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Correspondence and Communications

Consent, decision-making and operative planning in plastic surgery during the COVID-19 pandemic

The General Medical Council set out updated guidance effective from November 2020 highlighting the importance of consent and decision making. Traditionally, consent relies upon a capacitous individual having a conversation with the healthcare professional and receiving sufficient information that includes but is not limited to a discussion pertaining to the associated risks and benefits of the procedure. The COVID-19 pandemic has precipitated a paradigm shift in medical workflows, mitigating risks of SARS-CoV-2, and with regards to consent, we need to develop a dynamic and more fluid process whereby patients' legal and ethical rights are safeguarded through appropriate consideration of material risks. With the recovery of surgical services initiative, particularly within plastic surgery, consideration must be given to consent, quantification of risk, and organization of services to accommodate patient throughput.

The Montgomery vs Lanarkshire Health Board case in 2015 established the test for materiality of risk as “if a reasonably prudent patient in the situation of the patient would think it significant”, superseding the previous application of Bolam's principle which defined risk in reference to what would be considered important by a responsible body of medical opinion.

The salience of risks of hospital-associated transmission of SARS-CoV-2 for members of the public is axiomatic, and for the medical profession it is fraught with uncertainty. The reproduction number (R) estimates of SARS-CoV-2 in England ranged from 1.1-1.6 within individual NHS England regions in the third week of October 2020, which illustrates the dynamic and changing rates of SARS-CoV-2 infection and by extension, associated risks to patients of contracting the infection.

Within plastic surgery, early studies have explored the associated risks of SARS-CoV-2 related complications, with a prospective cohort study of 729 plastic surgery patients undergoing elective, trauma or burns surgery finding no 30-day post-operative complications of SARS-CoV-2 related deaths. SARS-CoV-2 positive tests were found in 5.9% of burns patients, 3.0% of trauma patients and 7.1% of non-operatively managed patients with no significant differences seen between groups. There remains a paucity of literature on quantification of material risk of contracting SARS-CoV-2 in plastic surgery. The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) estimates the risk of contracting SARS-CoV-2 in patients undergoing urgent surgery at 0.45% if they have close contact with SARS-CoV-2 positive patients in hospital, based on multiple early studies in America; however, they highlight that this depends on local infection rates.

Therefore, we feel it is important that within the consent process, local variations in prevalence of SARS-CoV-2 are explained to patients, and perhaps the latest local R rate for the local NHS region should be quoted as standard practice, with an explanation of the possibility of increased risks to patients undergoing plastic surgery. Furthermore, on a hospital level, consideration should also be given to local Intensive Care Unit capacity, given the known increased risk of 30-day-mortality and pulmonary complications arising from SARS-CoV-2 infection in surgical patients. This will necessitate a joined-up-approach towards consent and decision making, between the patient, the plastic surgeon, and other hospital services to ensure that both the patient, and the surgical team make informed decisions regarding the risk-benefit trade-off and best course of action for the patient.

Further work may also explore, using larger sample sizes, the safety profile of local versus general anaesthetic use in plastic surgery procedures, and associated SARS-CoV-2 complications. The novel and widespread disruption caused by SARS-CoV-2, to traditional and entrenched ideas about operative planning, decision-making and consent mandates an open-minded and dynamic approach of critically examining long-held practices with a new perspective. Leveraging the many recent advances and innovations in technology including virtual and e-consenting to enhance workflows has the potential to redefine the way we approach decision-making, consent and operative planning.

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The authors confirm that they have no conflicts of interest to declare.

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