



INFORMATION AND CONSENT FOR ANAESTHESIA

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Published by

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July 1999

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Acknowledgements

The Working Party is grateful to the following individuals and organisations for their advice and comments.

Dr S M Enright
Professor M D A Vickers
Council of the Association of Anaesthetists of Great Britain and Ireland
British Dental Association
European Society of Regional Anaesthesia (Great Britain and Ireland)
Faculty of Dental Surgery of the Royal College of Surgeons of England
General Medical Council
Obstetric Anaesthetists Association
Plastic Surgery and Burns Anaesthetists
Royal College of Physicians
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians of Edinburgh
The Association of Cardiothoracic Anaesthetists
The Association of Dental Anaesthetists
The Association of Paediatric Anaesthetists
The British Association of Day Surgery
The Patients' Association
The Royal College of Anaesthetists
The Royal College of Ophthalmologists
The Royal College of Paediatrics and Child Health
The Royal College of Physicians and Surgeons of Glasgow
The Royal College of Psychiatrists
The Royal College of Radiologists
The Royal College of Surgeons of Edinburgh
The Royal College of Surgeons of England

CONTENTS

Sections	page
1. Background	1
2. Consent	3
3. Adequacy of Consent	17
References	23

1. **Background**

- 1.1. The Association of Anaesthetists of Great Britain and Ireland has been approached by many members seeking advice regarding information and consent for anaesthesia. It is clear that considerable confusion exists among anaesthetists regarding their requirements in obtaining consent for anaesthesia, and this had led to wide variations in practice between departments, and amongst individuals within each department.
- 1.2. Subject to specific exceptions, patients have an entitlement to receive information regarding medical treatment, and a right to give or withhold consent to treatment. For a variety of reasons, matters of consent in relation to medical treatment have achieved a high profile in recent years. Issues of consent are raised in an increasing proportion of civil claims which allege negligence by anaesthetists. The NHS Litigation Authority regards consent as an issue of considerable importance. The General Medical Council expects doctors to conform with current good practice in seeking consent from patients [1].
- 1.3. This Working Party was established:
 - to consider issues of consent in relation to anaesthesia which is provided to facilitate another (usually diagnostic or therapeutic) procedure;
 - to consider issues of consent for anaesthesia in a number of specific clinical situations which have caused concern (e.g. emergency treatment, obstetrics, children, patients incapable of giving meaningful consent); and
 - to consider issues of consent which relate to teaching, research, and the use of new and unlicensed drugs.

- 1.4. The Working Party decided at the outset that it would *not* consider consent relating to treatment in the Intensive Care Unit, or relating to the treatment of chronic pain, or relating to resuscitation. It was recognised that anaesthetists are frequently involved in these areas of practice, but it was agreed that each area presents different problems of information and consent, and that to include them all would result in too extensive a remit.
- 1.5. Although the Working Party did not consider specifically the practice of sedation to facilitate a diagnostic or therapeutic procedure, it was recognised that many of the recommendations relating to anaesthesia will be applicable also to sedation administered by anaesthetists.
- 1.6. There is a difference in law between the duty to obtain consent from a patient and the duty to inform the patient of material risks. Failure to obtain consent at all constitutes the crime and civil wrong of assault. A breach of the duty to warn of material risks gives rise to an obligation to compensate for damage caused by that breach of duty; thus, it may result in a claim for compensation in respect of a complication or side-effect of treatment, even if the procedure was conducted properly. The Working Party has therefore considered separately the matter of consent and the duty to warn of material risks. The term ‘informed consent’ is one which, in the opinion of the working party, confuses the two areas, and that term is not used in this document.

2. **Consent**

2.1. Consent is a state of mind: a decision by a patient. 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 of health care. Any treatment, investigation or physical contact with the patient undertaken without consent may amount to assault. A patient who is able to demonstrate assault in a civil Court is entitled to compensation for the assault itself; in addition, the patient may be able to claim compensation for any injury suffered. Assault is regarded by the General Medical Council as an offence which may constitute serious professional misconduct.

