Consent for Anaesthesia

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Section 1 Recommendations

- Information about anaesthesia, preferably in the form of a patient-friendly leaflet, should be provided to patients undergoing elective surgery before they meet their anaesthetist.

- The anaesthetic room immediately before induction is not an acceptable place or time to provide elective patients with new information other than in exceptional circumstances.

- The amount and the nature of information that should be disclosed to the patient should be determined by the question: "What would this patient regard as relevant when coming to a decision about which of the available options to accept?"

- At the end of an explanation about a procedure, patients should be asked whether they have any questions; any such questions should be addressed fully and details recorded.

- Anaesthetists should record details of the elements of a discussion in the patient record, noting what risks, benefits and alternatives were explained.

- A separate formal consent form signed by the patient is not required for anaesthetic procedures that are done to facilitate another treatment or as part of an inter-related process.

- Adults should be presumed to have capacity to consent unless there is contrary evidence.

- The Mental Capacity Act 2005 (MCA) allows patients without capacity to express their previously-determined wishes by means of an Advance Decision or by means of a proxy using a Lasting Power of Attorney.

- The MCA places a duty upon carers to treat incapable patients in their best interests, to use the minimum necessary intervention when doing so, and to make efforts to reverse or minimise temporary incapacity to enable patients to make autonomous decisions.

- When planning to allow trainees or others to use an opportunity presented by a patient for training in practical procedures, the anaesthetist should make every effort to minimise risk and maximise benefits, and should consider alternative ways of achieving the same end. Specific consent for such procedures may or may not be required depending on the circumstances.

Section 2 Introduction

The Association of Anaesthetists of Great Britain and Ireland first formally addressed the issue of consent in 1999, establishing a Working Party chaired by Professor Alan Aitkenhead. The fruits of their labours – 'Information and Consent for Anaesthesia' – clearly explained the ethical, professional and legal responsibilities of anaesthetists with respect to providing information and seeking consent. The current Working Party has drawn considerably from this advice and is happy to acknowledge those who contributed to it.

In recent years, several developments have prompted the Association to revisit the question of consent. On the legal front, the introduction of the Mental Capacity Act 2005 in England and Wales – preceded by the Scottish Adults with Incapacity Act 2000 – has finally given a voice to adults without capacity to consent, and has imposed a series of duties upon clinicians to promote capacity. It has also formalised the Advance Decision (formerly Advance Directive) and extended Powers of Attorney to include medical decision-making. This alone was enough to justify the Association producing new advice, but perhaps of more impact to the 'ordinary' patient-doctor interaction is the increased emphasis placed by the courts on patient's autonomy, crystallised in the House of Lords judgment in *Chester v Afshar* in 2004 [1].

As well as addressing these issues, the Working Party has expanded the original document to take in views on consent with relation to chronic pain procedures and critical care. Increasing litigation and the influence of organisations like the Clinical Negligence Scheme for Trusts, the Healthcare Commission, the National Patient Safety Agency and the General Medical Council have caused the Working Party to examine carefully the amount of information that should be provided to patients and the way in which this provision, and the ensuing discussion about care options, should be documented in the patient's record. Finally, and in keeping with the ethical emphasis of this document, we have considered in more detail the obligations of the clinician who allows others to hone their practical skills on a patient.

Although there is much in this document that may seem novel or even contentious, the 'take-home messages' remain unchanged at the heart of professional practice: we must allow our patients to make their own decisions about their care in full possession of the relevant information; good communication makes for good medicine; and good records are essential for the defence of the doctor.

David Bogod
December 2005

Section 3 The importance of consent

3.1 Ethical aspects

3.1.1 Clinicians have an ethical obligation to respect patients' autonomy - that is, their right to be involved in decisions that affect them. In medicine, this is reflected in the requirement to obtain consent for treatment, which can only be valid if adequate information is supplied and the patient has the capacity to understand it and make a balanced decision, free from coercion [2]. Patients may change their mind and withdraw consent at any time, so long as these conditions still apply.

