Not just a separate consent for anesthesia!

A colleague recently commented about the practice of anesthesia consent in India: "In our country every institute has a separate consent for anesthesia." Such a state of affairs is arguably desirable but not true. The practice of obtaining a specific consent for anesthesia separate from the consent for surgery (separate anesthesia consent) is not uniform across hospitals within this country or in others. The hospitals accredited by the National Accreditation Board for Hospitals and Healthcare Providers or those certified by the Joint Commission International, do use a separate anesthesia consent form. Most of the others probably do not.

Even when a separate anesthesia consent is taken, it is mostly a mere signature on the form. Does it really constitute informed consent in the true sense? The essential components of informed consent are assessment of patient's capacity, disclosure of medical information, and voluntary consent/approval by the patient. Obtaining consent, therefore, requires an unhurried two-way interaction between the anesthesiologist and the patient, with the latter provided with relevant details, and time to understand and ask questions. Only such a decision can be considered a true informed consent. The recently updated guidelines for consent for anesthesia by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommend that the information should be provided as early as possible and that it should be in the form of a resource (online or a printed leaflet) to which the patient can refer to for deliberation.[1] This may not be practical in India at present but can be considered in the future.

In a commentary on separate anesthesia consent published in this issue of the journal, Singh states that obtaining consent is an ethical responsibility of anesthesiologists toward their patients. It improves patients' satisfaction with the medical care and may even afford some legal protection to the anesthesiologists.[2] The process of obtaining consent is also likely to enhance the status of anesthesiology.

So why is this not a universal practice? A small survey of conference attendees in India found that though most felt the need for a separate anesthesia consent, only a few practiced it.[3] This finding is probably generalizable. Why is that? What are the difficulties in obtaining a separate anesthesia consent?

First and foremost, anesthesiologists see their patients only for a brief period during preoperative evaluation, while obtaining a proper consent requires more time. Besides the plan of anesthesia, the issues to be discussed may include details of monitoring, intraoperative positioning, transfusion of blood and blood products, and postoperative pain management. The risks and benefits of each of these, and the available alternatives, must be communicated to the patient. This is time intensive and is challenging for day-care as well as admitted patients. However, as concerned anesthesia practitioners, we need to devise ways to allocate the time needed.

Second, it is not easy to decide on the appropriate amount of information which does not cause undue anxiety. A balance has to be struck between the frequency and severity of complications. Burkle *et al*. found that patients preferred discussion of common but inconsequential complications and rare but severe complications.[4] The amount of information provided may also be influenced by the person obtaining the consent. Lagana *et al*. found that in Australia, trainees discussed more risks with the parents of children compared to consultants.[5] This may not be universally true but is a factor to be kept in mind. Structured consent forms are likely to bring about some uniformity in this regard. According to the AAGBI guidelines, the amount and nature of information should be such that it helps the patient to make a decision regarding various options.[1]

Another difficulty is to individualize communication for each patient. Paternalistic assumptions regarding the patients' ability to understand technical information are outmoded in the 21st century. We should make every effort to convey all the necessary details to the patients taking into consideration their education, knowledge, understanding, and sociocultural background. Even if some patients put their entire trust in the physician to take a decision on their behalf, it does not obviate our responsibility to inform them. In a recent article in this journal, Rampersad *et al*. found that separate anesthesia consent increases patients' understanding of anesthesia procedures and side effects compared to a common surgical consent.[6] Even in the educated and medically aware Western society, a high proportion of patients do not understand[7] or recall[8,9] the provided information. One of the reasons for this could be that consent for anesthesia involves more abstract concepts than surgical consent and thus requires higher cognitive capacity.[10] Assessment of patients' capacity is also an essential component of informed consent.[11] This is difficult because of the limited time available for interaction and because we lack specific definitions and tools for identification of adequacy of capacity. This is an area which can be developed with the help of our psychology colleagues. In the UK, adults are presumed to have capacity unless there are reasons to believe otherwise.[1]

Many patients consider consent as a means for medical practitioners to protect themselves from legal action.[9] We need to work toward changing this attitude by providing information to the patients, by engaging them in discussion, and making them active participants in decision-making.

Formal training in communication with patients and in principles of informed consent during anesthesia residency is essential for this change to occur. I call upon all anesthesiologists to work toward overcoming the difficulties in taking informed anesthesia consent, starting with our own attitudes, established curricula, and work practices.

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