AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ABN 82 055 042 852

Review PS26 (2005)

GUIDELINES ON CONSENT FOR ANAESTHESIA OR SEDATION

INTRODUCTION

Consent should be obtained for all medical treatment. It is a basic tenet of our society that everyone has a right to determine what is done to his/her own body, and is entitled to know the implications of any treatment before it is administered and to seek clarification of any issues that may be of concern.

GENERAL PRINCIPLES

The standard for consent in Australia is established by the common law. In New Zealand it is embodied in the Code of Health and Disability Services Consumers' Rights.

Consent for treatment provided by an anaesthetist is different from a statement as to the necessity for anaesthesia (which may form part of the consent for an operative procedure).

Although legal processes that test the validity of consent differ, both Australian and New Zealand law state that the provision of information is an integral part of obtaining consent for a medical procedure.

The process of obtaining consent for medical treatment involves discussion in which both the patient and the doctor participate actively, and which is open, honest and effective.

The statements below are a general guide, and do not take precedence over local legal requirements.

In 1.3 – 4.7, the word "patient" means "the patient, or the person giving consent on behalf of the patient".

1. THE ELEMENTS OF CONSENT

1.1 Consent must be given voluntarily and without coercion; refusal or withdrawal of consent must be a realistic option. The environment, and timing of the consent process, and presence of support people (if so desired by the patient), are important in this regard.

1.2 Consent may only be given by a person capable of doing so.

1.2.1 All persons are presumed to be competent to give consent, unless there are reasonable grounds for believing otherwise. A judgement that the patient is incapable of giving consent must be supported by appropriate evidence, such as that of very young age, lack of mental capacity, unconsciousness or presence of sedative medication.

1.2.2 The age at which a young person is able to consent independently to medical treatment depends not only upon their age, but also the nature of the proposed treatment and local legislative requirements. To be able to give consent, the young person should be able to understand the nature, purpose and possible consequences of the treatment, as well as the consequences of non-treatment. (Currently there is variation across the Australian States and Territories and New Zealand with respect to the details of consent to medical treatment by young persons, and local legislation must be consulted). If in any doubt, consult appropriate management representatives or legal or other advisers.

1.2.3 In the absence of capacity to give consent, another person can give consent on behalf of the patient in certain legally defined circumstances, such as the parent or legal guardian of a child. In such circumstances, the person giving consent has a legal duty to always act in the best interests of the person for whom consent is being given.

1.2.4 If no person is able to give consent, then treatment can only proceed if it is in the patient's best interests, reasonable steps have been taken to ascertain the views of the patient, the doctor believes that it would have been chosen by the patient if he/she was competent to do so, or the doctor takes into account the views of other suitable persons who are interested in the welfare of the patient, and that further delay is likely to be detrimental to the patient. It may be necessary to arrange for a legal guardian to be appointed. In these cases, it is strongly recommended that appropriate legal or other advice be obtained.

1.2.5 If the situation is so urgent that immediate intervention is necessary to preserve life or prevent serious harm, it may not be possible or sensible to obtain full consent. In such cases, there must be provision of information and discussion of the treatment undertaken with the patient, or other suitable persons, as soon as possible.

1.2.6 In some circumstances, statutory bodies, such as a Guardianship Board, may give consent or authorise others to give consent.

1.2.7 It must be recognised that the patient can change her/his mind, and withdrawal of consent must be respected (e.g. during multiple attempts at regional blockade).

1.3 Consent must be informed.

1.3.1 The patient should be provided with the information that a reasonable patient in the position of that patient might wish to know, and to which she/he might attach significance. It is necessary to provide information about all material risks inherent in any proposed treatment.

1.3.2 Basic information about the proposed treatment should be provided, even if the patient requests no information. Where the patient clearly does not wish for further information, and states this wish, information should still be firmly offered and if still refused, that fact should be documented, and no further information forced on the patient.

1.3.3 The discussion of risks and benefits should include those associated with the proposed treatment, alternative treatments, or no treatment at all.

1.3.4 In considering risks to be discussed with the patient, ask:-

1. Would a reasonable person, in the position of the patient, be likely to attach significance to the risk?

2. Are you aware, or should you be reasonably aware, that this particular patient would be likely to attach significance to that risk?

In other words, is it possible that the patient, if informed of that risk, would change their mind about having the procedure?

1.3.5 Risks:

1.3.5.1 Discussion of risks should be based on the provider's assessment of the proposed treatment, the seriousness and nature of the patient's condition, the complexity of the proposed treatment, the questions asked by the patient, and the patient's attitude and apparent level of understanding.

1.3.5.2 Known risks should be explained when an adverse outcome is rare but the detriment severe, and an adverse outcome common but the detriment slight.

1.3.5.3 The uncertainty of adverse outcomes/events should be explained, as should the difficulty of relating the incidence of such events to the patient. (see appendix)

1.3.5.4 Where blood products may be required, discussion should take place concerning the advantages, disadvantages and alternatives to blood products.

1.3.5.5 The risk of doing nothing should be discussed.

1.3.6 Opportunity must be given to discuss the nature and risks of the treatment, and the alternative treatment(s), and to have questions answered honestly and accurately.

