

## Rethinking Anaesthetic Consent

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### INTRODUCTION

Consent, either for a medical procedure or financial, is now an integral part of the pre-anaesthetic consultation. Tacit consent is no longer considered acceptable; there is a consensus that patients should be informed about the procedures they are to be subjected to. Despite acceptance of the consent process, it does not fit comfortably into our clinical practice. Anaesthetists are often left short of time to adequately gain consent from patients and we lack a formal consent process like the one used by our surgical colleagues.

Even surgical consent is far from perfect - often the focus seems to be getting a signature on a piece of paper rather than the process of gaining consent. It is certainly the signature on the piece of paper that gains all the attention once the patient arrives in the operating theatre.

Consent from patients is seen primarily as a legal tool to protect against litigation. Because of this, lawyers and medical indemnity companies have driven much of the discussion of the consent process. Anaesthetists must take a role in determining how and more importantly why we are gaining consent from our patients. Lawyers and insurance companies need not dictate this to us.

A philosophical basis for consent can be derived from bioethics. Ethics is a branch of philosophy that systematically evaluates concepts of right and wrong. The consent process is strongly linked to the ethical principle of respect for autonomy. In order to respect the autonomy of our patients we need to communicate with them, understand them, allay their fears and answer their questions. The consent process also gives anaesthetists a chance to promote the skills, training and roles of our profession.

### THE BIOETHICAL FOUNDATIONS OF CONSENT

The process of consent is about decision-making and authorisation. From the time of the Hippocratic oath until the mid-twentieth century the paradigm underlying medical decision-making was paternalism. Paternalistic decisions are made by an authority figure in the best interests of a second person. In health care, paternalistic decisions are made by medical professionals who rely on their medical knowledge and experience to make decisions on behalf of patients, who have little or no say in the decision-making process <sup>1</sup>.

In the mid-twentieth century, driven by an explosion of medical options and patient education, a paradigm shift occurred, paternalistic decision-making was replaced with decision-making processes that respected patient autonomy <sup>2</sup>.

### WHAT WAS WRONG WITH PATERNALISM?

*One day Chuang-tzu and a friend were walking along a riverbank.*

*"How delightfully the fishes are enjoying themselves in the water!" Chuang-tzu exclaimed.*

*"You are not a fish," his friend said. "How do you know the fishes are enjoying themselves?"*

*"You are not me," Chuang-tzu replied. "How do you know that I do not know that the fishes are enjoying themselves?"*

*Taoist Mondo* <sup>3</sup>

Paternalistic decision making models fail to account for patient factors. The belief systems and past experiences of a patient are not available to medical professionals to incorporate into

medical choice. A paternalistic decision results in a choice that is not, what is best for the patient, but what you "think" is best for the patient. This is particularly the case in anaesthesia where we may only have limited contact with our patients before we decide on and undertake interventions.

Further, when we make a decision on behalf of a patient we stop the patient from taking responsibility for the decision or for the consequences of that decision. This in turn disempowers the patient and emphasises the "sick-role".<sup>4</sup>

Provision of information to patients should be empowering, it should allow the patient to "normalise" their situation. For example if a patient is told there is a risk of post-operative nausea and vomiting, they will understand this is a normal, often treatable consequence of their anaesthetic. If a patient is told they will not be able to move their legs after a spinal, they will not worry that this temporary paralysis is a complication.

### **A ROLE FOR PATERNALISTIC DECISION MAKING**

There are a group of patients who are unable to express autonomy. These patients range from neonates, to elderly patients with dementia, to unconscious adults, to the mentally handicapped. These patients can be split into two groups, patients who have never been competent to make decisions and those who have lost their competence either temporarily or permanently.

The patients who have lost their decision making ability temporarily should have decisions made for them by people who are able to imagine what they would have wanted in the given situation. This is known as substituted judgement. It has obvious flaws, however it is a system that attempts to approximate autonomous decision-making in the face of adversity.

In patients who have never been competent to make autonomous decisions, medical practitioners cannot use respect for autonomy as a bioethical principle on which to base the consent process. Decisions are by definition paternalistic. This process of medical decision making for the "never competent patient" is known as justified paternalism.

