

Appendix 2a

Frequently asked questions regarding consent (n.b. relating to England and Wales). Please note:

- i) When the new Mental Capacity (Northern Ireland) Act 2016 comes into force in Northern Ireland, the relevant legal provisions in England and Wales and in Northern Ireland will be very similar; for more information see <http://www.legislation.gov.uk/nia/2016/18/contents>.
- ii) For information about the implications of the new Assisted Decision-Making (Capacity) Act 2015 in the Republic of Ireland, see <http://www.hse.ie/eng/about/Who/qualityandpatientsafety/nau/AssistedDecisionMaking/>.
- iii) A separate document [Appendix 2b] relates to Scotland.

1. Can obtaining consent for anaesthesia be delegated to another healthcare professional?

It is recommended that the person who gains consent for anaesthesia from a patient is the anaesthetist who will perform the case. However, for logistical reasons this is not always possible. The person taking consent should always be an anaesthetist or a physician's assistant in anaesthesia (PA(A)) who understands the risks and benefits of the anaesthetic technique and also the alternatives. Surgeons and pre-operative assessment nurses should not be expected to take consent from patients for general or regional anaesthesia, although this may form part of their discussion about the procedure. Surgeons may take consent for procedures under local anaesthetic that they are going to administer.

2. How soon before the procedure should consent be taken?

Consent is a process and not a fixed point in time. The consent process for anaesthesia begins when the procedure necessitating anaesthesia is first discussed with the patient. At that point the mode of anaesthesia should be mentioned and written information about anaesthesia should be provided. (For urgent or emergency cases, provision of written information is not always practical or possible.) For elective cases, further information can be given at the pre-operative assessment visit. If the patient is seen by an anaesthetist at this point, consent may be taken for anaesthesia and any associated procedures. However, consent must still be confirmed on the day of the procedure by the anaesthetist. Verification that consent has been given should be done again in the anaesthetic room, although this should not be the place where risks, alternatives and additional procedures are discussed.

3. For how long does consent remain valid?

Consent is event-specific and there is no defined length of time for which it remains valid. It should be taken in advance of the procedure in question and confirmed immediately before the procedure. It may be withdrawn at any time.

4. Do patients need to receive written information about anaesthesia and its risks?

Elective patients should be offered written information about anaesthesia and the associated risks. Patients undergoing urgent or emergency surgery may also benefit from receiving written information although this is not always possible in practice.

5. What steps should I take to ensure that information is understood?

Potential barriers to comprehension include: language differences; communication difficulties; poor numerical literacy (quantifying risk); medical illiteracy (understanding medical conditions or terminology); preference for types of learning (visual or auditory); presence of pain and/or psychological and emotional distress; and lack of time. The consent process should involve presentation of information in a way that the patient can understand. This may involve the use of an interpreter, patient information leaflets (translated as required), infographics, diagrams, credible patient information websites and involvement of a family member, friend or other healthcare professional. Sufficient time must be allowed for the process and a phased approach may be necessary, allowing the patient time to absorb information before making a decision.

6. Which risks of anaesthesia do I need to document that I have discussed with the patient?

Ideally, all of the risks that have been discussed should be documented. Anaesthetic charts should have space for documentation of the discussion leading to consent. Some charts employ a tick-box system as an aide memoire; such systems can be useful but care must be taken to ensure that they are accurately completed.

7. Should I discuss a technique as a possible option even if I don't feel I have the skills to use it, e.g. shoulder block for shoulder surgery?

Discussion of the treatment options should in general include alternative techniques, but it would be unreasonable to require inclusion of an exhaustive list of treatments that are not available to that patient (thus the Montgomery ruling states that patients are entitled to decide: "*which, if any, of the available forms of treatment to undergo*" and that they should be made aware of: "*any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments*" [10]. The range of 'reasonable' anaesthetic techniques that should be discussed will depend on the individual anaesthetist's ability to provide them and their availability in that institution/setting, as well as the degree to which they are used in general to provide anaesthesia for the procedure in question. Thus, for example, it would be standard modern practice to discuss regional anaesthesia for caesarean section as the preferred option, but to include also discussion of general anaesthesia both as a technique in its own right and as a back-up technique should regional anaesthesia fail. It is also accepted practice to offer regional anaesthesia for other procedures, e.g. shoulder surgery, but it is not universal practice to offer this as the preferred option in all centres, although there are anaesthetists (and units) that might argue it should be. The Working Party accepts that opinions as to the preference for and availability of such techniques vary, and would suggest that anaesthetists present and explain the technique that is their/their unit's standard practice, whilst explaining that there are other techniques that are used elsewhere/by others, and that the patient may have heard of. If the patient has strong views/preferences around the use of e.g. a regional

or another technique, to the point where he/she would even consider seeking treatment elsewhere, then this should be discussed with patient and surgeon, along with the implications of such a course of action.