1.3.7 Where appropriate, the financial implications of the proposed treatment should be discussed.

1.3.8 Information should be provided in a form the patient is likely to understand. This may include the option of presenting information in the printed form or via computer or other electronic means (e.g. by video). Printed and visual aids are useful. Prepared information sheets or "consent forms" can help understanding, but are not a substitute for the required discussion with the patient.

2. DOCUMENTATION OF CONSENT

The extent of documentation may be dictated by local legislation and practice but it is wise to record significant details of the consent as part of the patient's notes, including reference to the discussion of relevant material risks and the agreement by the patient to undergo the treatment.

In order to defend claims that "informed consent" information was not given or was inadequate, it is highly recommended that detailed notes of the discussion and all risks considered are kept by the provider.

3. STANDARD CONSENT FORMS AND INFORMATION SHEETS

The use of standard "consent forms" and information sheets will not necessarily be sufficient to maintain "informed consent". Standard information forms are useful, but are no substitute for information to an individual patient. Under the requirements of "informed consent", the information to be given to a patient must be specific to the particular patient. It must take into account the particular circumstances, and requirements, of the patient.

Similarly, a simple form signed by a patient is not conclusive proof that valid consent has been obtained.

Prepared consent forms and prepared information sheets certainly can have their place and can be used as an aid or educational tool, as well as a prompt or checklist for the discussion that must take place between doctor and patient. They are also useful for the patient to take away after the discussion as a reminder of some of the issues that have been considered. However, they are not, **in themselves**, adequate to ensure that informed consent has been obtained.

4. PERSONNEL

4.1 Disclosure of information and discussion must be performed by a person who understands and is able to discuss the risks and benefits of the proposed treatment and the alternative treatments, which includes no treatment.

4.2 A qualified interpreter (not a family member) should be used wherever necessary.

4.3 Disclosure of information and discussion is best performed by the anaesthetist who will be conducting the treatment.

4.4 Ideally, consent should be obtained by the anaesthetist who will be conducting the treatment. (The treating anaesthetist may be liable if inadequate consent is obtained by another person on the anaesthetist's behalf).

4.5 When the procedural anaesthetist can only see the patient immediately prior to anaesthesia, a separate anaesthetist may interview the patient and provide information for the elements of consent noted above.

4.6 The procedural anaesthetist must still discuss the proposed treatment with the patient to ensure that all appropriate preparation has occurred. The need for this interview must be considered when sedative premedication is to be given.

4.7 Those involved with the consent process are individually responsible for appropriate documentation.

APPENDIX

Examples of risk which might be discussed with the person giving consent include:

a) Common adverse effects of general anaesthesia, which include fatigue, altered mental state, sleep disturbance, nausea, vomiting, sore throat, bruising from venepuncture
b) Less common but not rare adverse effects such as spinal headache and dental trauma
c) Rare adverse effects which are unpredictable, such as anaphylaxis, awareness, neurological damage or death in healthy people
d) Adverse effects which are related to pre-existing disease, such as death in a patient with recent myocardial infarction undergoing emergency surgery.

The information provided in these Guidelines should be considered in conjunction with the following College Professional Documents:

PS6 *Recommendations on Minimum Requirements for the Anaesthesia Record*
PS7 *Recommendations on the Pre-Anaesthesia Consultation*
PS20 Responsibilities of the Anaesthetist in the Post-operative Period

REFERENCES

1. Association of Anaesthetists of Great Britain and Ireland. Information and consent for anaesthesia. London: AAGBI, 1999.
2. Fearnside MR, Dooley BJ, and Gorton M. eds. Surgery, Ethics and the Law. Victoria: Blackwell Science, 2000.

3. Hope T, Savulescu J, Hendrick J. Medical Ethics and Law : the core curriculum. Edinburgh: Churchill Livingstone 2003.
4. Jenkins K and Baker AB. Consent and anaesthetic risk. Anaesthesia 2003; 58 (10): 962-84.
5. Medical Council of New Zealand. Information and Consent, April 2002.
6. Medical Council of New Zealand. Legislative requirements about patient rights and consent April 2002.
7. Health and Disability Commissioner. The code of health and disability services consumers' rights. Auckland: New Zealand.
8. Rogers vs Whitaker (1992) 175 CLR 4795
9. Savulescu J & Kerridge IH. Competence and consent. Med J Aust 2001; 175 (4): 211-3.

COLLEGE PROFESSIONAL DOCUMENTS

College Professional Documents are progressively being coded as follows:

TE	*Training and Educational*
EX	*Examinations*
PS	*Professional Standards*
T	*Technical*

POLICY – defined as 'a course of action adopted and pursued by the College'. These are matters coming within the authority and control of the College.

RECOMMENDATIONS *– defined as 'advisable courses of action'.*

GUIDELINES *– defined as 'a document offering advice'. These may be clinical (in which case they will eventually be evidence-based), or non-clinical.*

STATEMENTS *– defined as 'a communication setting out information'.*

This document is intended to apply wherever anaesthesia is administered.

This document has been prepared having regard to general circumstances, and it is the responsibility of the practitioner to have express regard to the particular circumstances of each case, and the application of this document in each case.

Professional documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version. Professional documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

Promulgated:	*1994*
Reviewed:	*1999, 2005*
Date of current document:	*Jun 2005*

College Website: http://www.anzca.edu.au/