2.2. Consent may be implied or express.

2.2.1. *Implied consent*

2.2.1.1. Consent is implied by the conduct of the patient for many of the physical contacts between doctors and patients, e.g. co-operation during physical examination for pre-operative assessment, or for attachment of monitoring apparatus. Consent may be implied if a conscious patient co-operates during venepuncture, or during performance of a local or regional anaesthetic block. Although implied consent granted in this manner would make it difficult for a patient to succeed in a claim for assault, it cannot be taken as an indication that material risks have been explained or understood (see section 3).

2.2.2. *Express consent*

2.2.2.1. Express consent should be obtained for any procedure which carries a material risk (see Section 3). Express consent may be obtained orally or in writing.

2.2.2.2. If oral consent is obtained, then an entry should be made in the clinical records indicating the advice which was given, and that consent was provided.

- 2.2.2.3. Written consent is not necessary to defend an action for assault, although it provides documentary evidence that consent has been obtained.
- 2.2.2.4. The Working Party does not believe that it is necessary to have anaesthetic consent forms signed by patients (see Section 3.3). Practitioners should be aware that, if there is a consent form in the clinical notes which has been left blank, this may give rise to a suggestion that the practitioner has disregarded the practice normally followed in that institution.
- 2.3. Other than in exceptional circumstances, consent should be obtained before the proposed procedure, and before any sedative drugs are given. Exceptional circumstances include those in which it is impractical to obtain consent because of the nature of the emergency or the condition of the patient.
- 2.4. *Competent adults*
 - 2.4.1. In England and Wales, a competent adult is a person who has reached 18 years of age, and who has the capacity to make decisions on his or her own behalf regarding treatment.¹ That capacity is present if the patient can comprehend and retain information provided about treatment; believes that information; and weighs that information in the balance to arrive at a choice [2]. No other person can consent to treatment on behalf of an adult.

¹ In Scotland and Northern Ireland, a person who has reached the age of 16 is a competent adult who has the capacity to make their own decisions regarding treatment.

2.5. *Children and young people*

- 2.5.1. In England and Wales,^{1,2} competent young people of 16 or 17 years of age can give consent for any surgical, medical or dental treatment; it is not necessary to obtain separate consent from the parent or guardian. However, if a person under 18 years of age refuses treatment which is deemed essential then the patient can be made a ward of Court and the Court may order that an operation may be carried out lawfully. The Court will not order a doctor to perform a procedure.
- 2.5.2. If a young person of 16 or 17 years of age is not competent to give consent, then the consent of a parent³ should be sought, unless immediate treatment is required to prevent death or permanent injury.
- 2.5.3. If a child under the age of 16 years achieves a sufficient understanding of what is proposed, he or she may consent to treatment. The child must be able to understand the nature, purpose and hazards of the treatment; thus, it is necessary to consider both the age of the child and the nature of the procedure before accepting that the child has sufficient understanding.

² In the Republic of Ireland, the age of majority is 18. The Irish Constitution places great importance on the rights of the family. Consequently, Irish Courts may be less likely to support the right of a doctor to override the wishes of parents, or to allow treatment of a minor without parental authority other than in an emergency to prevent death or permanent injury.

³ The mother has an automatic right to parental responsibility. The father has an automatic right only if he was married to the mother at the time of birth, although he can acquire parental responsibility by court order or by agreement. In some circumstances, another person may have acquired parental responsibility, e.g. a legal guardian, adoptive parent, or a social worker representing a local authority if the child is the subject of a care order.