3.1.2 The need to respect autonomy may sometimes conflict with other obligations, such as the principle of beneficence (doing good). For example, patients may decline treatment life-saving treatment, and generally this decision must be respected.

3.2 Professional aspects

3.2.1 Respect for autonomy and the need for consent is emphasised in professional guidance as being central to the doctor-patient relationship [3-5].

3.2.2 Patients also have an interest in knowing what is going to happen to them and what they should expect during a course of treatment or other medical encounter. It is a professional courtesy to explain such things to patients, to give them the opportunity to ask questions, and to provide honest answers to such questions.

3.3 Legal aspects

3.3.1 The legal requirements for valid consent reflect the ethical ones: it must be given voluntarily by an appropriately informed

patient, who has the capacity (competence) to exercise a choice – even if this choice appears irrational. Pain, illness and premedication do not necessarily render a patient incompetent to give consent.

3.3.2 Touching a patient without consent, irrespective of outcome, may lead to a claim of battery. Far more common, though, is a claim of negligence after a complication has occurred, on the basis that had a warning been given, the patient would not have agreed to the treatment and the complication would not have occurred [6]. Recent case law suggests that a doctor might still be found negligent even if the patient would have undergone the treatment had he/she been warned [7], precisely because of the importance that the law accords to the duty to respect the autonomy of the patient. In addition, Articles 3, 8 and/or 10 of the Human Rights Act 1998 might be invoked if consent is not sought from patients before treatment [8].

3.3.3 The treating doctor is responsible for ensuring that the patient has consented to the treatment.

3.3.4 Legal decisions concerning consent are historically based on the Bolam principle [9], i.e. the litmus test to be applied in deciding whether there was a duty to mention a given risk is whether the doctor who omitted to mention the risk was acting in accordance with a responsible body of clinical opinion. However, recent judgments have stressed that the opinion has to be rational and stand up to logical analysis [10] and an omission to mention a significant hazard (see 5.3.1) will usually be indefensible.

3.3.5 Patients without capacity may be treated without consent if it is in their best interests.

3.3.6 Various aspects of the above are addressed in the following pages.

Section 4 Capacity, Incapacity and Voluntariness

4.1 Adults have the legal capacity to consent to a medical procedure if they are able to understand and remember the information given to them about the procedure, and to use that information in order to decide whether or not to undergo the treatment proposed [11]. In most instances, it is for the doctor treating the patient to decide whether the patient is competent or not.

4.2 The decision made by the patient does not have to be sensible, rational or particularly well considered. However, a highly irrational decision that is based on a misinterpretation of the information presented may indicate that the patient is suffering from a mental illness. In practice, determining incapacity on the grounds of irrationality is fraught with difficulty and is a judgment probably best left to the courts.

4.3 Refusal of treatment by a competent adult is legally binding, even if refusal is likely to result in the patient's death [12].

4.4 Incapacity may be predictable (e.g. Alzheimer's disease, Huntingdon's dementia), permanent (e.g. perinatal brain damage or persistent vegetative state), or temporary (e.g. unconsciousness following intoxication, head injury, or during general anaesthesia).

4.5 In the case of predictable incapacity, where their competence is likely to be lost through future illness, patients may choose to prepare an 'Advance Decision' ('advance directive', 'living will'), stating which treatments they would accept and refuse, if needed (see Section 8) [13].

4.6 Currently, in England, Wales and Ireland, although it is undoubtedly good practice to consult with relatives, no-one can consent to medical, surgical or dental treatment on behalf

of an incapable adult patient [14]. Treatment of the incompetent adult is carried out without consent, and must be directed in the patient's 'best interests'. Legally, 'best interests' are more than just 'medical best interests', and include other personal, social and financial factors. In Scotland, the Adults with Incapacity Act 2000 allows a patient anticipating future loss of capacity to appoint a 'welfare attorney', who can then make healthcare decisions in the event of incapacity.

