Spine and Scoliosis Research Associates Australia

Melbourne Orthopaedic Group™ Celebrating 40 YEARS

Patient Name: _____ Date: _____

Patient Consent to Spinal Surgery
Prof Aaron Buckland - MBBS, FRACS, FAOrthA

WHAT YOU SHOULD KNOW ABOUT SPINAL SURGERY

It is important to understand that medicine is an inexact science. Although we plan and carry out our surgery as carefully as we can, the results can vary in their degree of success. It is only natural for a patient undergoing spinal surgery to want to be reassured that everything will turn out all right. Most of the time it will, but most of the time isn't all of the time, so it is necessary to talk about what can go wrong.

In the past, physicians did not always inform their patients about all of the risks of surgery because they didn't want their patients to worry about things that they felt were their responsibility. But now, it is considered very important that patients are made aware of the risks involved and actively participate in the decision of whether to have surgery. Patients should be aware of the potential risks as well as the potential benefits expected from the operation. Patients should also be aware of the alternatives to surgery, which always include not doing surgery. We cannot promise good results because it is impossible to deliver them every time, but we can promise you our best efforts.

It is very important that you think about all of this, ask questions, and be sure that you feel that you are doing the right thing, at the right time, with the right doctor. If for some reason you are not sure, then it's okay to consider waiting.

Please now go on to the following pages which discuss informed consent. Any questions that you might have with regarding the following content should be brought to my attention. I will attempt to answer all of your questions to your satisfaction.

33 The Avenue, Windsor, Vic 3181 Australia
Ph: +61 3 9124 7950 E: admin.buckland@mog.com.au

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Directions: Initial each paragraph after you read it, if you agree with what the paragraph says.

1. I am fully aware of the condition of my spine, the surgery or procedure offered and I hereby authorize **Prof Aaron Buckland** with any other surgeon and/or such assistants as may be selected and supervised by him, to perform the following procedure under general anaesthesia

_____

____ Initial

2. If indicated I consent to performance of a spinal fusion utilizing internal fixation devices or implants. The purpose of the implant(s) may include immobilization of the spine during fusion healing, correcting spinal alignment when necessary and/or stabilizing structural bone graft or other implants. Bone graft may be used and would be obtained from either my own body (iliac crest, rib, local bone, etc.) or from a commercial source: allograft, which is donor bone, is processed to be free of germs. Bone graft substitute, if determined to be appropriate for my surgery, may be used instead of, or in addition to other bone graft material.

____ Initial

A. I give consent for the use of bone morphogenetic protein (Infuse; rhBMP-2), stem cells, or other supplements to aid bone healing to be used for my surgery. These bone graft substitutes including rhBMP-2 may be used in an off-label manner and I give permission to this off label use during my surgery. The research on these supplements including rhBMP-2 has been discussed with me and I consent to the use of the products during my surgery.

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3. **Prof Aaron Buckland** has discussed with me and I fully understand the **nature and purpose** of the proposed procedure(s), and the **risks** of the procedure(s) including but not limited to:

- Death
- Blindness or loss of vision
- Infection
- Haematoma (blood collection)
- Dural leaks (leakage of spinal fluid through the dura, which is a lining over the spinal cord and nerves)
- Non-union of bone (failure of a fusion to heal)
- Adjacent segment degeneration or fracture
- Failure of internal fixation device(s) (loosening, bending, pullout or breakage)
- Embolism (caused by blood clot, fat, air, or foreign body)
- Numbness or loss of sensation
- Failure of relief of pain, numbness, or weakness
- Worsening pain, numbness, or weakness
- Pneumonia or respiratory failure
- Phlebitis (formation of blood clots)
- Loss of bladder or bowel control
- Stroke
- Myocardial infarction (heart attack)
- Arachnoiditis (inflammation or scarring of nerve roots)
- Blood vessel injury, bleeding, or anaemia (loss of blood)
- Major organ failure
- Paralysis (loss of muscle control) or paresis (muscle weakness)
- Disability
- Retrograde ejaculation
- Vocal or swallowing dysfunction
- Treatment may not accomplish the desired objective(s) and I may have no improvement or may have worsening of my symptoms.