- 2.5.4. The parents of a child under 16 years of age should be asked to authorise non-emergency treatment, unless the child forbids the practitioner to inform the parents that treatment is required. The most frequent example in anaesthetic practice involves termination of pregnancy; in these circumstances, if the clinician is satisfied that the child is mature enough to understand the nature of the procedure, common complications and the issues involved, and that the requirements of the Abortion Act 1967 (as amended) are met, then he or she may proceed provided that it is considered that to do so without informing the parents is in the child's best interests.
- 2.5.5. Parents have a responsibility to ensure that their child's best interests are served. They can therefore authorise treatment of an 'incompetent' child, even though the child dissents. However, it is good practice to have both the child's consent and the parents' authority, where practical. Individual judgement must be exercised, for example, in determining the degree of restraint which is acceptable to achieve induction of anaesthesia in an unco-operative child, even when the parents appear willing to have the child restrained. When faced with a child who is uncontrollable for whatever reason, the anaesthetist should consider ceasing treatment, giving an appropriate explanation to the parent or representative, and arranging necessary future treatment for the child rather than continuing in these circumstances.
- 2.5.6. If a 'competent' child under 16 years of age refuses treatment, that refusal does not necessarily override authorisation by a parent. However, treatment should normally be given only if failure to treat would result in death or permanent injury. An application to a Court can be made if time permits [3].
- 2.5.7. In life-threatening situations, parental authorisation should be obtained if possible, but immediately essential treatment should not be denied in the absence of parental authorisation if it is in the best interests of the child.

- 2.5.8. Written consent by a parent is not necessary. Verbal consent, including consent obtained by telephone, is adequate, and urgent treatment need not be delayed while waiting for a parent to attend in person. The nature of consent obtained from the parent should be documented.
- 2.5.9. Occasionally, parents refuse authorisation for treatment which, medically, seems to be in the best interests of the child, e.g. refusal for blood transfusion in a child of Jehovah's Witnesses. An application can be made to a Court for authority to treat the child who needs a transfusion [4], but it is important to give due regard to other significant factors, such as potential damage to the child's position within its family and community, in assessing what is, on balance, in the child's best interests. In an immediately life-threatening situation, essential treatment should not be withheld.
- 2.5.10. When a child is the subject of a care order, the local authority acquires parental responsibility and can authorise treatment on the child's behalf. Either parent can also authorise, or refuse, treatment of the child, but the local authority can override the parent's decision if necessary.
- 2.6. *Treatment without consent*
- 2.6.1. Treatment may proceed without obtaining the patient's consent in the following circumstances.
- 2.6.1.1. For life-saving procedures when the patient is unconscious or cannot indicate his or her wishes.

- 2.6.1.2. Treatment for physical disorder where the patient is incapable of giving consent by reason of mental incapacity and where the treatment is in the patient's best interests. The term 'best interests' is defined in the Mental Health Act 1983⁴ as: 'only if it is carried out in order either to save ... lives or to ensure improvement or prevent deterioration in ... physical or mental health'.
- 2.6.1.3. Treatment for **mental disorder** of a patient liable to be detained in hospital under the Mental Health Act 1983. The Mental Health Act 1983 does not contain provisions to enable treatment of **physical disorders** without consent, either for detained patients, or for people who may be suffering from mental disorder but who are not detained under the Mental Health Act, unless the physical disorder arises from the mental disorder, or is judged to be contributing to the mental disorder.
- 2.6.1.4. If, during a routine procedure, circumstances suddenly alter and result in a potentially life-threatening situation, a change in the treatment plan may need to be instituted for the benefit of the patient.
- 2.6.2. **No other person can consent to treatment on behalf of any adult, including incompetent adults** [5]. However, it is prudent to consult with the next of kin before treating an adult without consent.

⁴ In England and Wales. The Mental Health (Scotland) Act 1984 and the Mental Health (Northern Ireland) Order 1986 contain very similar provisions. Treatment of mentally ill patients in the Republic of Ireland is governed by the Mental Treatment Act 1945 as amended by the Mental Treatment Act 1961 and differs from UK provisions.

