When to Say No

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A shift is needed

- We have Informed Consent
  - But does this process truly inform decisions?
- Need to move to Informed Choice
  - Personalised by & for each patient
  - Informed by relevant data
- Need to empower patients to say “No”
- Need doctors to know why “No” may be the right answer in the right circumstances

Why change?

- Hindsight is not necessarily a wonderful thing
- Risks of an outcome needs to be relevant to the patient's decision making
  - Vary depending on:
    - Disease and outlook from it in our system
    - Impact of treatment in our system
    - Impact of treatment on quality of life based on the above
- Whilst focused on surgery, same logic applies to prescribing of medications including chemotherapy
- Enduring Power of Attorney is increasingly common

What do we know?

- Risks of complications generally well known for a specific procedure
  - But not for a specific patient
- Risks on QOL generally less well understood
  - Risk of losing independence
  - Risk of memory deterioration
- Longer-term outcomes often not well understood
  - Survival dominates

Example: Rectal cancer

- Same disease, same treatment options
  - What are the issues for patients in deciding?

Issue Discussed	Relevance to a 40 year old man	Relevance to an 85 year old man
Cancer cured	Yes	Yes
Impotence	Very	Rare
Operative Death	Rare	Some
Loss of function or independence	Negligible	Very real

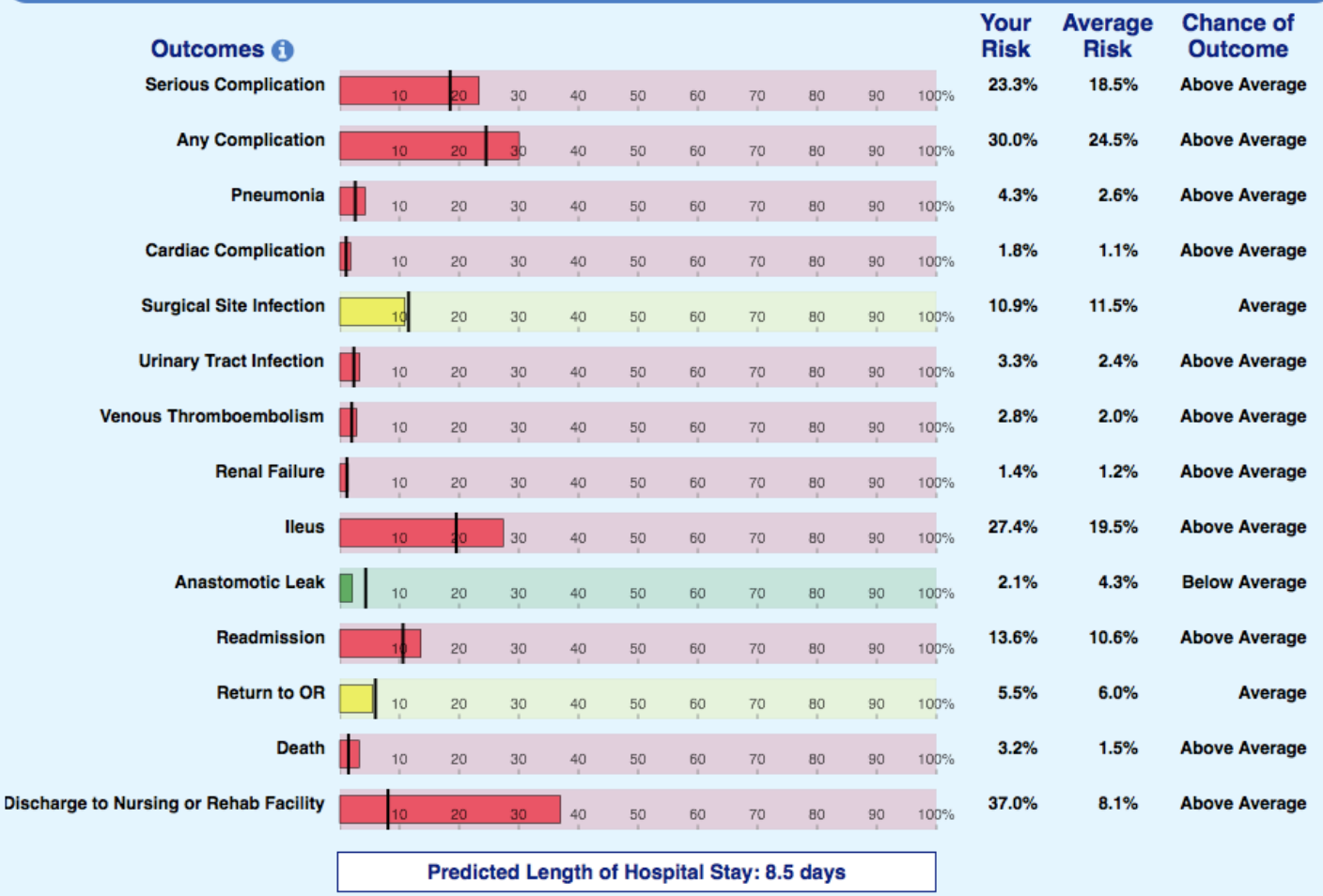
Knowledge is power

- Need relevant data at our finger-tips for our patients
- Systems exist but data broadly based on overseas experiences
- Must have prospectively gathered local data
  - Not just on perioperative complications
  - Need longer-term outcomes
- Integrated National Health Record will help
  - Change in residential needs
  - Development of new problems

Procedure: 44140 - Colectomy, partial; with anastomosis

Risk Factors: 85 years or older, Partially dependent functional status, HTN, Dyspnea with moderate exertion, Over Weight

Change Patient Risk Factors



Appropriate Potential Non-operative Treatment Options Are Available and Should Be Discussed

NSQIP

- Data base estimates outcome in 15 domains
- All within 30 days of surgery
- All retrospective
  - 2010-2014
- All based on US surgeons and units
- An advance over no system
  - But will rapidly be outdated even in the US

Acute vs elective

- Electives offer the luxury of (some) time
- Acute illness may affect decision-making by patient and/or by doctor
  - Rare that a bad outcome is 100% guaranteed
- Key question in all circumstances:
  - What are we trying to achieve?
    - Cure of illness?
    - Cure of symptoms?
    - Palliation of symptoms?
  - Is “good” safer than “better”?

Summary

- Need to shift to “choice” over “consent”
- “No” is a good answer if the right circumstances
- Informed choice is the best way for patients or their EPOA to say ”No”
- If we always have the patient at the centre we will generally give the right opinion
- Patients broadly guided by their doctors
- Technology offers enormous opportunities but requires a whole of system approach
  - Not by individual DHBs