4.7 If a patient lacks capacity, practitioners must make a clear record of the grounds on which they have reached this decision, the treatment which will be undertaken, and how this treatment will be in the patient's best interests. It is good practice – but not a legal requirement – to contact and seek the approval of relatives or others significant to the patient, but failure to do so should not compromise care in an emergency.

4.8 *Mental Health Act, 1983*

4.8.1 Mental illness may impair a patient's capacity to provide valid consent for treatment. However, a person receiving treatment for mental illness (even if they are detained under the Mental Health Act, 1983) should not be assumed to be incapable of providing valid consent for medical, surgical or dental treatment.

4.8.2 The patient's consent is not required for any medical treatment of the mental disorder from which the patient is suffering. However, the patient's consent, or a second opinion, is required before the administration of electroconvulsive therapy (ECT). 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. Licence to treat in this way would also extend to the use of general anaesthesia for the purpose of administering ECT [15].

4.9 *Mental Capacity Act 2005*

4.9.1 The Mental Capacity Act 2005 [16] has entered the statute books for England and Wales, but is not due to be implemented until 2007. Until then, and before the associated Codes of Practice have been drawn up, it is unclear how much impact the Act will have upon anaesthetic practice. The Act:

- emphasises the fact that adults should, by default, be regarded as having capacity unless clearly incapable;
- directs clinicians to use the minimum necessary intervention if acting in the best interests of an incapable adult;
- encourages clinicians to try to reverse or minimise a temporary loss of capacity to enable patients to make decisions for themselves;
- allows competent patients to appoint 'Lasting Powers of Attorney' (LPAs), permitting others to take decisions about healthcare and welfare on their behalf if they lose capacity in the future (c.f. the old 'Enduring Power of Attorney' which did not extend to healthcare issues); LPAs need to be registered with the new Office of the Public Guardian before they become legally valid;
- formalises the role of the 'Advance Decision' (formerly 'advance directive'), which will become legally binding if the patient has lost capacity and the situation which he/she has anticipated then develops;
- creates a Court of Protection, which can make judgments regarding treatment decisions in incapable adults, or appoint a Deputy to undertake such decisions;
- directs bodies caring for patients to nominate Independent Mental Capacity Advocates.

4.10 *Voluntariness*

4.10.1 For a decision by an individual to be valid, it must have been taken voluntarily, i.e. without coercion [17]. In general, it is good practice for the clinician who is seeking consent to indicate whether they favour one therapeutic option over

another, but the imbalance of power and influence in the doctor-patient relationship means that the vulnerable patient may feel coerced by the doctor's enthusiasm. Anaesthetists seeking consent should be aware of this and not allow their preferences to override the patient's autonomy.

4.10.2 Coercion is more likely to arise when patients are influenced by the beliefs or preferences of friends or relatives. This is more likely to arise where a competent child is accompanied by a parent, in areas where both parties have a major stake in the outcome, such as obstetrics, or in certain cultures. Where such a situation is suspected, anaesthetists should seek to speak to the patient away from the coercive influence.

Section 5 Information and the process of consent

5.1 Information about anaesthesia and related procedures is not exclusively provided by anaesthetists, but the anaesthetist caring for the patient must take responsibility for the adequacy of information provided for each patient.

5.2 *Timing*

5.2.1 The process of consent should begin before the anaesthetist and the patient meet. Where appropriate, the patient should be provided with a patient-friendly information leaflet around the time he/she is booked in, or pre-assessed for surgery. This is particularly important for day surgery patients where the opportunity for prolonged discussion is limited. Patients should be informed that they will meet the anaesthetist before their operation, so that further queries and discussions can take place before finally consenting to anaesthesia.

5.2.2 Patients must be given sufficient time to come to a considered view after they have been provided with relevant information about their treatment. It is neither practical nor desirable for all information to be provided to patients at the pre-operative meeting with the anaesthetist.

