Hello, I'm Jenny Stedman. I'm a consultative anaesthetist at Fremantle Hospital in Western Australia and I have a special interest in the area of indigenous health through my work with the Red Cross in war zones and also from time I spent working at Port Hedland hospital. I want to talk to you about consent for anaesthesia. In western culture, the development of the separation of consent for anaesthesia from consent for surgery is now quite well advanced.

The current aim of consent is to give the patients a comprehensive idea of the risks they may be exposed to during the course of the anaesthesia, to discuss particular techniques that may relate to the type of surgery they're having and to their clinical condition and to receive permission for them to proceed to operation. In western culture, consent is surrounded by medico-legal implications and has sometimes become part of a defensive practice to reduce risk to the individual anaesthetist. Thus we have generic forms for consent and they're widely used for elective surgery in many public and private hospitals.

The information given is usually very general but quite exhaustive and ultimately includes risks of death and brain damage, which can strike fear into the heart of even the most stoical western patient, let alone one of our indigenous friends. This format of consent may not be appropriate for all and doesn't take into account the cultural context of the individual. There are some key differences between consent obtained in the western context and consent from our indigenous patients. As discussed in the podcast on cultural issues, there can be differences between urban and remote indigenous communities and also between different geographical indigenous communities. It's important to understand that there's no single fit for our indigenous patients and that each individual must be treated within the context of their community.

There are also often assumptions made based on the colour or darkness of the patient's skin and this can lead to miscommunication and confusion. The result of the historical White Australia Policy is that fair-skinned members of an indigenous community may not be recognised as such by the anaesthetist, but they retain a strong connection with their community. In fact, it's the community that decides who is Aboriginal or not, rather than ourselves, and that relates directly to links within the community and not their skin colour. Therefore it is important not to make assumptions when obtaining consent for anaesthesia.

Another important aspect of this topic is language. Indigenous people speak many languages, not just the one, and English is almost always not their first language. This
has important implications when obtaining consent. Their ability to read can be somewhat limited and thrusting a consent form at them may be confronting and culturally insensitive.

Communication is of paramount importance and for informed consent to be obtained the anaesthetist, as with anybody, has to establish a relationship based on trust and safety. This means understanding the individual’s cultural context, taking the time to establish a relationship, possibly in a busy clinic or on a ward, and having empathy to the health care circumstances of each person, for example, whether they’re urban or remote.

The inclusion of an Aboriginal liaison officer in your interview may be very useful in this context, though the assumption that all ALOs can communicate effectively with all different Aboriginal communities is erroneous. There’s current support for the training of ALOs as cultural brokers in anaesthetic issues. A second important issue arises when considering paediatric patients in particular. We’re used to the idea of obtaining consent for anaesthesia from the parents or parent of the child.

In order to obtain consent for anaesthesia for an indigenous child it’s important to understand that kinship may have a different meaning, depending on the particular community. Aunts, uncles and grandparents may well accompany the child and in some communities, permission for surgery and anaesthesia needs to be obtained from a particular elder. In addition, children are often ‘taken in’ by adults other than their biological parents and in these circumstances there’s no official adoption policy in the community. However, the adults who are taking care of the child may be the only accompanying persons to give consent.

Again, your ALOs may be helpful in determining the family relationships and ultimately in helping gain meaningful consent. The most important aspect of obtaining consent in this context is to have tried in good faith to establish contact with the most appropriate person to give the consent, particularly if the patient is from a remote community. We shouldn’t just accept that because the child is indigenous any accompanying relative is suitable. It’s important that the information given to the patient or parents is detailed enough for them to evaluate such issues as risk and benefit and that enough time is allowed for them to ask questions.

Always remember that you’re in a power relationship and that establishing trust and empathy with you make take them some time. The terminology used may also be unknown to them so using simple explanations is important, but without being patronising. There may be some social norms that are not being followed and may make our discussion difficult. For example, sometimes eye contact is avoided and female patients are not normally interviewed by males, so these can cause communication issues.

There may be a limited understanding of western medicine and a lack of trust in it. We may also have no knowledge of pre-existing indigenous health systems and our patients’ reliance on their own traditional treatments. The role of the traditional healer, or Ngangkari, shouldn’t be ignored and may be very important in helping with post-operative issues, particularly pain management. This is also discussed in the pain management podcast. Acknowledging this can help in building a more trusting and comfortable relationship and assist in the process of consent.
Remember that your patient may not only be physically alone but they may be feeling very lonely if they have been removed from their connection with the land and community and brought into a hospital. The hospital itself can be a very threatening environment, and particularly if any members of the patient's family have died inside a hospital, they can be particularly frightened and suspicious of the therapies being offered. Quite often patients won't leave their own remote communities to seek offered western medical help for fear of losing the security of their community and they may have social or kinship obligations of which you have no knowledge.

In conclusion, cultural sensitivity is required to navigate the intricacies of consent in terms of anaesthesia and patients' understanding, and diplomacy should be shown. No two circumstances will be alike and you may want to seek advice from your Aboriginal liaison officers where available. Ensure that you've taken all reasonable steps to establish who is a responsible guardian, accepting that this may not be the biological parents.

Dr Jennifer Stedmon

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