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Informed consent – A Survey among Anaesthesiologists in South India

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Abstract
The practice of obtaining consent prior to conducting any procedure is necessary. The manner of obtaining consent varies between different individuals and institutions. We conducted a survey to find out the nature of consent and the actual procedure practiced while obtaining it. A prepared questionnaire was distributed among the participants and responses were noted. Various conferences conducted in south India over a period of six months from November 2017 to February 2018.Both consultant anaesthesiologists and post graduate trainees participated in this survey. As it was a survey no interventions were done. The results were analysed with frequency Anaesthesia consent was considered to be separate from surgery consent by majority of respondents. The method of obtaining consent and nature of consent varied from institute to institute. Though a small minority had been involved in medicolegal cases it was not due to inadequacy of consent Consent is a vital document in the process of anaesthetizing a patient for surgery. Anaesthesia consent is the unique domain of anesthesiologist and a separate anaesthesia consent taken by the attending anaesthesiologist after explaining the pros and cons of different anaesthesia techniques is the need of the hour.

Highlights
- *Survey among practicing anaesthesiologists regarding practice of obtaining consent.*
- *Importance of consent as a medicolegal document*
- *Need for a separate anaesthesia consent form*
- *Need to explain pros and cons of various anaesthesia techniques especially in high risk cases.*

Keywords: *Informed consent, Anaesthesiologist, South India, Survey.*

Introduction

Consent is defined under Indian Contract Act (because Doctor Patient relationship isa contract) as "two or more persons are said to consent when they agree to the same thing in the same sense."[1]

The basic requirement in the process of obtaining an informed consent is that accurate information about the procedure should be provided to a mentally alert patient who can decide for himself the pros and cons of various techniques and no compulsion for a certain technique should be made by the treating clinician.

Medical consent is an important document which has to be obtained prior to conducting any procedure. If the procedure requires anaesthesia an additional consent for anaesthesia is also necessary. This consent can be in continuity with the surgical consent or separate. We conducted a survey among both consultant anaesthesiologists and post graduate trainees regarding the consent and manner of obtaining consent in their work place. The survey was done through a questionnaire. This survey was conducted among anaesthesiologists working in corporate hospitals, teaching hospitals and free lancers. We conducted this survey to get an insight into content of consent and the manner of obtaining consent and the patient interaction prior to anaesthetic administration.

Methodology

The prepared questionnaire (annexure 1) was distributed in various anaesthesia conferences among both consultant anaesthesiologists and post graduate trainees. This survey was conducted over a period of six months from November 2017 to February 2018.

The questionnaire was validated by collecting data from anaesthesiologists working in our centre. From the same group of anaesthesiologists, the same information was collected after a month. The difference between the survey responses at both time intervals was tested and found to have no significant difference. By this dual questionnaire response approach we validated the questionnaire and we found it to be reliable.

A total of 239 responses were obtained to the 300 questionnaires distributed. A drop box was placed in each venue to help us collect the responses. The identity of the participants was kept confidential and participation was voluntary.

The survey contained a total of twenty questions with ten questions being of demographic nature and ten questions pertaining to consent, ie. manner of obtaining, detailing of consent, plan of anaesthesia, medical fitness of patient for giving consent, need for high risk consent, checking of consent prior to anaesthetizing the patient, post operative pain control, need for anesthesia consent being separate and the unique domain of the anaesthesiologists. Involvement in litigation and its relation to consent were also queried upon.

The questionnaire was analysed using Excel. The data were summarized using frequencies and percentages.

Results

On analysis of the responses collected on analysis we found that majority(69%) of the respondents were practicing anaesthesiologists, out of which 21% had more than 20 years experience in the field of anaesthesia.(Table 1).

The majority of participants (61%) were from teaching institutes either government or private. But these included both consultants and students working and training in these institutes.

The procedure for obtaining consent varied from institute to institute. Consent was obtained by anaesthesiologist (57%) in most of the hospitals though surgeons (20%) and nurses (22%) also were instrumental in obtaining the consent for anaesthesia preoperatively.(Table 2).

Though many respondents (32%) still practiced adding the anaesthesia consent as a note along with the surgical consent, majority of the respondents (63%) had a separate hand written or typed anaesthesia consent form in their workplace. (Table 2).

Consent was obtained routinely for all elective cases on the previous day in most of the centres (75%) surveyed. Only 18% of the respondents practiced obtaining the consent on the day of the surgery. Majority of the respondents (70%) had a plan in place for anaesthetizing the patient when obtaining the consent itself. All the participants had a high risk anaesthesia consent form but high risk form was included along with the anaesthesia form in 57% and 43% respondents had a separate high risk form.(Table 3).

Mental capacity of patients for giving consent for anaesthesia was being evaluated by most of the respondents (82%) prior to obtaining consent. But pros and cons regarding each anaesthetic technique was discussed routinely only for 49% of the patients with detailed discussions being confined to high risk patients in 39%. The remaining respondents rarely if ever discussed pros and cons of different anaesthesia techniques with patients.

