Should all patient consent include accidental awareness under anaesthesia?

In 2017, the Association of Anaesthetists of Great Britain and Ireland released *Consent for Anaesthesia* (Yentis et al, 2017), a guideline responding to the Montgomery ruling (UK Supreme Court, 2015) that doctors must seek consent for risks on the basis of whether 'a reasonable person in the patient's position would be likely to attach significance to the risk'. Accidental awareness under general anaesthesia arguably falls into the category of 'significant risk', yet the fifth national anaesthesia project (NAP5) found that patients are often not consented for this risk (Pandit et al, 2014). This article discusses the arguments for and against routinely seeking consent for accidental awareness under general anaesthesia from all patients.

Consent should not routinely be sought

A short preoperative assessment on the day of surgery has insufficient time to explore fully the complexities of accidental awareness under general anaesthesia. A long discussion about accidental awareness under general anaesthesia with each patient could reduce the 'operating' portion of the day and lead to fewer operations, impacting on provision of care in the name of increasing autonomy for individuals.

Few patients in NAP5 had documented evidence of consent for accidental awareness under general anaesthesia but those who did had not experienced less distress than those in whom there was no prior discussion (Pandit et al, 2014). If preoperative discussion about accidental awareness under general anaesthesia does not reduce psychological trauma (and may increase anxiety), there is no benefit to preoperative counselling in the majority who will not experience this complication (and a possibility that harm is caused).

Difficulties relating to any discussion of complications include that understanding of statistics in the population is limited and it is challenging to provide a true sense of risk for an emotive subject (Adams and Smith, 2001). Statistics from NAP5 could be used, but some feel that this overestimated the incidence of accidental awareness under general anaesthesia, for example by including patients having conscious sedation (Pandit et al, 2014) (who were therefore deliberately, not accidentally aware). Others have argued that it underestimated accidental awareness by relying on spontaneous reporting rather than direct postoperative questioning: Walker et al (2016) reported rates of accidental awareness of 1:800 on direct postoperative questioning. These complex statistics may make it harder to give a true sense of risk of accidental awareness under general anaesthesia in the preoperative visit, so can the patient give 'informed' consent?

Consent should be routinely sought

The idea that a doctor should not fully explain risk to protect patients from anxiety is an outdated, paternalistic concept. Anxiety does not satisfy the criterion of 'serious harm' which might justify withholding such information (Yentis et al, 2017). The argument that prior counselling does not mitigate the distress caused by a complication is flawed – by that logic, patients would not be told about many risks for which consent is routinely sought.

If time constraints prevent a thorough consent process, changes are needed to remedy this through e-learning, leaflets and internet resources, providing the patient with a better understanding to allow them to consent to the risk of accidental awareness under general anaesthesia on the day of surgery. Clear posters are available (https://www.rcoa.ac.uk/system/files/Risk-infographics_2019web.pdf) which compare complications to more relatable risks such as road traffic accidents. The anaesthetist must confirm that the patient understands these concepts before the day of surgery (Yentis et al, 2017). At this point, patient-led discussion about specific aspects of anaesthesia could facilitate a more insightful preoperative encounter. For simple cases, NAP5 suggests asking something like 'have you read and understood the information about general anaesthesia or do you have any questions?'. In situations associated with a higher risk of accidental awareness, such as cardiothoracic anaesthesia or caesarean section (Pandit et al, 2014), a longer discussion may be merited – most suitably in the perioperative clinic.

Conclusions

The authors argue that consent should be routinely sought for accidental awareness under general anaesthesia. As medicine shifts away from paternalism but also becomes increasingly litigious, anaesthetists should monitor and proactively adapt their systems to ensure that consenting of patients for anaesthesia is valid and meaningful. **BJHM**

Dr Penelope Beddoes, Core Anaesthetic Trainee, Department of Anaesthesia, Whipps Cross Hospital, London E11 1NR

Dr David Burtle, Specialty Registrar in Anaesthetics and Intensive Care, Barts and the London School of Anaesthesia, London

Correspondence to: Dr P Beddoes (penelopebeddoes@nhs.net)

Adams AM, Smith AF. Risk perception and communication: recent developments and implications for anaesthesia. Anaesthesia. 2001 Aug;56(8):745–755. https://doi.org/10.1046/j.1365-2044.2001.02135.x

Pandit JJ, Cook TM, the NAP5 Steering Panel. 2014. NAP5. Accidental Awareness During General Anaesthesia. London: The Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland.

UK Supreme Court. 2015. Montgomery v Lanarkshire Health Board. (accessed 4 November 2019) https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf

Walker EMK, Bell M, Cook TM, Grocott MPW, Moonesinghe SR; Central SNAP-1 Organisation; National Study Groups. Patient reported outcome of adult perioperative anaesthesia in the United Kingdom: a cross-sectional observational study. Br J Anaesth. 2016 Jun 12;117(6):758–766. https://doi.org/10.1093/bja/aew381

Yentis SM, Hartle AJ, Barker IR et al; Association of Anaesthetists of Great Britain and Ireland. AAGBI: consent for anaesthesia 2017. Anaesthesia. 2017 Jan;72(1):93–105. https://doi.org/10.1111/anae.13762

Anaesthetic and critical care dilemmas are coordinated by **Dr Yasser Mandour**, Anaesthetic Registrar (ST7), Royal Free London NHS Foundation Trust, London and **Dr Anna Petsas**, Specialist Registrar in Anaesthesia and Intensive Care, Guy's and St Thomas' Hospital, London

© 2019 MA Healthcare Ltd