- 2.6.3. Neither the presence of mental disorder nor detention under the Mental Health Act implies incapacity to give consent either for treatment of the mental disorder, or for treatment of physical conditions. Each patient's capability to give consent must be judged individually in the light of the nature of the decision and the mental state of the patient at the time.
- 2.6.4. If a patient detained under the Mental Health Act requires electroconvulsive therapy for the treatment of mental disorder, then this requires the patient's consent or a second opinion. If the patient consents to treatment, then the responsible medical officer or a specifically authorised medical practitioner must also certify that the patient has consented, and that he or she is capable of understanding the nature, purpose and hazards of the treatment. When the patient is not capable of consenting, or refuses treatment, electroconvulsive therapy can be given in an emergency if the authorised practitioner certifies the patient's lack of capacity or refusal, and that the treatment is likely to alleviate, or prevent deterioration in, the patient's condition. It is reasonable for an anaesthetist to assume that authority to perform electroconvulsive therapy in a patient who is not capable of consenting, or who refuses treatment, encompasses the administration of general anaesthesia.
- 2.6.5. When treatment is provided without consent, a note must be made in the clinical records to explain the absence of formal consent, the reasons why the patient is incapable of giving consent and the reasons why the doctor (or dentist) in charge of the patient's treatment is of the opinion that the treatment proposed should be given and is in the patient's best interests. It is good practice to involve relatives or other carers in decision-making, and to inform them of decisions which have been reached, but when necessary the clinician should not delay taking such actions as the best interests of the patient demand.

2.7. *Restricted consent*

- 2.7.1. Competent adult patients have a right to refuse treatment with or without good reason. If a patient refuses to consent to the anaesthetic technique which the anaesthetist believes to be the most appropriate, then reasonable attempts should be made to persuade the patient that the proposed technique carries the least risk of adverse sequelae. The advantages and disadvantages of the proposed procedure and the reasons for the advice should be explained clearly. However, it is not acceptable to coerce patients into accepting a specific anaesthetic technique.
- 2.7.2. Occasionally, a refusal of treatment appears so bizarre or irrational that it raises the possibility of mental disorder. If this is considered to be a possibility, then a psychiatric opinion should be sought.
- 2.7.3. Some patients, for religious or other reasons, may consent in general for their treatment, but refuse consent for specific aspects of the treatment. Anaesthetists must recognise the importance and complexity of a patient's religious beliefs. The commonest example is the Jehovah's Witness. Individual Jehovah's Witnesses may have different interpretations of the acceptability of blood transfusion, and these must be clarified and documented. Some Jehovah's Witnesses will accept autologous or cell-saver blood; most will refuse homologous blood transfusion. Cardiopulmonary bypass with non-haematogenous primes, and organ transplantation, are usually regarded as acceptable [6]. Management of Jehovah's Witnesses by anaesthetists is considered in detail in a separate document [4].

- 2.7.4. Restricted consent does not remove a patient's right to reasonable and proper care, including provision of all other essential forms of treatment. If an individual anaesthetist does not feel capable of providing reasonable care consistent with the patient's wishes, then he or she can refuse to treat the patient provided that no additional risk results from that refusal. Reasonable attempts should be made to find an alternative anaesthetist. However, in an emergency situation, it is advisable to act to meet the patient's need, and essential that the competent patient's wishes are heeded.
- 2.7.5. If consent is restricted, the patient should be told, in the presence of a witness, of the benefits of the procedure which is being refused, and the hazards which may be encountered in the absence of the procedure. An attempt should be made to help the patient understand the reasons for the clinical recommendations. If the patient remains adamant, attention should be drawn to the clause on the consent form that specifies the patient's right to list procedures for which consent is not agreed. The doctor should also make a note of the precise nature of the restriction which has been imposed by the patient.
- 2.8. *Advance statements (or directives)*
- 2.8.1. Some patients elect to express their wishes concerning future treatment in the event that they may subsequently become incompetent to provide consent or to express their wishes. The commonest example pertaining to anaesthetic practice is a directive indicating refusal to undergo surgery for advanced and irreversible malignant disease, or an intercurrent surgical condition in the presence of a severely incapacitating and progressive degenerative disease. Many Jehovah's Witnesses carry with them an advance statement forbidding the administration of blood or blood components, and may have lodged copies with their general practitioner as well as family and friends [4].
- 2.8.2. An advance statement may be binding upon doctors when it expresses refusal of treatment in circumstances that the patient had anticipated. When a situation falls fully within the terms of the advance statement, then the clinicians should respect its terms unless there is evidence that the patient may have changed his or her mind since signing it.