5.2.3 The anaesthetic room is not an acceptable time or place to provide patients with new information other than in exceptional circumstances.

5.3 *Standards for information provision*

5.3.1 The amount and the nature of information that should be disclosed to the patient should as far as possible be determined by the question: "What would *this* patient regard as relevant when coming to a decision about which, if any, of the available options to accept?" [7, 18]

5.3.2 Written information should be available in languages commonly *read* by local patients. Braille and large print versions should be available for situations where impaired vision is likely (e.g. information about local anaesthesia for cataract surgery). Translators or readers should be available for those patients unable to read the written information provided.

5.3.3 Individual anaesthetists and departments may wish to use nationally available written information or to produce their own [19]. Consideration should be given to regular departmental audit of information provision.

5.3.4 The ultimate responsibility lies with the anaesthetist to determine that the patient has received and understood the information regarding anaesthesia or other planned procedures. Sufficient time must be allowed for the process of consent to take place during the pre-operative visit.

5.3.5 Good clinical practice has moved in advance of the law with respect to paternalism and the withholding of information on the grounds of 'therapeutic privilege'. Information must not be withheld because the anaesthetist feels it may deter a patient from undergoing a beneficial procedure. Conversely, any information which might lead a patient to cancel or defer a procedure should be considered significant. While not clear in law, it is possible that patients who refuse information may invalidate their own consent, if it means that they no longer understand what it is that they are consenting to undergo [20]. Thus, basic information about the nature of the procedure should always be provided: however, detailed information should not be forced upon patients who have repeatedly indicated that they do not want to hear it.

5.3.6 In broad terms, patients must understand what they are consenting to. Therefore, anaethetists should tell the patient:

- what procedures they intend to do, and why they intend to do them;
- what the significant, foreseeable risks of these procedures are, and what the significant, foreseeable consequences of these risks might be.

5.3.7 The law currently still judges information provision by the standards of the 'prudent doctor' (see 3.3.4), as long as the standard can be shown to be rational and logical [10, 18]. However, recent judgments have equated the term 'significant risk' with the degree of risk to which a reasonable patient (in the patient's situation) would attach relevance, and it is likely that this is the standard which will increasingly apply [21].

5.3.8 Information should be provided about:

- generally what may be expected as part of the proposed anaesthetic technique. For example, fasting, the administration and effects of premedication, transfer from the ward to the anaesthetic room, cannula insertion, non-invasive monitoring, induction of general and/or local anaesthetic, monitoring throughout surgery by the anaesthetist, transfer to a recovery area, and return to the ward. Intra-operative and postoperative analgesia, fluids and antiemetic therapy should also be described;
- postoperative recovery in a critical care environment (and what this might entail), where appropriate;
- alternative anaesthetic techniques, where appropriate. Patients do not have to agree to the anaesthetist's preferred anaesthetic technique;
- commonly occurring, 'expected' side-effects, such as nausea and vomiting, numbness after local anaesthetic techniques, suxamethonium pains and post dural puncture headache;
- rare but serious complications such as awareness (with and without pain), nerve injury (for all forms of anaesthesia), disability (stroke, deafness and blindness) should be provided

in written information, as should the very small risk of death. It is good practice to include an estimate of the incidence of the risk [22]. Anaesthetists must be prepared to discuss these risks at the pre-operative visit if the patient asks about them;

- specific risks or complications that may be of increased significance to the patient, for example, the risk of vocal cord damage if the patient is a professional singer;
- the increased risk from anaesthesia and surgery in relation to the patient's medical history, nature of the surgery and urgency of the procedure. If possible, an estimate of the additional risk should be provided;
- the risks and benefits of local and regional anaesthesia in comparison to other analgesic techniques;
- the risk of intra-operative pain, and the need to convert to general anaesthesia, should a proposed local or regional technique be inadequate or ineffective. The risks and benefits of adjunctive sedation or general anaesthesia should be discussed;
- the benefits and risks of associated procedures such as central venous catheterisation, where appropriate;
- techniques of a sensitive nature, such as the insertion of an analgesic suppository.