### **WHAT IS "RESPECT FOR AUTONOMY"?**

In competent adults paternalistic decisions fail to incorporate patient factors, they reinforce a subordinate role for the patient and may leave the patient poorly informed about the medical procedure they are about to undergo. Paternalistic decisions threaten a patient's capacity for rational choice, a capacity, which Emmanuel Kant described as, "a corner-stone of morality".

"Autonomy", is derived from Ancient Greek and literally means self-rule. In antiquity it was a term applied to societies. The philosopher Kant applied the term autonomy to people. In particular he suggested that you must respect a person's right to make free choices. This is because he believed that all people have, "unconditional worth", and, "the capacity to determine their own moral destiny". By stopping another person making a free choice, you are treating them as a "means to an end", rather than a "moral end themselves".<sup>5</sup>

In more contemporary bioethics, Beauchamp and Childress<sup>6</sup> have described, respect for autonomy, as one of four *prima facie* bioethical principles. These four bioethical principles are applied to bioethical decisions, to provide a structured framework for analysis.

The four ethical principles Beauchamp and Childress describe, Justice, Non-maleficence, Beneficence and Respect for Autonomy, are non-hierarchical and as a result they come into conflict, with no clear method of determining which is the more important. As a result the principles based ethical approach does not provide clear answers to ethical problems but it provides a framework for ethical analysis. Despite the non-hierarchical nature of the four principles, respect for autonomy has received a significant amount of attention and has been described by one author as, "a first amongst equals".<sup>7</sup> The practical facet of respect for autonomy is the use of consent as a tool.

### **THE PROCESS OF CONSENT**

There is more to consent than a hastily gathered signature on a hospital form. It has been described in the ethical literature as "the modern ritual of trust"<sup>8</sup>. Gaining consent from a patient is a process. The first action a doctor must perform in gaining consent for a procedure is to assess the competence of the patient. Competence is a quality that describes the ability to

perform a task, in this case, to make a decision. To decide if a patient is competent a medical professional must understand the decision making process.

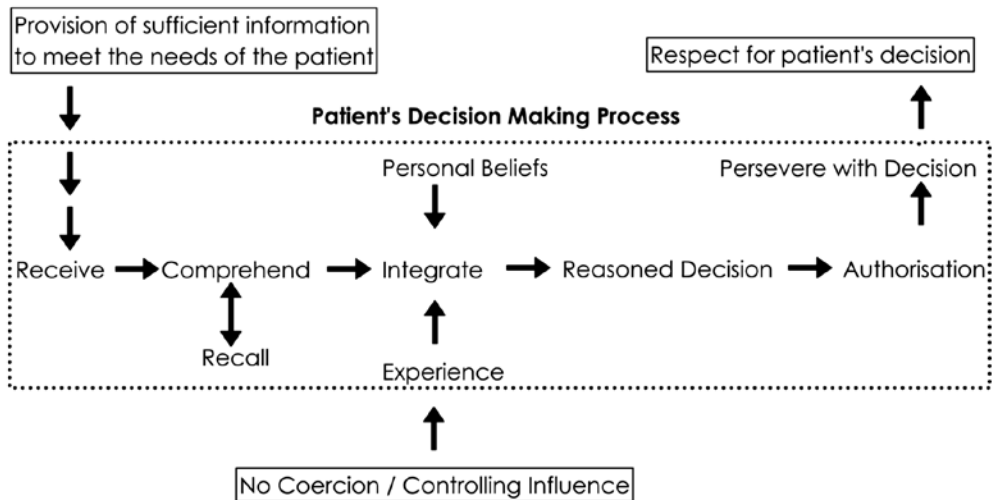


Figure 1. The Consent Process; Within the dotted lines are the mental tasks the patients must undertake in making a medical decision. This acts as a framework for a medical practitioner to assess competence. Outside the dotted line are the medical practitioner's tasks in the consent process. Adapted loosely from text in <sup>9</sup>.

