Opinion

# The language of consent: do we take or does the patient give?

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Let us start with some gentle debate. Informed consent is a time-consuming process that uses valuable resources. Do you agree? Probably, in private, you will think this way sometimes. Now let us change the words a little. Informed consent is a valuable process that can occasionally be time consuming. What are your thoughts about this? Nodding? Hopefully. The point is that the words we use and the order that we place them in is important. They frame our emotions and reflect our thinking but, moreover, the words we use influence the way that we think.

There are many better than I at disguising their thoughts, using words that are different to those that they are actually thinking. Politicians spring to mind. On the other hand, as the saying goes, if we say something often enough, we start to believe it. The words we use and how we use them matter immensely because they shape the way we perceive the world and participate within it.

So, what has any of this to do with consent? The definition of consent in the Cambridge Dictionary is 'permission or agreement' and in law as 'an act of giving agreement to something that is recognised by law, or the form this agreement is written on'. While we as doctors may think that we have a monopoly on the use of consent, in reality it is far more important in society. Every (legal) physical interaction is based on freely given consent. No one signs a form for a hug, but if it is not freely given and is instead taken it is a grasp not a hug and is probably illegal.

Too often in discussions about consent for a specific procedure I hear 'what did you consent the patient for?'. Well, the patient consented for an endoscopy and its positive outcomes (a diagnosis or a procedure). I, the endoscopist, did not consent for anything. Moreover, the patient did not agree to an adverse event, whether mild or fatal. The importance of consent is simply that they accept that an adverse event is a risk that runs alongside the thing that they agreed to, the endoscopic diagnosis or treatment. They put their money on black and hope it comes in but accept that half of the time they lose. Hopefully the odds are better in endoscopy, but it is the same deal.

Another popular set of words in clinic letters is 'I told the patient they need an endoscopy and I have advised them of the risks'. So, the patient has been duly informed but at no point does such a form of words acknowledge that the patient has a view or if the well-meaning doctor asked them their preference. As an alternative, consider 'I recommended an endoscopy to the patient for the following reasons … I have described an endoscopy, the possible outcomes, the sedation options and explained that unfortunately it is accompanied with the following risks … Having discussed this the patient has agreed to proceed'. Takes a few moments longer but in that discussion there are patients who will decline, especially when you tell them how rarely diagnostic endoscopy actually finds something worth finding!

The other thing I hear frequently is how best to 'take consent'. Let us be clear, we cannot 'take consent'. The only action that deems consent to be legal is that it is 'freely given' and that is the basis on which we should talk to our patients. The patient gives us their consent and we receive it, but we do not take it.

Is this just pointless pedantry? Maybe, but if we are using words that describe the consent process incorrectly, it is likely that we are not allocating the time and space that this discussion requires. If we continue to use incorrect terminology, we will continue in the paternalistic way of

thinking. Too often in medical practice consent is seen as a time-consuming barrier to doing the things that we believe to be best for our patients. Yes, it can be time consuming, but the more I avail patients of my time, the more I find they need it.

In the recent BSG guidance on consent for endoscopy, the term taking consent is dispensed with and replaced with the terms seek or obtain.[1] They are not perfect but they are at least passive and acknowledge that without the patient's agreement to the whole package, we must not proceed. If we use different words, we will think about it differently. If we say 'taking consent' and 'what we consented for', it is likely we will continue to see consent as a hurdle that has to be negotiated so that we, the wise, can do the things we feel the patient should have done.

So, why does any of this matter? Because if we use the wrong words often enough, we will believe them. And the key issue is this: consent is indeed a valuable process that can be time consuming. It is valuable because our patients value the discussion but, equally important, if we see consent as putting the patient at the centre of the decision to have an invasive procedure, then we will, more often than not, choose the right procedure and not do the things that our patients do not want doing. And if that procedure does not achieve the desired outcome, it is less likely that our patients will blame us. Choosing the right words to describe consent helps frame that process in our minds.

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## REFERENCE

1 Burr NE, Penman ID, Griffiths H, *et al*. Individualised consent for Endoscopy: update on the 2016 BSG guidelines. *Frontline Gastroenterol* 2023;14:273–81.