Routinely 80% of the respondents cross checked the anaesthesia consent prior to anaesthetizing the patients with 16% crosschecking only for high risk patients. Only 5% of the respondents had been involved in litigation with all of them agreeing that anaesthesia consent inadequacy or absence was not the cause for litigation. Obtaining and explaining the anesthesia consent was deemed to be the unique domain of the anaesthesiologist by 76% of the respondents. (Table 4).

Surgical consent did not imply anaesthesia consent for majority (93%) of the participants. Even postoperative care and pain control techniques were explained by most (70%) of the participants.(Table 4).

Table1 Demographic data

Variable	Frequency
Professional status	
Consultant	163 (68.2%)
Postgraduate trainee	76 (31.8%)
Years in Practice	
0- 5 years	98 (41.4%)
6-10 years	32 (13.5%)
11- 15 years	28 (11.8%)
16-20 Years	29 (12.2 %)
>21 years	50 (21.1%)
Practice setting	
Teaching	
Government	104 (43.5%)
Private	43(18%)
Non Teaching	
Government	30 (12.6%)
Private	62(25.9%)

Table 2 Consent Details

Variable	Frequency
Taken by whom	
Surgeon	50 (20.9%)
Anaesthesia provider	41 (17.2%)
Any anesthesiologist	94 (39.3%)
Nurse	54 (22.6%)
How consent	
Note with surgery consent	77 (32.2%)
Medical record	11 (4.6%)
Separate form	151 (63.2%)
No consent	0
When consent	
Day of surgery	42(17.6 %)
Previous day	180 (75.3%)
Any time	17 (7.1%)
Plan of anesthesia at time of consent	
Yes	165 (69.1%)
No	74 (30.9%)

Table 3 Consent Details

Variable	Frequency
High risk consent separate	
Yes	135 (56.5%)
No	104 (43.5 %)
Evaluation for capacity to make decisions	
Yes	196 (82%)
No	43 (18%)
Discussion of different anaesthesia techniques	
Routinely	116 (48.5%)
Only high risk	93 (38.9%)
Rare or never	30 (12.6%)
Consent cross check	
Routinely	193 (80.8%)
Only high risk	38(15.9%)
Rarely	8(3.3%)
Involvement in litigation	
Yes	12 (5%)
No	227(95%)
Litigation due to inadequate consent	
Yes	0
No	12 (100%)

Table 4 Consent Details

Variable	Frequency
Anaesthesia consent unique domain of anaesthesia	
Yes	181 (75.7%)
No	58(24.3%)
Surgical consent implies anaesthesia consent	
Yes	16(6.7%)
No	223(93.3%)
Postoperative pain control information	
Yes	167 (69.9%)
No	72 (30.1%)

Discussion

Consent once obtained from a patient remains valid for an indefinite period, but if there is a change in patient condition or proposed intervention a fresh consent will be needed.[2] Consent should always be confirmed at the time of surgery, if obtained earlier preferably prior to administration of anaesthesia.[2] In our study anaesthesia consent was obtained on the previous day by 75% of the respondents but consent was cross checked by the majority of respondents (81%) prior to anaesthetising patients. AAGBI (Association of Anaesthetists of Great Britain and Ireland) in their revised guidelines state that information about anaesthesia and its associated risks should be given early to patients, preferably as a leaflet or evidence based online resource. These can be kept for reference and queries asked after perusal of these material to the anaesthesiologist[3]. Consent for anesthesia had earlier been considered as "implied" since once the patient consents to surgery, the need for anaesthesia and associated risks come as part and parcel of surgery. But these consents are taken by surgeons before the patient gets to meet an anesthesiologist. A surgeon cannot discuss nor answer questions regarding the risks, benefits, and alternatives of various anaesthesia techniques. These can only be adequately explained by ananaesthesia provider. Moreover there is an increasing need for monitored anesthesia care for the young, claustrophobic, or developmentally delayed individuals for nonsurgical procedures in outpatient settings and using a surgical consent is unnecessary in such situations.[4] The practice of adding a note with the surgical consent and taking that as the anaesthesia consent is continued to be practiced only in government hospitals both teaching and non teaching. These respondents, would prefer it should be changed to a separate anaesthesia consent form according to their suggestions. In some corporate settings the anaesthesia consent was included as a foot note in the medical record.

Free lancers usually working in corporate or government district hospitals were of more than 20 years' experience. They usually had no anaesthesia plan formulated and anesthesia consent was obtained by nurses.

In response to our question whether obtaining the anaesthesia consent is anunique domain of the anaesthesiologist 24 % had dissented. These respondents were found to use nurses or surgeons to obtain anaesthesia consent.

