Is it time to separate consent for anesthesia from consent for surgery?

Is it time to separate consent for anesthesia from consent for surgery? This topic has been under discussion for quite some time now around the world promoting various anesthesia societies to publish guidelines for use by practitioners. In this article, we aim to look at some of the more recent advances, research, and discussions about this topic and discuss if there are any legal guideline for the same.

Obtaining patient consent for anesthesia interventions is the ethical and legal obligation of the anesthesiologists. Legal guidelines mandate that this is informed consent, which means that the proposed procedure and available alternatives be fully discussed along with their benefits and risks and all the questions answered in simple language to help patients make a decision to accept or reject the proposed plan. Patient's ability to understand the discussion and voluntary acceptance of the plan is of utmost importance. The Joint Commission on Accreditation of Healthcare Organizations requires documentation of all of the elements of the informed consent "in a form, progress notes, or elsewhere in the record" (Standard RI.2.4.0).[1]

Consent for anesthesia has traditionally been considered as "implied" once the patient consents to surgery, with the surgical consent stating that anesthesia will be needed for the surgery and there are associated risks with anesthesia. The problems with this are that it is signed in the surgeon's office and the patient has yet to meet an anesthesiologist. In addition, the surgeon is neither trained to formulate an anesthesia care plan or to discuss the risks, benefits, and alternatives participated in the actual administration of anesthesia services – these are the roles of the anesthesiologist. In addition, there is increasing need for anesthesia for the young, claustrophobic, or developmentally delayed individuals for nonsurgical procedures, and using a surgical consent is inappropriate in such situations. Moreover, some surgeons refuse to discuss anesthesia and its risks in "their" consent document for liability reasons.

Anesthesiologists have long been engaged in the battle to be recognized as skilled professionals whose scope of practice is far different from that of surgeons.[1] Delivery of safe anesthesia care is a challenging process, and we should engage our patients as partners in their care to ensure the best outcome. An informed consent empowers the patient to have a greater involvement in his or her own health-care decisions and improves satisfaction. It is not acceptable that a surgical team member obtains consent for anesthesia. Anesthesiologists need to do this to ensure that the patient is fully informed of the process, risks, benefits, and alternatives.[2]

The next challenge is about the accurate documentation of the informed consent process, for which there are three options: a customized handwritten note, a separate anesthesia consent document, or documentation in the medical record of the patient. Rampersad *et al.*[3] have shown that obtaining a separate anesthesia consent had a positive impact on the patients' understanding of the nature and purpose of the intended anesthesia procedures. In addition, satisfaction with the adequacy of information provided about common side effects and complications was better.

We may think that having the signed document may help in cases of litigation, but this may not be entirely true. Patients may state that they did not have complete understanding of the process and there may be arguments about their capacity to understand the discussion in its entirety. Marcucci *et al.*[4] showed that patients might need to have a higher capacity to understand the abstract concepts associated with anesthesia and its risks compared to understanding the surgical options and risks. Rosique *et al.*[5] showed that 64% of their patients had little or no recall of the information presented to them on the preanesthesia informed consent document. A signed document at best provides evidence to the jury that information was presented to the patient and that the patient agreed to the plan after the information was given to them, and as a result, it directs the focus of the jurors to assess the quality of

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care provided. On the other hand, issues regarding informed consent have not shown to be a major part in litigations. The American Society of Anesthesiologist (ASA) Closed Claims Data review by Caplan showed that only 1% of the total claims were based on informed consent issues.[6] In an ASA article in 2007,[7] Sanford states that from a liability standpoint, the verdict is clear and anesthesia should have a separate consent. The reason for this is not that the consent will provide a shield against future litigation but that the process of obtaining informed consent and engaging patients actively in their own healthcare decisions is one of the most effective ways of reducing the risk of litigation itself.[8] For these benefits to materialize, the consent process should be adhered to in principle and not just as a formality.

In a recent article, Ajmal[9] assessed the quality of the informed consent process for cesarean deliveries in a single institution and found that the risks and benefits of all available anesthetic techniques were not adequately discussed with the patients. This defeats the purpose of the informed consent. O'Leary[1] in his publication in the ASA Newsletter Series states that obtaining an informed consent through discussion with the patient is a legal requirement in all states of the USA. Physicians commonly do not document this well and may find themselves vulnerable if the patient has an unexpected outcome or if litigation is involved. As far as legality is concerned, "If you did not write it down, it did not happen." A well-designed anesthesia consent form ensures that professional discussion is documented appropriately.[1]

The Association of Anesthetists of Great Britain and Ireland in its publication on Consent for Anesthesia recommends having a clear discussion with the patient about the risks and benefits, but it does not require a separate anesthesia consent form. The emphasis here is on ensuring that the informed consent is obtained appropriately but the lack of a signed anesthesia consent that stands as a proof of this discussion leaves some gaps in the process. These gaps are not acceptable anymore.

Having a preprinted anesthesia consent form has advantage of saving time. A well-designed consent form can incorporate common complications of anesthesia as well as rare but more serious complications so that the discussion with the patient is complete. The drawback is that the same discussion may not be sufficient for every patient or situation. Having some free space to document specific discussion points pertinent to the situation can overcome this drawback. In conclusion, the anesthesia community should move universally toward obtaining separately documented informed anesthesia consent. A separate consent would also emphasize that anesthesia in itself is a separate medical entity distinct from surgical and nonsurgical interventions and may additionally afford some degree of legal protection.

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