

# Anaesthetic consent: how much information and when?

**A**utonomy refers to an individual's right to 'self-govern', to run one's own life and make one's own decisions. Respect for autonomy (along with justice, beneficence and non-maleficence) is one of the moral principles underpinning medical ethics (Beauchamp and Childress, 2001). The Association of Anaesthetists of Great Britain and Ireland regards autonomy as the most important of the four principles (Association of Anaesthetists of Great Britain and Ireland, 2008; Wee, 2009).

In the context of consent, respecting a patient's autonomy refers to supplying the individual with sufficient information in a manner that is comprehensible by the patient such that the patient can make up his/her own mind whether to accept or refuse a proposed treatment plan. In addition to the need to facilitate patient autonomy, fully informed consent is important to protect medical staff from the possibility of litigation in the event of complications occurring. The balancing act for any doctor obtaining consent from a patient is in deciding just how much information to provide: enough to make consent fully informed, but not so much as to induce unnecessary fear. The additional problem facing anaesthetists is that the first patient contact is frequently on the day of surgery. Time for discussion is thus limited and the patient is likely to be nervous already.

## The Bolam test

In the past, the Bolam test would have been applied in order to ascertain whether a doctor had given sufficient information to a patient about a proposed treatment. If a 'responsible body of medical men' [*Bolam v Friern Hospital Management Committee* 1957] would have given the same warnings, then a claim against a doctor for failing to warn of a particular risk would be likely to fail. On such a basis, an anaesthetic department could formulate a list of risks to be discussed for a particular anaesthetic and thus provide their colleagues with a responsible body of medical men

with similar practice. However, society has evolved since 1957. The emphasis is changing from a paternalistic model of health care where the doctor decides what the patient should and should not be told (Brazier, 1987) to a more patient-centred approach, where the patient's ability to exercise his/her autonomy in the consent process (to the limit of his/her individual ability) is paramount.

## Guidelines

This change has been reflected in the development of guidelines issued by bodies such as the General Medical Council (2008) and the Association of Anaesthetists of Great Britain and Ireland (2008) to assist doctors in the consent process. The General Medical Council and Association of Anaesthetists of Great Britain and Ireland undoubtedly represent a 'responsible body of medical men' and so the existence of such guidelines has the effect of setting a new Bolam standard of information to be disclosed in the consent process.

The General Medical Council (2008) requires doctors to tailor their explanations to each individual patient, taking account of the patient's wishes, views and preferences. This is a high standard to set in an era when preoperative anaesthetic assessment is frequently delegated to specially-trained nursing staff and patients tend to be admitted on the day of surgery.

In addition to discussing common and minor complications, risks that are rare but serious must also be explained. The Royal College of Anaesthetists (2009) quotes a risk of death of healthy, elective patients as a complication of anaesthesia as 1 in 100 000. This obviously constitutes a serious risk, but is extremely rare. However, according to General Medical Council (2008) guidelines, consideration should be given to discussion of this risk. It would be inappropriate to broach complications such as death or brain damage with patients for the first time on the day of elective surgery, but nor should such information be denied to patients who want to know

the full risks. The natural answer is thus to ensure that patients have easy access to accurate information regarding anaesthesia in advance of their surgery. Indeed, the Association of Anaesthetists of Great Britain and Ireland (2008) guidance highlights the need for information regarding anaesthesia to be accessible to patients from the time when surgery is booked.

## The role of the anaesthetist

Anaesthetists are already involved in the preoperative assessment of patients with multiple or severe comorbidities. The level and type of risk to be discussed warrants time for such patients to reflect on the information imparted before consent is given. However, it would be extremely costly to involve anaesthetists in the preoperative assessment of all patients.

New ways of ensuring patient education before anaesthesia should be explored. Explanatory leaflets describing the risks and benefits of general, neuraxial and regional anaesthesia should be openly available to patients at pre-assessment. The problem with this approach is that different anaesthetists use different techniques for the same procedure, and different techniques for different patients. A one-size-fits-all approach would therefore fail. Good communication between the preoperative assessment and anaesthetic departments would be imperative for such a plan to work and is likely to involve increased staff numbers and time. Information regarding the rare but serious complications of anaesthesia should be available to those who enquire but should not be forced on those who do not wish to know (General Medical Council, 2008).

The Royal College of Anaesthetists in conjunction with the Association of Anaesthetists of Great Britain and Ireland has published an excellent range of leaflets detailing the risks of anaesthesia, which would provide answers for the most inquisitive of patients (Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland,

2008). These leaflets do not, of course, replace a consultation with an anaesthetist. Patients should have the opportunity to discuss any concerns with an anaesthetist before the day of their surgery in addition to the standard preoperative visit.

## Conclusions

We practice in an era when patients may rightly expect to make decisions regarding their treatment in conjunction with their doctor. The pendulum has swung away from medical paternalism and towards patient autonomy. This change has been recognized by both the courts [*Chester v Afshar* 2004] and the medical governing bodies. The high standards set by guidelines concerning information to be imparted during the consent process may be difficult to achieve given the constraints of time, staffing and hospital budgets. However, these are the standards that anaesthetists are likely to be judged against in the event of a claim by a patient. Departments of anaesthesia would be wise to use the guidelines to develop recommendations for their staff regarding acceptable levels of information to be given when consenting for anaesthetic procedures. In

this manner, individual anaesthetists can ensure that their practice measures up to the expectations of their patients, the profession and the law. **BJHM**

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## KEY POINTS

- Respect for autonomy and current guidelines require a high standard of information disclosure in the consent process.
- A balance must be reached between information disclosure and overloading patients with fear-inducing information.
- There is a particular issue with consent for anaesthesia, as patients usually meet their anaesthetist on the day of surgery.
- Guidelines should be used by departments of anaesthesia to develop methods of providing information to patients in a timely manner.