The anaesthesiologist must ensure that consent is always given due importance, and legal formalities completed prior to providing services. In the event of a mishap these are the usual omissions and mistakes seen:

- Consent is not takenas procedure was considered trivial
- Despite patient being a competent adult, consent of relative is taken
- Consenting person is minor, intoxicated or of unsound mind
- Consent is not procedure specific and not renewed for a fresh procedure
- Consent for blood transfusion is not obtained.
- All necessary information regarding procedure is not given and not documented even if given verbally
- Alterations or additions are made in the consent form after obtaining patient consent signature
- Consent lacks the signature of a witness and concerned doctor.[5]

In the present era of medicine and surgery consent is of utmost importance. Practitioners should be proficient in explaining the consent in detail in the patients mother tongue and answer all the questions arising regarding the procedure and its attendant risks and complications. Patients and relatives should be given information with regard to their individual circumstances, education, ability to comprehend, sociocultural and economic background, comorbidities and patient wishes

Anaesthesiologists who initially encounter patients and relatives only on the first preoperative visit or on emergency tables should try to establish a rapport with them prior to explaining the consent to them especially in high risk cases. Counselling patients for anaesthesia in potentially stressful situations and taking their consent requires a sensitive approach and good communication skills from those involved. With a separate consent for anesthesia, adequacy of the informed consent process improves. Patients were better informed about the nature, purpose of anesthesia and side effects when a separate anesthesia-specific consent form was used.[6] A general well-designed printed anesthesia consent form written in the commonly spoken regional language incorporating common as well as rare complications of anesthesia has advantage of saving time. As the same consent may not be sufficient for every patient or situation having free space to document extra points will be ideal.[4]

In an ASA newsletter of 2007, from a medicolegal liability stand, anesthesia should have a separate consent.[7] A recent survey on anaesthesiologists' reactions to implementation of laws suggested that setting of medico-legal cell, regular interaction with legal experts and uniformity at national level with ISA taking a lead in these issues is needed.[8]

The process of informing patients regarding the options available to them, answering their queries and spending more time with them helps in establishing a rapport with the patient. This behavior may reduce the spectrum of litigation haunting us in the present practice scenario.[9]

Capacity for surgical consent may be inadequate for consent to anesthesia because anesthesia involves more abstract concepts requiring a higher cognitive state than surgery, thus requiring a higher state of cognitive capacity for understanding.[10]

Communication training in residency period with patients and in principles of informed consent is needed.[11]

The limitation of our survey was that we distributed our questionnaire only in conferences limited to south India and a national picture regarding informed consent could not be obtained

Conclusion

We conducted this survey to understand the general trend and importance regarding consent among anaesthesiologists. Due importance is being given to a separate anaesthesia consent which is usually explained the day prior to the procedure. A separate anaesthesia consent taken by the attending anaesthesiologist after explaining the pros and cons of different anaesthesia techniques is the need of the hour. So an anesthesia specific consent form will help to educate the patient about nature and purpose of anaesthesia, side effects and complications

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References

1. Indian Contract Act, Sec 13; 1872. Available from: http://www.indianlawcases.com/Act-Indian.Contract.Act,1872.-2386
2. Anderson OA, Wearne IM. Informed consent for elective surgery - what is best practice? J R Soc Med 2007;100:97-100.doi: 10.1258/jrsm.100.2.97
3. Yentis SM, Hartle AJ, Barker IR, Barker P, Bogod DG, Clutton-Brock TH, et al. AAGBI: Consent for anaesthesia 2017: Association of anaesthetists of great Britain and Ireland. Anaesthesia 2017;72:93-105. URL:http://onlinelibrary.wiley.com/doi/10.1111/anae.13762/full
4. Singh TSS. Is it time to separate consent for anesthesia from consent for surgery? Journal of Anaesthesiology, Clinical Pharmacology. 2017;33(1):112-113. DOI: 10.4103/0970-9185.202206
5. Kumar A, Mullick P, Prakash S, Bharadwaj A. Consent and the Indian medical practitioner. Indian J Anaesth 2015;59:695-700 DOI: 10.4103/0019-5049.169989
6. Rampersad K, Chen D, Hariharan S. Efficacy of a separate informed consent for anesthesia services: A prospective study from the Caribbean. J Anaesthesiol Clin Pharmacol 2016;32: 18-24 DOI:10.4103/0970-9185.173364
7. Sanford SR. Informed consent: The verdict is in. ASA Newsl. 2006;70:15–6
8. Momin SG. Survey of anaesthesiologists' reactions to implementation of laws related to anaesthesia practice. Indian J Anaesth 2015;59:103-9doi: 10.4103/0019-5049.151374
9. Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. JAMA. 1997;277:553–9.
10. Marcucci C, Seagull FJ, Loreck D, Bourke DL, Sandson NB. Capacity to give surgical consent does not imply capacity to give anesthesia consent: Implications for anesthesiologists. Anesth Analg 2010;110:596-600.doi: 10.1213/ANE.0b013e3181c7eb12.
11. Yaddanapudi S. Not just a separate consent for anesthesia!. J Anaesthesiol Clin Pharmacol 2017;33:1-2doi: 10.4103/joacp.JOACP_364_16.