# Consent matters:
# Audit of undergraduate consent teaching at the University of Edinburgh

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## 1.Background

**Consent is not a signature on a document to avoid a lawsuit**. It is an essential and dynamic component of clinical activity and forms the ethical, legal, and professional basis of the doctor-patient relationship. Consent teaching improves student knowledge and application of informed consent (1-3), but teaching in undergraduate training is variable (4-5), content is unmonitored, and coordination between modules scarce, leading to gaps, inconsistencies, and confusion. This results in an increased reliance on an informal or 'hidden' curriculum obtained during clinical placement (6-8).

Using a novel auditing tool we previously developed, **we set out to evaluate the provision of consent-based teaching in the University of Edinburgh's curriculum.**

## 2.Methods

**Identifying consent-related online teaching materials** across all 5 years of medical school curriculum using a keyword search technique - **157 resources**

**Thorough screening** of all included teaching resources from primary word search to exclude those where the word was out of context - **36 resources**

Reviewing all remaining material **using our previously established audit tool** (scan QR code above)

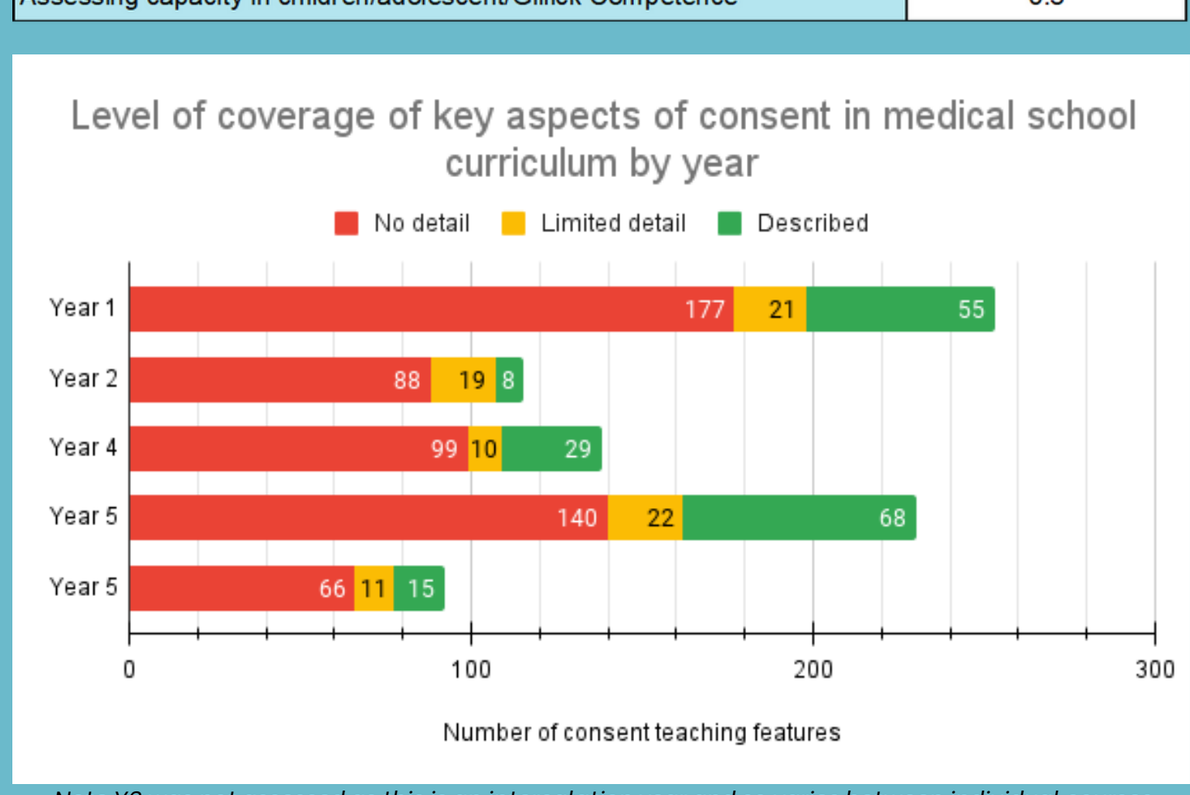
*Project approved by local Medical Teaching Organisation*

