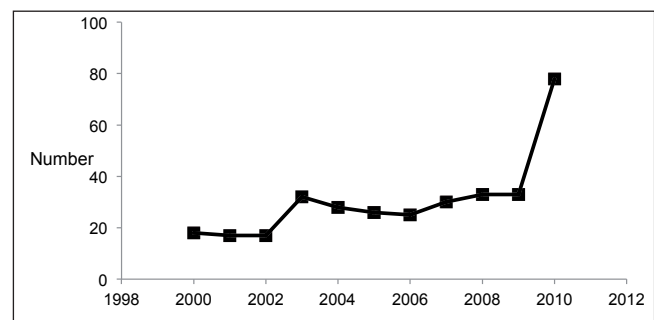
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THE EVER INCREASING DEMAND FOR METASTATIC SPINAL SURGERY.

Dear Sir,

Clearly, to allow appropriate resource planning, trends in clinical practice need to be recognised and acted upon.

In the field of spinal surgery, the management of metastatic spinal disease has significantly changed over the years. Surgical techniques have improved and patient survival is increasing. The Patchell paper¹ demonstrated an advantage in clinical outcomes for patients undergoing surgery followed by radiotherapy. NICE guidelines for malignant spinal cord compression (MSCC)² promoted spinal surgical input. Improved medical and oncological treatments are leading to increased survival times.



Graph 1. The number of patients with malignant spinal cord compression undergoing surgery

We recently reviewed the fracture outcome research database (FORD) for the last 10 years to assess if our impression of an increasing demand for surgery was real or perceived.

The results are startling.

Of the 3468 patients admitted to the RVH trauma unit in 2000, 351 were spinal admissions of various causes. By 2010, the

TABLE 1:

	Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number	Tumour	18	17	17	32	28	26	25	30	33	33	78
	Fracture	292	352	348	306	279	326	299	326	303	339	357

total number of admissions for general fractures had remained relatively static at 3483, but the number of spinal admissions had increased to 650. 18 patients underwent surgery in 2000 for MSCC, whereas an exponential rise in numbers lead to 78 patients being operated on in 2010 for MSCC (table 1, graph 1). Fractures of the spine undergoing surgery showed no significant increase.

The impact of this increase is twofold. These patients undergo complex surgery taking significant theatre time often displacing other work and the operations these patients undergo require expensive implants. However, the effect of this surgery for the patient is often significant. Whilst survival time may or may not increase, quality of life is significantly improved and the demand for this surgery will not go away in the short term.

This trend will in all probability continue and the impact on time and financial budgets will continue to increase. With advances in medical oncology, the demand will in all likelihood eventually plateau, but as yet we have not reached such a point.

From a managerial perspective, it needs to be clearly understood that this patient group quite rightly will continue to place an increasing financial and time burden on our service. Unlike other conditions, time is of the essence by definition and it will be hard if not impossible to restrict this budget demand.

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