For All Patients:
After Anterior Spinal Surgery, there may be a warm feeling in the leg of the operated side which may last for 1-2 years (sympathetic effect).

_____ Initial

For Male Patients Only:

There is reported a small incidence (less than 5%) of retrograde ejaculation and/or impotence in male patients undergoing Anterior Spinal Surgery. Retrograde ejaculation means that the semen goes backwards. Impotence is the inability to have an erection. Retrograde ejaculation and impotence may be either permanent or temporary. I accept the possibility that these or other risks may occur.

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4. All feasible alternative treatments have been discussed (including the risks, consequences and probable effectiveness of each), including but not limited to:

- Doing nothing
- Non-operative treatment with medications and/or exercise and/or injections
- Decompression surgery alone
- Decompression surgery with fusion and an internal fixation device(s)
- Posterior fusion alone without an internal fixation device(s)
- Posterior fusion alone with an internal fixation device(s)
- Internal fixation device or devices without fusion
- Anterior Surgery (decompression with or without fusion and an internal fixation device(s)
- Combined posterior and anterior fusion with or without an internal fixation device(s)

____ Initial

5. That the use of metallic surgical implants (internal fixation device) provides the surgeon with a means of internal spinal immobilization and helps generally in the management of reconstructive surgery. However, these implants are not intended to replace normal body structures or bear the weight of the body in the presence of incomplete bone healing.

- I understand that any metallic instrumentation is only considered as a temporary means of stabilizing my spine. It has been explained to me that if my spine does not fuse, my metallic implant may loosen, a screw may break, or the system may fail and implants might break.
- I also understand that the metallic implant is only as strong as the bone it is inserted into and could fail early if the bone is not strong (osteoporosis).

- Until full bone union (healing) is achieved, the patient should follow physician instructions on brace use for external immobilization (when ordered) and the assigned restrictions in physical activity, thus reducing stress upon the implant(s) which can cause possible delay or prevention of bone healing and implant fatigue and failure.
- I understand that a fusion of my spine is not guaranteed. I understand that if I choose to smoke cigarettes or use other nicotine products or engage in vigorous activities after my surgery that I will decrease my chance of getting a solid fusion.

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6. I understand that I may require blood transfusions during or after my spine surgery. My questions/concerns about blood donation/transfusion have been answered to my satisfaction and I consent to receiving a blood transfusion.

____ Initial

7. I have had sufficient opportunity to discuss my condition and treatment with **Prof Buckland** and his associates, and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent to the proposed treatment. **Prof Buckland** has informed me that the decision to have this surgery is mine and I am proceeding with this surgery at my request.

____ Initial

8. I consent to the performance of operations and procedures in addition to or different from those now planned, as deemed medically necessary by **Prof Buckland** or his associates during the course of the presently authorized procedure because of unforeseen conditions.

____ Initial

9. I impose no specific limitations or prohibitions regarding treatment other than those stated:

_____

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1. I have been advised that in some cases there may be visitors attending my surgery for educational purposes and therefore, I consent to visiting surgeons or allied health professionals, television or photography for the purpose of scientific presentation, medical publications and similar purposes. I consent to the use of evoked potential neurologic monitoring (spinal monitoring) during my surgery(s) or procedure(s).

____ Initial

11. I give my consent to the use of my de-identified health information for use in clinical research, quality improvement programs and surgical audit.

____ Initial

_____ DATE _____
(SIGNATURE and PRINTED NAME of PATIENT or RELATIVE/GUARDIAN if patient is a MINOR or UNABLE TO CONSENT)

_____DATE _____
(SIGNATURE and PRINTED NAME of WITNESS)

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