## 3.Results

| Key Features of Consent Guidances | Degree of coverage across whole medical school curriculum (0=no detail, 1=well described) |
|---|---|
| Patient must have capacity | 0.64 |
| Specific legislation e.g. Adults with Incapacity Act in capacity criteria | 0.6 |
| Start with a presumption of capacity | 0.35 |
| Capacity (or lack of) is restricted to specific decision at specific time | 0.15 |
| If capacity is impaired, decisions should be deferred where possible | 0.15 |
| Emphasis placed on dialogue leading up to consent | 0.54 |
| Provide information in an unbiased manner/do not pressure patient into choice | 0.24 |
| Allow adequate time and support for a decision e.g. translations, leaflets/supplementary material | 0.25 |
| Share relevant information on material risks | 0.32 |
| Discuss reasonable alternatives (including option to take no action) | 0.17 |
| Therapeutic privilege | 0.04 |
| Patients whose right to consent is affected by law should be involved in the decision-making process as much as possible | 0.35 |
| If the patient lacks capacity, choices must be of overall benefit to them and decisions should be made by consulting their advocates | 0.46 |
| Obtaining consent needn't always be formal (is situation dependent) however informed consent should always be obtained and recorded | 0.21 |
| Patient consent must not be exceeded except in an emergency with risks of compromise to patients decision making ability addressed and planned for | 0.13 |
| Consent must be given of free will | 0.28 |
| Documentation of discussions and consent forms is vital but does not replace consent | 0.17 |
| Mention of cost | 0.01 |
| The physician consenting the patient must be able to provide all the necessary information and provide answers to questions | 0.32 |
| Maintenance of consent + consent can be withdrawn at any point | 0.17 |
| Consent for using patient information in research/education | 0.14 |
| Place of audio recordings in documenting patient discussions | 0.06 |
| Assessing capacity in children/adolescent/Gillick Competence | 0.3 |

Key features of consent and their degree of coverage

Degrees of coverage by year group




*Note Y3 was not assessed as this is an intercalation year and so varies between individual courses*

## 4.Discussion

**The coverage of important concepts related to consent across the medical school curriculum is varied**, with some ideas such as capacity covered often but more difficult concepts, such as when breaching consent is appropriate, covered in much less detail.

Whilst all key features of consent were covered across 5 years, many employed a **low level of Bloom's taxonomy** to deliver the content:

Cognitive skill level

- **31%** **Remember:** retrieve, recall, or recognize relevant knowledge from long-term memory
- **33%** **Understand:** demonstrate comprehension through one or more forms of explanation
- **19%** **Apply:** use information or a skill in a new situation
- **6%** **Analyse:** break material into its constituent parts and determine how the parts relate to one another and/or to an overall structure or purpose
- **8%** **Evaluate:** make judgments based on criteria and standards
- **3%** **Create:** put elements together to form a new coherent or functional whole; reorganize elements into a new pattern or structure.

This demonstrates little opportunity within the 'seen' curriculum to practice the application of principles of consent in a scheduled, non-clinical environment.

Limitations of this audit include the availability of content on the online platform 'Blackboard Learn'; used by the medical school for content delivery. Where possible, efforts were made to source the teaching materials that were not uploaded to this platform.

A **centralised consent education curriculum** through communication between course organisers may ensure comprehensive consent training for medical students.

## 5. Conclusion

**This audit tool highlighted important improvements** to be made to the teaching of consent in our local curriculum.
Importantly, it has highlighted less guidance around topics students may find harder, when consent may not be so black and white.

**Next steps:**

- Findings have been passed onto our local MTO so changes can be made to the curriculum where appropriate.
- Publish our findings so that **the audit tool may be used by other universities to reflect on the completeness of training around concepts of consent.**

**Related Literature**

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