



## Consenting in the COVID situation: consenting support briefing document

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**NOTE: Owing to the emergency and evolving nature of the Pandemic, the attached advice is dated, and time limited and will require updating as more data regarding COVID19 procedure specific elective morbidity and mortality rates become available.**

## Consent:

Obtaining informed consent from patients should be performed in line with the Irish Medical Council Guide to Professional conduct & Ethics (1), the Code of Practice for Surgeons (2) and the HSE National Consent Policy (3).

During the COVID19 pandemic, you should consider, and provide patients with, information on how the pandemic might alter the risks and benefits of their treatment. The situation regarding COVID19 is evolving rapidly and to guide you in decision-making and speaking with patients, you should consider the following:

In addition to general and procedure specific information to patients, the context of having Surgery in the current COVID19 pandemic should be addressed (as per paragraphs 11.1-11.5, information for patients (3)). The **following are specific notes concerning the COVID19** context for the consenting process, relevant at the time of writing:

1. **COVID19 is a pandemic** and therefore any patient or staff member may contract the disease at any time. Community prevalence is a factor
2. Steps should be taken to **screen booked (elective) patients** to limit the risk of a patient having COVID19, but there remains a small chance that the patient may be in the incubation phase at the time of surgery and this may not be detected by current screening tools (swabs and questionnaires).
3. Steps should be in place to **limit the chance of contracting COVID19 while in hospital** including staff PPE use, strict hand hygiene, patient cohorting and (staff-staff and patient-patient) social distancing when not on the ward. These steps reduce the risk of transmission so over 90%\* of patients will not contract COVID during a planned admission.
4. If patients **develop symptomatic COVID19 in the perioperative period, their outcome will be worse** than if COVID19 is contracted under other circumstances or if they were to remain COVID19 free.
5. The **data on outcome is limited** to a small series and one larger observational study (4, 5) both having mixed populations of scheduled/ unscheduled patients. These 2 (limited) studies suggest that *if COVID19 is contracted in the perioperative period:*
  - a. pulmonary complications occur in 50% of those affected
  - b. up to 40% may require ICU care
  - c. overall 30-day mortality is at least 20%
  - d. males, those over 70 years, patients having surgery for malignant disease or other major procedures (and those having emergency surgery) are at higher risk
6. Consultants in each discipline are best placed to consider how patient and procedure-specific issues might alter this overall risk.

7. Length of Stay to be minimised should be discussed with the patient as risks of nosocomial COVID19 probably increase
8. When discussing these risks with patients, it is better not to use percentages, instead using numbers out of 100. Furthermore the use of framing should be considered (3 out of 100 die, rather than 97 out of 100 doing well) as heuristics are likely to play a significant part in patients own decisions.

\*Estimates of nosocomial rates for patient acquisition of COVID19 per hospital are difficult but achievable. A robust infection control service must be available in the elective hospital to determine and control same. A definition of nosocomial infection must be agreed bearing in mind the median time to symptoms is usually 5-7 days after exposure. An interim definition is a new COVID19 positive swab 5 or more days post admission. The weekly total nosocomial rate (%nosocomial COVID19 patients per average bed base for that week) should be calculated and available to those consenting patients. Sample estimates have been undertaken in Model 4 Hospitals in late April and early May 2020. These reflect nosocomial transmission to any patient (predominately acute medical and acute surgical patients) over a given 7 day period. Estimates have suggested a 3-5% risk, so less than 10% has been assigned as a conservative estimate. (If there is a greater than 10% risk in a week, it would be difficult to justify commencing/ continuing elective activity at any site)

**Elective mortality (*additional*) RISK percentage** = (% estimated procedure mortality risk per patient) + (% hospital weekly rate of nosocomial acquisition of COVID19 x Current estimated 30-day mortality risk)

e.g. (Colorectal resection mortality per patient of 2%) + (Hospital nosocomial CV19 rate of 5%, of which estimated 20% mortality) = procedure specific composite risk of 2% + 1% = 3%

**Elective pulmonary morbidity (*additional*) RISK percentage** = (% estimated procedure morbidity risk per patient) + (% hospital weekly rate of nosocomial acquisition of COVID19 x Current estimated morbidity risk)

e.g. (Gastric resection significant pulmonary morbidity per patient of 30%) + (Hospital nosocomial CV19 rate of 5%, of which estimated 50% pulmonary morbidity) = procedure specific composite risk of pulmonary complications 30% + 2.5% = 32.5%

**In summary**, the risk of a perioperative patients developing COVID19 during the perioperative period is estimated at currently <10% over a seven day period. Those who do develop COVID19 have a 50% incidence of pulmonary complications (<5% of all patients), a 40% likelihood of requiring ICU admission (4% of all patients), and an additional COVID-specific mortality risk of less than 2%.