### THE "TASK" OF DECISION MAKING

Medical decisions are based on information provided by medical professionals, patient's belief systems, patient's prior experience and increasingly on research patients have performed prior to consultation. The patient must be able to receive information from medical professionals; this very basic step may be impeded by a language barrier or physical handicap. The patient must understand the information that is provided to them. A lack of comprehension may be due to medical jargon or poor communication skills on the part of the medical professional or impaired mental faculties on behalf of the patient; delirium or dementia for example. Once the patient has received and comprehended the information they must be able to integrate it with their belief systems and personal experience. This culminates in a reasoned choice that needs to be communicated as an authorisation or refusal. Once a choice is made a patient needs to persist with that choice for consent to remain valid.

### ASSESSING COMPETENCE

There is no universal test of competence. Competence must be assessed for each patient for each decision making task. The description of "*the task of decision making*" gives a framework upon which to make this assessment. In addition to assessing the patient's ability the surrounding environment also plays a role in assessing competence, is a patient being coerced or controlled? Medical professionals should know that the patient is making their own decision.

### THE MEDICAL PROFESSIONAL'S "TASKS"

Once the medical professional has assessed the patient's competence to make a specific medical decision they must provide the amount of information a patient requires in a fashion that facilitates comprehension. The medical practitioner must then respect the patient's reasoned choice and allow them to withdraw their consent wherever this is practical.

### PROVIDING INFORMATION

Disclosure of information seems to provide the most legal and ethical discussion in the consent process<sup>10</sup>. In summary the patient should be provided with the information *they* need to

make a decision. This goes to the very heart of the ethical argument and is handled elsewhere in this article. The term "informed consent" is being replaced by the term informed choice by some authors<sup>11</sup>. This reinforces the fact the patient is not actually being asked to accept a procedure, but is being offered a range of options from which to choose. For example when talking to a patient before a laparotomy an anaesthetist is not asking a patient to consent to an epidural, but to choose between an epidural and patient controlled analgesia for example. The key to adequate disclosure is two-way communication. Passage of information from medical professional to patient only, fails to allow for an assessment of what information the patient actually needs. Some patients require fine details, some require no information at all.

### **RESPECTING CHOICES**

In law patients have the choice to refuse any treatment with the exception of palliative care. Part of the process of informed choice is that the medical professional will respect the patient's reasoned choice and their right in law to refuse treatments. This holds even when the choice made by the patient is clinically dubious in the eyes of the treating team. The patient retains the right to withdraw their consent to a procedure at any practical time and the treating team must respect these choices in the same way as the initial consent decision, as long as the patient retains their competence.

### **CONSENT AND CONFLICTS IN PRINCIPLES BASED ETHICS**

When looking at the consent process using principles based ethics conflicts can be found. The process of consent is based firmly in respecting autonomous choice. However do patients have a right to decide how much information they receive? Do they have a right to make choices that are, "self-centred, pig-headed, impulsive, random, ignorant, out of control and regrettable or unacceptable"<sup>12</sup>. Contemporary philosopher Dame Onora O'Neill turns the concept of respecting choices on its head. She claims that autonomous choices must be worthy of respect! She states, "by insisting on the importance of informed consent we make it possible for individuals to choose autonomously... But we in no way guarantee that they do so"<sup>12</sup>.

Patients are vulnerable members of society, they are asked to make critical decisions at the most difficult times of their lives. They may be depressed, in pain or simply un-well. Despite what may be an outward appearance of competence they are literally not themselves, as a result decisions they make may not be reasoned and clear.

The critics of respect for autonomy claim that it is a goal that cannot be reached and that we fail in our attempts to gain consent in such a way that patients can make truly autonomous choices. The critics are probably correct. It is almost impossible to ensure that patients can make choices that are completely autonomous. This does not mean that respecting patients autonomy should be discarded as a principle on which to base patient interaction. It only means that medical professionals must be aware of the limitations of this approach when applying it to patients or using it to justify ethical decisions.

