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Informing and consenting for anaesthesia

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Public expectations of healthcare have changed dramatically over the last 10–20 years, particularly in relation to the involvement of patients in determining treatment options and the selection of the most appropriate treatment plan. Paternalistic actions of doctors, which involved telling the patient what treatment they were going to receive, without discussing risks and benefits of various options, are no longer acceptable. This has been reflected in decisions reached by the courts in cases in which patients have entered litigation on the basis that inadequate information was given to them before treatment, and that they were unaware of risks of complications which subsequently materialised. If such claims are successful, the patient is entitled to financial compensation even if the treatment was carried out to the highest standard. Although most claims of this nature are brought against surgeons, similar claims are likely in relation to anaesthetic procedures. Complaints about lack of information or inadequate consent can also result in a doctor being reported to regulatory authorities. It is therefore necessary for anaesthetists to be aware of current issues surrounding provision of information and obtaining consent for anaesthesia in various categories of patient. This article summarises these issues.

Key words: consent; informed consent; consent forms; information; risk; injury; complications; medicolegal; competent adults; incompetent adults; children.

INTRODUCTION

This chapter refers predominantly to the legal situation in England and Wales. Broadly similar principles apply in other jurisdictions in the developed world, but details may differ, and each jurisdiction has its own case law.

The competent adult patient has a fundamental right under common law to give, or to withhold, consent to examination, investigation or treatment. This is a basic principle

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of health care. Any treatment, investigation or physical contact with the patient undertaken without consent may amount to battery.[a] It is highly unlikely that a health care professional would be charged with criminal assault for treating a patient without consent; a criminal charge would be appropriate only if harm was intended or was an obviously foreseeable risk. However, a patient who is able to demonstrate battery in a civil court is entitled to compensation for the battery itself; in addition, the patient may be able to claim compensation for any injury suffered, even when the treatment has been conducted competently. Battery by medical practitioners is regarded by the General Medical Council as an offence which may make them unfit to practise and may also result in employers invoking disciplinary procedures.

Patients consent to treatment after receiving information about the treatment and about material risks which may be associated with the treatment. A material risk is one to which a reasonable person in the patient's position would be likely to attach significance. If a foreseeable complication materialises from a risk which was not mentioned, the patient may argue that consent for the procedure would not have been given if the risk of that complication had been explained. This has two potential consequences in law.

The patient may argue that the consent was invalid, and that performance of the procedure amounted to battery as a result of failure to obtain 'informed consent'. Outside the United States of America, this found little favour with the Courts, although recent decisions suggest that this position has changed.

Alternatively, the patient may argue that, by refusing to undergo the procedure if appropriate warnings had been given, the complication would have been avoided. If this argument is successful, then the patient is entitled to compensation for the consequences of the injury, even if the injury occurred despite all reasonable care in undertaking the procedure. Thus, in contrast to claims for negligent treatment, it is not necessary for the patient to show that the standard of care in performance of the procedure was inadequate; it is necessary only to demonstrate that the warnings which were given did not conform to an acceptable standard and that if the warning had been given, the patient would not have consented to undergo the procedure.

In theory, the test in law is based on a comparison between the risks which were explained and the risks which a reasonable doctor would have mentioned.[1] In clinical negligence claims which centre on the standard of clinical care, often involving very complex issues, judges rely on expert evidence to determine the standard of care which would have been regarded as appropriate by a reasonable and responsible body of medical opinion at the time; judges have no experience in medical practice, and must base their judgements on the opinions of doctors who have experience in the relevant field. However, judges are actual or potential patients, and are able to form their own view as to the adequacy of information provided to a patient, irrespective of evidence about the risks which a reasonable doctor would have mentioned. Consequently, it cannot be assumed that judges will accept an argument that most doctors would not have explained a potential risk before the patient consented to undergo the procedure if in the opinion of the judge that risk should have been explained.

The General Medical Council[2] believes that successful relationships between doctors and patients depend on trust. To establish that trust, doctors must respect the autonomy of patients, including their right to decide whether or not to undergo any

[a] A battery is an unauthorised physical contact. In an assault, the victim is caused to fear that a battery is about to occur. In most medical cases in which unauthorised physical contact occurs, there is no assault.