5.3.9 Day-stay patients 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.

5.3.10 All patients should be given the opportunity to ask questions and honest answers should be provided.

5.3.11 Many questions relate to the operation itself. 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 surgical procedure and answers the patient's questions before anaesthesia is induced.

Section 6 Documentation

6.1 Currently, the Working Party is of the view that a formal signed consent form is not necessary for anaesthesia and anaesthesia-related procedures, since it is the process of consent itself that is important, and a signed form does not increase the validity of the consent.

6.2 In many cases, verbal consent for anaesthesia is acceptable. However, for significant planned procedures, e.g. those that are invasive or which carry significant risks, it is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussions which led up to that agreement. This can be done on a standard consent form, on the anaesthetic record or separately in the patient's notes. Departments of Anaesthesia may wish to design anaesthetic records to document the discussions and agreement to specific modes of anaesthesia and interventions.

6.3 Most procedures carried out by anaesthetists are done either 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). In these cases, the above advice applies. Sometimes, however, the anaesthetic procedure is the primary therapeutic intervention. Examples include invasive procedures for the treatment of chronic pain, epidural blood patch for the treatment of post-dural puncture headache or placement of a central line for chemotherapy or parenteral nutrition. In these circumstances, and especially when the procedure is carried out in the operating theatre complex, many Trusts insist that a Department of Health consent form be completed and signed by the patient as evidence that consent has been given, and the Working Party's advice is that local procedures should be followed.

6.4 Documentation is particularly important in circumstances when the patient's decision goes against the anaesthetist's advice e.g. during regional anaesthesia where for whatever reason the patient wishes to convert to general anaesthesia or alternatively to continue with regional anaesthesia despite suboptimal anaesthesia. The latter is a relatively common occurrence in obstetrics.

6.5 Where a patient wishes to reverse a previously documented decision, it may help to protect the anaesthetist from later dispute if the patient is asked to countersign the written details of the discussion that led up to this decision.

Section 7 Qualified consent

7.1 Some patients, for religious or other personal reasons, may qualify their general consent to treatment by refusing specific aspects of that treatment. Doctors must respect these wishes.

7.2 Individual Jehovah's Witnesses, for example, may have different interpretations of the acceptability of blood transfusions. Most Jehovah's Witnesses will refuse homologous blood transfusion. However, some will accept autologous or cell-saver blood. Cardiopulmonary bypass with non-haematogenous primes and organ transplantation are usually regarded as acceptable [23]. The anaesthetic management of Jehovah's Witnesses is considered in detail in a separate document [24].

7.3 If a patient gives qualified consent, a record should be made in the hospital notes indicating that the patient has been informed of the likely consequences of this decision, together with the reasons why such treatment was proposed in the first instance. 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.

7.4 Qualified consent does not remove a patient's right to reasonable and proper care, including provision of all other forms of treatment that are appropriate in the circumstances. If an individual anaesthetist does not feel capable of providing proper care consistent with the patient's wishes, then he or she can refuse to treat the patient, provided that no additional harm is likely to result from that refusal. Reasonable attempts should be made to find a different anaesthetist who is willing to treat that patient. However, in an emergency when treatment is immediately necessary, the anaesthetist should comply with the wishes of a competent patient.

Section 8 Advance Decisions ('advance directives', 'living wills')

8.1 Competent patients who anticipate future incompetence through illness may indicate their preferences for future treatment by completing an Advance Decision. For example, patients may indicate that they do not wish to undergo life-saving surgery if they suffer from dementia when they are older. Many Jehovah's Witnesses carry with them an Advanced Decision forbidding the administration of blood or blood components.

8.2 Advanced Decisions are legally binding on healthcare workers if they are made voluntarily by a competent, adequately informed patient, who expresses an explicit refusal of treatment under certain defined circumstances [12].

