31 Information and consent

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Introduction

Recent events in cardiac surgery in the UK have led to a heightened awareness among doctors and their patients of the issues of patient information and consent. A number of relevant documents have been published on both subjects and those from the GMC, the Association of Anaesthetists of Great Britain and Ireland and the National Health Service Executive are essential reading for all doctors in the United Kingdom. This chapter will apply particularly to practice within the jurisdiction of British courts.

Principles

To give consent is a conscious decision, made by a competent adult, to allow examination, investigation or treatment to be carried out. It usually follows a consultation during which the patient is given information about the examination, investigation or treatment proposed. The information should include a description of:

- The proposed procedure itself
- The reasons why it is necessary; benefits that may result from it
- The material risks involved
- The risks involved if the procedure is not carried out
- The options for alternative investigation or treatment
- How the patient may be monitored or assessed during and following the procedure
• Whether the procedure is conventional or experimental
• A reminder that the patient has a right to change her mind and to seek a second opinion.

The information must be given in a way that the individual can understand. When providing the information the obstetric anaesthetist should consider the patient's personality, level of education, intelligence, previous experience, beliefs and culture (religious or racial) and any other factors that may influence the information she needs in order to make a decision. Obtaining consent and providing information are therefore closely related but not identical. Failure to obtain consent makes any subsequent procedure that is undertaken an assault.

A failure to inform of material risks is a breach of duty, which will expose the practitioner to a liability to compensate for any damage caused as a result of the breach of duty and actions arising from that breach of duty.

Information

Historically the patient informed the doctor about her symptoms and the doctor informed the patient what he would do in order to improve the patient's condition. The underlying principle was that doctors would tell patients what was good for them to know. Now the principle is that medical practitioners should give patients as much information as possible about their condition and the options for treatment. In other words tell patients as much as possible and tell them the truth. This simple axiom is sometimes difficult to follow because:

• Giving bad news is difficult and doctors genuinely don't want to upset their patients.
• The doctor may not know all the relevant facts.

The second factor can be addressed. If a doctor does not know the relevant facts it is best to say so and offer to find out. If the facts are not accessible it is best to tell the patient that too.

Underlying the historical approach was the idea that if patients are told the extent of risk of complications for the proposed procedure they will not consent to it. That is to say they will refuse the treatment that the doctor has decided is best for them. Our decisions on what is best are often made with a superficial knowledge of the patient's circumstances. This approach can cause a patient to consent to a procedure that may be appropriate to her particular illness but entails risks that could blight her remaining life. The risk of vocal cord abnormalities following endotracheal intubation is small but to a singer may be very significant.

The obstetric anaesthetist must be able to give a pregnant woman an honest review of:

• The options for pain relief or anaesthesia
• What each option involves
• Their benefits and risks
• Which option is thought best for the particular parturient and why

followed by an invitation to the parturient to question and comment.