8. What level of detail of anaesthetic technique do I need to discuss with the patient?

Discussion of a treatment (or anaesthetic) should include those components that are of importance to that patient. However, it would be unreasonable to list every drug and technique that together constitute 'anaesthesia', so that the patient may 'approve' each one; thus the Montgomery ruling states: *"The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp"* [10]. The broad range of information considered appropriate for discussion with patients during the consenting process in most cases is provided in Table 2 of the consent guidance [link]; further discussion should be guided by the patient's wishes.

9. What level of risk requires me to inform the patient about a particular complication?

It is occasionally stated that complications with a risk < 1% do not need to be discussed with a patient. However, what might constitute a 'material risk' to a particular patient does not depend on its size. The Montgomery ruling states that: *"...the assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient"* [10].

10. What should I do if a patient indicates that he/she does not wish to know about the risks of anaesthesia?

A patient who refuses to hear about the risks of anaesthesia should be given the opportunity to change his/her mind and this may require a repeat appointment. Information should not be forced upon a patient and so if a patient repeatedly indicates that he/she does not wish to hear about the risks of anaesthesia then the implications of this should be explained and the details of this conversation must be documented in the notes.

11. Is a signed consent form for anaesthesia recommended?

No, a signed consent form for anaesthesia is not recommended if the anaesthesia or anaesthetic procedure is done to facilitate another treatment (e.g. anaesthesia for surgery) or as part of a larger and inter-related process (e.g. epidural pain relief for childbirth). The statement in the Montgomery ruling, above (see FAQ 8) goes on to state: *"The doctor's duty is not therefore fulfilled by bombarding the patient..., let alone by routinely demanding her signature on a consent form"* [10].

For procedures done as primary therapeutic interventions, e.g. interventional pain procedures, local practices/policies should be followed and this may include a written consent form.

12. If a patient signs a surgical consent form mentioning general or regional anaesthesia, do I need to discuss the risks associated with anaesthesia with him/her?

Yes. Unless the patient has received accurate information about the anaesthetic and the risks and alternatives, it cannot be said that he/she has given his/her consent. A signature on a form does not remove the requirement for a discussion to take place.

13. My patient is refusing a treatment that is clearly in his/her best interests; does this mean he/she lacks capacity?

A patient's capacity to decide is not defined according to whether or not the patient's decision is in what his/her doctor believes to be his/her best interests, so if a treatment decision appears not to be sensible, rational or well considered, it does not necessarily mean that the patient lacks capacity to make it. However, if a decision is highly irrational and based on persistent misinterpretation it may be that the patient is suffering a mental illness, in which case a specialist clinical opinion should be sought, since deeming incapacity on the grounds of irrationality is unlawful.

14. Who can determine whether a patient has capacity?

In most cases, this will be the responsibility of the person providing the treatment and therefore taking consent. If you doubt your patient's capacity, the GMC's *Good Medical Practice* guidance states that you need to seek advice from others involved in his/her care and those close to the patient, who may have knowledge of his/her usual abilities and methods of communication. Gaining opinions of colleagues with specialist experience, for example neurologists, psychiatrists and speech and language therapists, is also advised. If you are still unsure about a patient's capacity, the GMC states that legal advice should be sought, since application to a court may be appropriate.

15. Under what circumstances can someone else consent on a patient's behalf?

A person can consent on behalf of another person: (i) if a healthcare proxy has been appointed through a lasting power of attorney, and the attorney has the power to make the decision in question; (ii) if a court has appointed a deputy with the appropriate powers; or (iii) if the patient is a child or young person, in which case his/her parents or those with parental responsibility, local authorities or the courts may consent (although children and young people should be involved as much as possible in decisions about their care, even when they are not able to make decisions on their own).

16. When does an Independent Medical Capacity Advocate (IMCA) need to be consulted?

An IMCA should be consulted to assist with decision-making when a patient over 16 lacks capacity, and a treatment is proposed that is felt by medical professionals to be in his/her best interests but there are no family or friends to consult. The IMCA acts to represent the patient and will decide if the best interests' framework has been appropriately followed, but the IMCA does not make the decision him/herself. If the IMCA feels that due

process has not been followed, he/she will issue a formal challenge. More information about IMCAs can be found at <http://www.scie.org.uk/publications/imca/information/doctors.asp>.