8.3 When a situation falls fully within the terms of the Advanced Decision, clinicians should respect the terms unless there is evidence that the patient may have changed his or her mind since signing it.

8.4 Advance Decisions cannot authorise doctors to do anything outside the law, or compel them to carry out a specific form of treatment [25, 26].

Section 9 Special circumstances

9.1 *Chronic pain*

9.1.1 Anaesthetic interventions for patients with chronic pain are often primary in nature – that is, the intervention is intended to be curative, rather than enabling a more definitive procedure to take place. When this is the case, written, signed consent on conclusion of the consent process is recommended, and is often a Trust requirement.

9.1.2 Such interventions cannot be regarded as essential to save or prolong life. Therefore, patients require the fullest information about the probable benefits and the potential risks so that they can judge whether or not the procedure is appropriate for them. Patients who are in constant pain may feel that nothing could make their pain worse, and that trying anything is better than doing nothing. Although they are free to make that choice, it should be on an informed basis, as some may develop unrealistic expectations of treatment.

9.1.3 Patients may consent to a course of treatment, rather than be asked repeatedly for their consent at every treatment episode (for example, a course of acupuncture). In these circumstances, consent for the procedure need only be recorded on the first occasion and may be inferred from conduct on subsequent attendances, although it is prudent on each occasion to enquire about any concerns resulting from the previous procedures, and to offer the patient an opportunity to ask further questions.

9.1.4 One problem which is more common in the palliative care setting concerns the effect of large doses of drugs (particularly opioids) upon the competence of the patient to make decisions. Although drugs (or, for that matter, confusion, shock, fatigue or pain) may completely erode capacity, the anaesthetist concerned must be satisfied '*that such factors are operating to*

such a degree that the ability to decide is absent' before deciding that the patient lacks capacity [11].

9.2 *Critical care*

9.2.1 The principles of consent are as relevant to patients in the Critical or Intensive Care Unit (ICU) as they are to the general population. The specific problem for many ICU patients is the fact that many of them may lack competence, either because of disease, or because of essential therapy (e.g. sedation). The provisions of the Mental Capacity Act 2005 (MCA) are therefore particularly relevant to the ICU although, at the time of writing, there is still some uncertainty as to how its practical application will be affected by the Codes of Practice to be introduced before implementation in 2007.

9.2.2 Patients in the ICU should not be considered to lack the competence to decide about their medical treatment, merely because they are gravely ill, are receiving sedative drugs or lack the ability to communicate orally. These patients should be allowed to indicate their consent, and wherever possible, written documentation of consent discussions should be recorded [25]. The MCA makes an explicit demand that every effort should be made to try to assist a temporarily incapacitated individual in making an informed decision. In order to satisfy the provisions of the Act, critical care clinicians will still need to make adequate efforts to overcome difficulties with communication (e.g. tracheal intubation), and approach patients at a time when such decisions may be optimally made. In many cases these approaches may be inappropriate because of the clinical context; in such settings there needs to be clear documentation that adequate capacity could not be achieved despite best efforts.

9.2.3 However, the majority of ICU patients will either be unconscious or have fluctuating levels of consciousness, such

that they lack the competence to make decisions about their treatment. In these instances, the courts recognise that doctors may treat patients in their best interests. It should be reiterated that 'best interests' does not necessarily equate with 'medical best interests'; this has obvious relevance to end-of-life decision making. Discussions about 'best interests' should involve other health professionals, and be informed by the patient's relatives or next of kin. Although doctors are usually the final arbiters in these decisions, the court's opinion should be sought whenever there are disputes about treatment between doctors and relatives. The MCA requires that clinicians "consult widely" so as to obtain the subject's true views from relatives and friends. It would be important in such instances to state clearly why wider consultation was not practical.