2.8.3. An advance statement cannot authorise doctors to do anything outside the law, or compel them to carry out a specific form of treatment. In particular, an advance statement cannot permit a clinician to commit an act intended to end a patient's life.

2.9. *Obstetric patients*

2.9.1. In obstetric practice, anaesthetic or analgesic techniques may be required at short notice for patients who may be in acute pain and some distress, and who may already have received systemic opioids. The patient may be incapable of providing consent within the terms set out in paragraph 2.4.1.

2.9.2. It is therefore important that every obstetric unit has a policy whereby, during the antenatal period, patients are given a clear explanation of pain relief and of operations under regional or general anaesthesia. This information must be prepared in conjunction with an anaesthetist, and arrangements should be in place to ensure that any patient who wishes to discuss techniques with an anaesthetist may do so. It is still necessary to give the patient an explanation at the time of the proposed procedure, even though she may not fully understand what is being said because of pain, or because of confusion caused by analgesic or sedative drugs. All explanations should be documented.

2.9.3. Birth plans may include reference to analgesic and anaesthetic techniques, and may be regarded as advance statements (see section 2.8).

2.9.4. If the pregnant woman's wishes are unusual, they should be noted carefully in the antenatal record. If the woman insists on restrictions which the doctor thinks unsafe for her or her baby, or on conditions which make the doctor reluctant to accept responsibility, then the doctor should say so and, if possible, refer her to a colleague for advice (see Section 2.7).

2.9.5. Like any other patient, the pregnant woman may refuse any treatment with or without good reason and irrespective of the consequences for the fetus. However, if restrictions which a woman places on her own

treatment inevitably result in danger for her unborn infant, it is appropriate for the medical team to consult the Courts.

- 2.9.6. In exceptional cases, a Court has authorised Caesarean section under anaesthesia in a patient who has refused consent. In these cases, it is necessary to demonstrate that the patient lacks the capacity to take a decision as described in paragraph 2.4.1. Because these circumstances are so rare, hospitals should have standing arrangements to enable applications to the Court to be made at any time of day or night.

2.10. *Research*

- 2.10.1. Clinical research can be conducted only if the study has been approved by a properly constituted Research Ethics Committee (REC). Before approving a study, the REC will take into account the validity of the research, and the welfare and dignity of the patient [7].
- 2.10.2. Consent is normally required before a patient can be included in a research study. Sufficient information must be given regarding the nature of the research, its purpose, the possible hazards and benefits (if any) and the degree of risk involved in participation. The information should be presented in a manner, form and at such a time as to permit the patient to consider as fully as possible all the relevant issues, and to reach an informed decision. Consent must be voluntary and should not be influenced by a desire to avoid the disapproval of the researcher, or by any form of inducement. It must be made clear that there is no obligation to participate, and that the patient may withdraw from the study without disadvantage at any time.
- 2.10.3. In some circumstances, research may involve patients who are not legally competent to give consent (e.g. unconscious patients in whom the treatment under investigation is urgent). Normally, only therapeutic research can be conducted in such patients; subject to the approval of the REC, a decision can be taken to include the patient in a research project provided that participation is in the patient's best interests.

2.10.4. Young people of 16 or 17 years of age are legally entitled to give consent to therapeutic research. Children under the age of 16 years who have the capacity and understanding to take their own decisions can consent to therapeutic research provided that the research is of minimal risk to the child. If a child under 16 years of age is not competent to decide, a parent or other person with parental responsibility may consent to therapeutic research on behalf of the child provided that the research is of minimal risk to the child.

2.11. *Teaching during anaesthesia*

2.11.1. The Department of Health [8] has recommended that medical students must not examine or undertake a procedure on a patient unless his/her prior consent has been obtained. Other than in exceptional circumstances, this recommendation applies to anaesthetised patients. We agree with these recommendations.

2.11.2. We recommend that the same considerations should apply to teaching of student nurses, trainee paramedical staff and other trainee health care workers which involves physical contact with an anaesthetised patient or direct participation in the procedure.