17. What if the medical teams disagree as to what is in the patient's best interests if he/she doesn't have capacity?

Assessing the best interests of somebody lacking capacity requires consideration of that person's point of view, and what his/her decision would be under the circumstances were he/she to have capacity. Assessment of somebody's best interests is a process rather than an event, and must take into account any evolving factors including the urgency and seriousness of the situation. The Mental Capacity Act 2005 includes a checklist for assessing best interests that includes: ensuring a non-judgemental, non-discriminatory approach; taking account of all relevant circumstances including the possibility that the person might regain capacity later; enabling the person to participate as much as possible; considering his/her wishes, feelings, beliefs and values; and seeking the views of others (e.g. relatives) where appropriate. No one person or group of people has the ultimate say in determining best interests over any other, and it is feasible that different people/groups might apply the above process and conclude that different treatment options represent the patient's best interests. If consensus cannot be reached, then a Clinical Ethics Committee could be consulted if one exists, but the ultimate decision would rest with the Court of Protection. An exception to this would be in the case of a valid lasting power of attorney or court-appointed deputy, when the decision between treatment options would rest with the attorney/deputy (but even their decisions may be referred to the Court of Protection if they are disputed). See <http://www.39essex.com/content/wp-content/uploads/2016/08/Capacity-Assessments-Guide-August-2016.pdf>.

18. Is there a specified lower age limit for 'age of consent'?

No. Under 16, the treating doctor may decide that the child has 'sufficient intelligence and understanding to appreciate fully what is proposed'. Young persons (16- and 17-year-olds) are presumed to have the capacity to consent.

19. Who has parental responsibility?

Mothers automatically have parental responsibility from birth. There are different conditions for whether fathers and same-sex partners have parental responsibility in the devolved nations and Ireland (see <https://www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility> and https://e-justice.europa.eu/content_parental_responsibility-302-IE-en.do?clang=en). Other people who may have parental responsibility are: someone who has successfully applied for it; a legally appointed guardian; a person with a residence order for that child; the local authority designated to care for that child; or a person with an emergency protection order for that child.

20. What resources are available to help children, young people and their parents understand about the risks of anaesthesia?

The AAGBI in association with the Royal College of Anaesthetists and the Association of Paediatric Anaesthetists of Great Britain and Ireland have produced a selection of leaflets and activities for this purpose as part of the 'Anaesthesia information for children and young people' project (see <http://www.aagbi.org/news/information-public/information-about-anaesthesia-children-and-young-people>).

21. What other resources can I use to help me with the consent process?

The AAGBI and the Royal college of Anaesthetists have also produced a series of information leaflets for adults (see <http://www.aagbi.org/news/information-public/information-about-anaesthesia-adults>). Some of the other specialist societies also have information available. In the UK, guidance is available from the GMC (see http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp).

If your patient lacks capacity to consent and has nobody whom he/she is willing for you to consult, the Independent Mental Capacity Advocate (IMCA) service should be used (see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365629/making-decisions-opg606-1207.pdf).

22. What should I do if a patient has given consent for a particular anaesthetic technique and the situation changes and I think an alternative is indicated? (e.g. a laparoscopic procedure is changed to an open procedure and regional analgesia is now indicated.)

If the patient has not consented to a particular technique before induction of anaesthesia, then any alternatives must be in the patient's best interests. The risks and benefits to that patient must be carefully considered, along with any preferences expressed during the pre-operative discussion. Ideally, possible changes in circumstance, e.g. the risk of conversion of laparoscopic cholecystectomy to open, should be anticipated and discussed pre-operatively.

23. If the anaesthetist responsible for the case changes, does the consent process need to be repeated?

The anaesthetist caring for the patient is the one responsible for the discussions with that patient regarding that procedure. If you are satisfied that consent was appropriately taken by someone suitably qualified and trained, then it is acceptable to continue without repeating the consent process – though it would be good practice to introduce yourself and confirm consent.

24. Do I need to seek specific consent for an arterial line or central venous catheter?

If this is an intended or likely procedure as part of a patient's care then it should be discussed with the patient, along with a discussion of any significant risks and consequences. If the need arises unexpectedly once the patient is anaesthetised, any additional procedures must be in the patient's best interests. The decision to perform such procedures must be recorded in the patients' notes.

n.b. all websites accessed on 20/10/2016. References refer to those in the main article document.