9.2.4 In any setting where another individual is providing substituted judgment for an incapacitated patient, he/she will need to act against the following checklist of requirements:

1. Does the subject lack capacity?
2. Have all reasonable attempts been made to involve the subject in decision making?
3. Is the action in the subject's best interests?
4. Is the action proportionate (i.e. is the degree of invasion warranted for the intended benefit)?
5. Has the least restrictive option (i.e. minimum invasion of autonomy) been chosen?
6. If incapacity is temporary, can a decision be postponed until capacity is regained?

9.2.5 It is good practice after the event to explain to temporarily incapacitated patients what interventions were performed during their stay on ICU.

9.3 *Children*

9.3.1 A child is any person under the age of 18.

9.3.2 In England and Wales, 16 and 17 year-old children are presumed to be competent to consent to treatment, as if they were adults. However, this does not invalidate the parental right to consent on their behalf. Refusals of treatment by competent 16 and 17 year-olds can also be overruled by the court, if the child is likely to suffer harm as a result of their refusal.

9.3.3 Children under the age of 16 are not presumed to be competent to consent to treatment, unless the doctor decides that the child 'has sufficient intelligence and understanding to appreciate fully what is proposed' (i.e. are '*Gillick* competent' [27]). The degree of understanding they will need to show will vary depending upon the nature of the procedure and the severity of the condition being treated. *Gillick*-competent under-16s should be encouraged to inform their parents about treatment, but the doctor must still respect their right to confidentiality and a refusal to permit disclosure to the parents.

9.3.4 Consent may be provided for incompetent children by parents, temporary carers, local authorities or the courts, provided the treatment for which the consent is given in the best interests of the patient. Usually, parents (or those with parental responsibility, namely legal guardians nominated by the parents, or unmarried fathers who have entered and registered a parental rights agreement) will make the decision, although they themselves must be competent to make the decision and it must be made in the child's best interests. Either parent may give consent. If there is disagreement between the parents, the courts may limit the power of one parent to refuse treatment that is in the best interests of the child. If both parents refuse, an application may be made to the court to overrule the parents.

9.3.5 In life-threatening situations, parental authorisation should be obtained if possible and, in default, application should be made to the court if necessary. Whatever happens, the best interests of the child are the touchstone and treatment that is

immediately essential to safeguard the child's life or health should not be denied in the absence of parental authorisation, even if there is no time to get court authority.

9.3.6 In Scotland, 16 and 17 year-olds have the same legal rights as adults to give consent to (or refuse) any medical, surgical or dental treatment. Children under the age of 16 years have the legal capacity to consent to any surgical, medical or dental treatment where, in the opinion of a qualified medical practitioner, they are capable of understanding the nature and possible consequences of the procedure or treatment.

9.3.7 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.

9.3.8 Individual judgment must be exercised in determining the degree of restraint which is acceptable to achieve induction of anaesthesia in an uncooperative 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.

9.4 *Obstetrics*

9.4.1 The adult parturient is presumed, like all adults, to have capacity. This may be compromised by drugs, fatigue, pain, or anxiety, although the compromise will need to be severe to incapacitate her.

9.4.2 Labour is the wrong time to burden women with excessive information. It is important that every obstetric unit provides

antenatal advice for women concerning pain relief and anaesthesia during labour and delivery [28]. 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. Nevertheless, the patient must still be provided with appropriate information at the time of the procedure, the details of which must be documented.

9.4.3 Birth plans often include references to analgesia and anaesthesia. If a woman obviously loses capacity during labour, the birth plan should be treated as an Advance Decision, and any documented refusal of therapy must be respected. However, a presumption of capacity remains in these circumstances. Therefore, competent women who request epidural analgesia during labour, despite recording a refusal in their birth plan, should have their request respected, although they should be asked to countersign any documentation concerning consent for the procedure (see Section 6).

9.4.4 In law, a competent pregnant woman can refuse any treatment for any reason, even if this puts the unborn child at risk of harm or death. An emergency court order may be requested in such circumstances, but will only be granted if the court concludes that the woman lacks capacity.