2.12. *Administration of new drugs, or drugs used outside product licence*

2.12.1. There are many examples of the use of drugs by anaesthetists outside their licensed indications [9]. These include the administration of opioids by the spinal or epidural routes, the use of new drugs in groups of patients for whom a licence has not yet been obtained (e.g. children) and the administration of mixtures of drugs. Any adverse event which occurs becomes the responsibility of the prescribing doctor. The decision to prescribe an unlicensed drug must be capable of support from an informed, reasonable body of clinicians skilled in the relevant field of practice.

2.12.2. New unlicensed drugs which are undergoing clinical trials are normally administered only as part of a formal research investigation, and the guidelines in section 2.10 should be followed. Indemnity from the manufacturer should be obtained in relation to adverse events occurring as a consequence of administration of the drug. This indemnity does not cover negligence on the part of the prescriber or the person who administers the drug. All drug trials which involve unlicensed drugs, or drugs used outside the terms of the Product Licence, require permission from the Medicines Control Agency.

2.13. *Multiple procedures*

2.13.1. In some circumstances, a patient may consent to a course of treatment, rather than consent being obtained formally on every occasion, when the treatment on each occasion is the same or of a similar nature, e.g. a course of radiotherapy, a course of electroconvulsive therapy, or repeated change of dressings of a wound. In these circumstances, consent for anaesthesia may be inferred after appropriate discussions on the first occasion, although it is prudent on each occasion to enquire about any concerns resulting from the previous anaesthetics, and to offer the opportunity for the patient to ask further questions.

2.14. *Ensuring correct surgical treatment*

2.14.1. The anaesthetist has a duty to confirm the identity of the patient and the nature of the proposed surgical procedure before anaesthesia

commences. The anaesthetist should ensure that the proposed procedure described on the operating list is consistent with the procedure to which the patient has consented on the surgical consent form. It is the anaesthetist's duty to ensure that the correct patient is anaesthetised. However, it is the responsibility of the medical practitioner who undertakes the surgical or investigative procedure to ensure that the correct procedure is performed.

3. **Adequacy of consent**

3.1. *Duty to warn of material risks*

3.1.1. A material risk is one to which a reasonable person in the patient's position would be likely to attach significance. 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 [10].

3.1.2. 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.

3.1.2.1. The patient may argue that the consent was invalid, and that performance of the procedure amounted to assault as a result of failure to obtain 'informed consent'. However, outside the United States of America, this has found little favour with the Courts, which have taken the view that a charge of assault cannot be sustained provided that the patient has been advised in broad terms of the nature of the procedure to be performed.

3.1.2.2. 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

- 3.1.2.3. 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.
- 3.1.3. The following are factors which the anaesthetist should consider when deciding what should be explained to patients.
 - 3.1.3.1. The gravity of the risks involved in the proposed anaesthetic technique.
 - 3.1.3.2. The frequency with which a complication is encountered according to the literature. A doctor cannot avoid the obligation to mention a recognised hazard of a procedure merely because it has never happened in the doctor's own practice. However, if it has been encountered more frequently in the doctor's own practice than the literature suggests is usual, then the doctor will be wiser to rely upon his or her own experience in describing the frequency of the complication.
 - 3.1.3.3. The estimated risks of alternative techniques.
 - 3.1.3.4. The estimated added risks for the individual patient (e.g. as a result of concurrent disease).
 - 3.1.3.5. The estimated capacity of the patient to want to know, and to be able to understand, the risks.
 - 3.1.3.6. The degree of urgency of the proposed treatment.