### **CONSENT AND BENEFICENCE**

Beneficence is a bioethical principle that suggests we do good. Paternalistic decisions are based in beneficence. That is, medical professionals making decisions on behalf of patients, in the patient's best interests. The downfalls of this approach have already been discussed.

### **CONSENT AND NON-MALEFICENCE**

The principle of non-maleficence is based in the Latin phrase; "Primum non-nocere", above all, do no harm. The conflict between respect for autonomy and non-maleficence is more subtle; some anaesthetists argue that providing patients with information about the risks of anaesthetic techniques places undue stress on patients at a time when they are at their most vulnerable. Whilst this holds some truth, there is a paternalistic twist. Patients have a right to be informed and it is the anaesthetists job to inform patients of the risks of procedures in a balanced fashion, giving them information they need to make a choice and discussing their concerns. The disclosure of risks to patients is often compounded by poor timing of discussions, i.e. immediately prior to a procedure, and inadequate time for discussion.

## **CONSENT AND JUSTICE**

If you spend an hour with a patient, explaining the intricacies of a decision, that is an hour that is lost to the care of other patients. This creates an issue of justice. Clearly time is a precious commodity. In a profession such as anaesthesia where time can be pressured and there is not a specific allocated point in the doctor patient interaction for the consent process to take place, long discussions are difficult, and respecting autonomy can be practically impossible. If anaesthetists want to take the consent process seriously, time must be allocated in the patient's clinical pathway for discussion of anaesthesia and the techniques we apply to benefit the patient during their hospital stay.

## **WHY DO ANAESTHETISTS GET CONSENT?**

As anaesthetists the consent process can serve more than one purpose, we need to undertake it to protect ourselves legally, but it can also be argued that the primary role of consent should be communication with and education of our patients.

## **WHAT ARE WE TRYING TO DO?**

It is important to define exactly what you are trying to do with the consent process. Are you asking the patient to consent to a given procedure or are you giving them a choice between several options.

If a patient needs a general anaesthetic there seems to be little benefit to the patient to choosing between sevoflurane and desflurane as the risks and outcome differences are insignificant. In this case you would gain consent for a general anaesthetic. However if a patient was being offered regional anaesthesia for a procedure that could be performed equally well under a general anaesthetic, the patient should be offered a choice. This is because each technique has a distinct set of risks and benefits. Only the patient is in a position to combine this information with their previous experience and beliefs to come up with a decision. In some cases the anaesthetist will have a strong preference about why the patient should have one type of anaesthetic or another. In this case a recommendation should be given but with a description about how the proposed anaesthetic technique will benefit the patient.

## **HOW CAN WE BENEFIT THE PATIENT?**

Educating the patient and informing them about the procedures in the operating theatre normalises the peri-operative experience for the patient as previously discussed. Open discussion of the anaesthetic process may unearth concerns that patients have that they may not otherwise have been comfortable disclosing, awareness, for example. Discussion of these concerns may decrease the patient's anxiety levels. Primarily open communication during the consent process leads to patients gaining the information they want, from their anaesthetist. This in turn builds trust.

## **HOW CAN ANAESTHETISTS BENEFIT?**

Building a trusting relationship with patients is protective. If a patient feels comfortable with and trusts their doctor they are less likely to respond adversely in the case of a poor outcome. This is the basis for the courses made available to anaesthetists by medical defence companies promoting better doctor-patient interaction.

Almost as important is the opportunity for anaesthetists to promote their profession. Public understanding of the role of the anaesthetist seems to be poor. It is not uncommon to hear that we just put the drip in and send the bill. Explaining the anaesthetic process and the anaesthetist's role in post-operative pain management has a positive impact on the public's understanding of our profession.

## **CONCLUSION**

Anaesthetists should drive the formalisation of the consent process for anaesthesia, because, anaesthetists understand the limitations imposed by the hospital system and the needs of their patients. It would be foolish to ignore the legal component of the consent process entirely, however biomedical ethics provides a framework to analyse the consent process and ensure that we are doing what is right. Most importantly we should look on the consent process

as a time to communicate with our patients, strengthening the anaesthetist-patient relationship and promoting our profession.

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