9.4.5 In general 16 and 17 year-old parturients are to be regarded as adults from the point of view of making decisions about interventions, and children younger than this may be competent depending upon the circumstances. However, young parturients are probably more likely to become temporarily incompetent under the emotional and physical stress of labour. Units should therefore have guidelines in place to ensure that these patients receive ante-natal information and advice and, if necessary, anaesthetic referral.

9.5 *Emergencies*

9.5.1 Emergency medical treatment does not exclude the need for informed consent. Until proven otherwise, the patient is presumed to be competent to make a decision, and retains the right to refuse any treatment for whatever reason, or for no reason at all. However, if an adult patient is not competent to consent to or refuse treatment (for example, because they are unconscious), immediate treatment that is necessary to preserve the life or health of the patient may be provided in the patient's best interests (as decided in an emergency situation by the doctors treating the patient – but see 4.6).

9.5.2 The emergency treatment of children still requires an attempt to obtain consent (from a parent, person with parental authority or the court), unless life-saving treatment is immediately necessary.

Section 10 Research, audit and training

10.1 *Research and audit*

10.1.1 The distinction between these is not always easy, but what is actually being done is more important than the label attached. The need for participants' consent and for review by an independent Research Ethics Committee is no different in anaesthetic and related research to any other area of medical research, and anaesthetists are referred to the copious guidelines and regulations that already exist [29].

10.2 *Learning/maintaining practical skills*

10.2.1 Although practical procedures can be rehearsed and practised on manikins and to a lesser extent, volunteers, most learning and maintaining of practical skills occurs during patients' care (unlike research, in which the process is usually extra to care).

10.2.2 It may be difficult to define what constitutes a single 'procedure' since most can be separated into several components. In addition, practitioners learn from every procedure they do. It is therefore impossible to seek patients' consent for every aspect of every 'procedure' in which there may be a learning component. The Working Party endorses the following approach [30]:

- The risks and benefits of each procedure and its components, both to the patient concerned and to society in general, must be considered;
- The harms should be minimised as much as possible, e.g. by close supervision, prior practice on manikins, etc;
- The benefits should be maximised as much as possible, e.g. by close supervision, and targeting skills to practitioners most likely to use them in the future;
- Alternatives should be considered, e.g. other ways of learning/maintaining skills, other techniques.

10.2.3 In some cases, e.g. a novice in fibreoptic orotracheal intubation wishing to learn the technique, patients' specific consent should be sought since there may be additional risks from inexperienced use and there are limited benefits to the patient. In other cases, e.g. an experienced endoscopist using the fibrescope as part of his/her routine technique, specific consent would not be required since the risks have been minimised and the benefits maximised, and the technique constitutes part of the general procedure of 'orotracheal intubation' (so long as the associated risks remain equivalent to or less than the alternatives). However, if a particular patient wishes to discuss intubation, e.g. if they are especially concerned about damage to teeth or sore throat, the anaesthetist should provide more details, as for any other aspect of anaesthesia – upholding the principle that disclosure of information should be flexible according to what the individual patient wants to know.

10.2.4 The same principles should apply to supervision of others: consultant anaesthetists should include trainees' experience as part of the assessment of overall risks and benefits, including the need to minimise the former and maximise the latter, as described above.

10.2.5 Sometimes anaesthetists are approached by medical students and paramedical staff wishing to learn/maintain skills e.g. in airway management. Such individuals are not only less skilled than anaesthetists but also not medically qualified, making the risk/benefit assessment even more crucial. The Department of Health's guidance states that patients' specific consent is not required for procedures done by students if such procedures are part of patients' normal care. However, the Working Party considers that this depends on the student's competence and the risks involved. For example, while it would be acceptable for a novice to hold a facepiece under supervision without specific consent, since the risks are minimal, tracheal intubation is more invasive and requires a greater level of

competence before the patient's specific consent is no longer required. In particular, the Working Party is strongly opposed to the practice whereby students or paramedics move between anaesthetic rooms to 'do' intubations, without any consideration of the above issues.

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