- 3.1.4. We do not recommend that every risk of every component of the anaesthetic technique should be explained ('sectionalised consent'). We believe that this would require presentation of a bewildering quantity of information. This could result in patients providing restricted consent which was entirely inappropriate; for example, a patient requiring emergency abdominal surgery might agree to general anaesthesia but not to tracheal intubation.
- 3.1.5. However, anaesthetists should normally warn patients of common risks (e.g. muscle pains following administration of suxamethonium, postural headache after spinal anaesthesia). The patient should normally be told that there is a small risk of more serious complications associated with any anaesthetic, and the anaesthetist should provide details if asked to elaborate (e.g. regarding awareness, nerve damage, cerebral damage, death).
- 3.2. *Recommendations on information for patients⁵*
- 3.2.1. The anaesthetist should explain what the patient will experience before and after anaesthesia. This includes the need to fast, administration and effects of premedication, transfer to the anaesthetic room, connection to monitors, insertion of needles and injection of anaesthetic drug. It may be reassuring to the patient to be told that the anaesthetist will be present at all times during the operation to maintain anaesthesia and to ensure the patient's safety. Where appropriate, the need for blood transfusion should be discussed.
- 3.2.2. Patients should be told that, postoperatively, they will awaken in a Recovery Room soon after the end of the operation, but may remember nothing until they have returned to the ward. When the patient regains consciousness, there will be an oxygen mask on the face and (if appropriate) the patient will be aware that a nasogastric tube has been introduced. If appropriate, patients should be told that pain should be anticipated postoperatively. The proposed method of pain control should be explained (e.g. patient-controlled analgesia,

⁵ See also the Association of Anaesthetists' document 'Anaesthesia and Anaesthetists: Information for Patients and their Relatives'.

intravenous injection of opioids in the recovery area, epidural analgesia).

- 3.2.3. If a patient is expected to go to a High Dependency or Intensive Care Unit postoperatively, then appropriate information should be given, including information relating to any invasive monitoring techniques which are planned.
- 3.2.4. Day-stay patients in hospitals or dental surgeries must be supplied with clear and comprehensive pre- and postoperative instructions, and told that, when they leave the premises, they must be accompanied by a responsible adult.
- 3.2.5. If a local or regional anaesthetic technique is to be used, then patients should be informed of the nature of the technique, and that numbness and/or weakness may be experienced in the first few postoperative hours. The patient should be told also that alternative techniques, including the use of general anaesthesia, may be required if the block is unsuccessful.
- 3.2.6. If it is proposed that local or regional anaesthesia is to be used alone, then this should be explained to the patient. Some patients do not wish to remain conscious during an operation, and they may reject these techniques. In those who consent, it should be explained that they may experience some sensations during surgery, including possibly a degree of pain, even if a sedative drug is to be administered concurrently.

- 3.2.7. If a technique of a sensitive nature, such as the insertion of an analgesic suppository, is to be employed during anaesthesia, then the patient should be informed, so that there is no anxiety afterwards if there are unusual sensations or if the residuum of a suppository is evacuated.
- 3.2.8. Patients who are at increased risk from anaesthesia and surgery should be told the nature of the increased risk, and if possible an estimate of the probability of the risk materialising should be provided.
- 3.2.9. **All patients** should be given the opportunity to ask questions, and honest answers should be provided.
- 3.2.10. Many questions relate to the operation. The anaesthetist should not provide information about the surgical procedure beyond his or her capability. The anaesthetist should ensure that an appropriate person discusses the procedure and answers the patient's questions before anaesthesia is induced.

3.3. *Documentation*

- 3.3.1. The anaesthetist should make a record of the anaesthetic techniques (e.g. general anaesthesia, regional anaesthesia, local anaesthesia, or a combination) which have been discussed with and agreed by the patient, and should list the material risks which have been explained. Anaesthetic record forms should include a section in which these matters can be documented.
- 3.3.2. The Working Party does not recommend that the anaesthetic record should contain a check-list of possible risks, because the anaesthetist must exercise clinical judgement in discussing risks, for the reasons set out in section 3.1.3.
- 3.3.3. The Department of Health recommends that written consent should be obtained for general anaesthesia [11]. However, the Working Party sees no reason why it should be recommended that written consent should be obtained specifically for general anaesthesia when it is agreed that it is unnecessary for local or regional anaesthesia. Further,

we do not believe that there is any virtue in requiring the patient to sign a consent form for anaesthesia, or a separate section on the surgical consent form relating specifically to anaesthesia, provided that the advice in paragraph 3.3.1 is heeded.

References

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