

What should I tell my patient? Disclosure in anaesthesiology: difficulties, requirements, guidelines and suggestions

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South African anaesthesiologists have embraced the requirement for authentic informed consent, but there is no consensus regarding the comprehensiveness and specificity requirements with regard to the information that needs to be supplied to the patient, and upon which decisions will be based. Anaesthesiology is an unusual specialty. The scope of knowledge and expertise that practitioners require is wide-ranging, from the basic and applied biomedical sciences and technology, clinical knowledge and experience, through to hands-on operating room experience and expertise, feeding into the requirement to inform. Contemporary practice environments limit contact time with patients. Societal ethos demands recognition of basic human rights, amongst others the right to personal autonomy. The South African Health Professions Council has published a series of booklets describing guidelines to ethical medical practice, one of which is on informed consent. This article discusses the information requirements for valid informed consent from both a moral and regulatory perspective. The practical implications for anaesthesiologists of the HPCSA guidelines on informed consent are discussed, a model interview is proposed, and a number of illustrative cases are discussed. The aim is to answer the question: What should I as an anaesthesiologist tell my patient?

Keywords: disclosure standards, informed consent in anaesthesiology, moral requirements of informed consent, patient autonomy, regulatory requirements for informed consent

Introduction

South African anaesthesiologists face unique difficulties in determining the quantum and extent of the information they are obliged to provide to their patients during the informed consent (IC) negotiation. There are several reasons:

- (1) Anaesthesiology is a unique specialty. Contemporary practice requires:
 - wide-ranging clinical acumen and expertise;
 - extensive knowledge of human physiology, pathophysiology and clinical pharmacology;
 - experience of surgical procedures and surgeons in order to provide the best operative conditions, appropriate monitoring, blood management and postoperative care;
 - the ability to collate a wide range of knowledge, technical skills and technology with the unique needs of each patient;
 - management of the sometimes unpredictable demands of the operating theatre (OT) and perioperative developments.

This feeds into what may be expected of them to disclose. Anaesthesiologists are usually not first-line treating physicians unless they run pain clinics or intensive care units. They provide clinical services at the request of surgeons when decisions to operate under some form of anaesthesia have already been made. Generic consent for *an* anaesthetic may appear to be implicit but needs to be confirmed. As explained later, implied consent is *never* regarded as valid in any patient–professional interactions. Specific consent for the *type* of anaesthesia to be administered and associated interventions needs to be sought. The choice of anaesthetic is usually limited to regional or neuraxial block with or without sedation, or general anaesthesia.

Realistic treatment choices for patients are limited. Anaesthesiologists may be required to impart additional information that is highly technical and difficult to understand, yet, fortunately rarely of such a nature that patients refuse anaesthesia (and surgery).

- (2) The social and professional environment within which we practise has changed. Society demands adherence to a culture of human and constitutional rights. Economic and financial constraints and managed healthcare have enforced the migration of patients from inpatient wards to outpatient settings. Outpatients are often admitted shortly before surgery, and many inpatients on the day of surgery. Anaesthesiologists typically work in multiple clinics and hospitals and are frequently under pressure to start lists on time. This limits the time available for a meaningful discussion that forms part of the consent process. Pre-anaesthetic clinics and telephone consultations can be employed but have their limitations.
- (3) Patients have access to other sources of information such as the media and Internet, and are often better informed than formerly. This may benefit both doctor and patient since it can raise the level of the discussion. However, not all texts and websites provide unbiased, scientifically correct information. Patients may have become misinformed by their interpretations of a particular text, TV programme or IC encounter. The result is that patients may be more demanding during the IC interview requiring more of that rare commodity: our time.
- (4) The transmission of information is an active process as opposed to the passive model formerly described by the

container-conduit metaphor of transfer.¹ This metaphor implied that informing is as simple as pouring fluid from one vessel to another. Patients as recipients of information need time to unpack and process what they read or hear from the anaesthesiologist. They need to make sense thereof by relating new information to their unique frames of reference. Only then are they able to respond and ask questions. This process may take time.

(5) Finally, the anaesthesiologist has to satisfy multiple standards of disclosure:

- In the landmark Salgo case of paraplegia following translumbar aortography, the court held that:

A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by a patient to a proposed treatment.²

This judgement established the principle of IC in United States law, introduced the notion of materiality and defined it.

- The *reasonable doctor* or professional standard was established in *Natanson v. Kline*.³ Ms Natanson developed skin burns after radiotherapy treatment for breast cancer, and the judgement stated that Dr Kline as a professional should have known of this possibility, should have judged it material and should have informed the patient.
- The *reasonable patient* standard evolved in *Canterbury v. Spence*. Mr Canterbury developed quadriplegia after cervical laminectomy.⁴ The judgment held that any reasonable person undergoing this type of surgery would have wanted to know of this complication before consenting to the procedure. The reasonable patient standard has also been accepted in South African case law.⁵
- The anaesthesiologist should, finally, in the limited time available try and assess what the particular patient would like to know, based on her/his own unique world view, experience and attitudes. This so-called 'subjective standard' is promoted by the Health Professions Council of SA (HPCSA) guidelines (Booklet 4)⁶ and SA National Health Act, Act 61 of 2003 (NHA).⁷
- While making these judgements, the anaesthesiologist must also satisfy the full scope of the *legal and regulatory demands* of IC as promulgated in the NHA, in the National Patients' Rights Charter⁸ and in HPCSA Booklet 4. These are the requirements against which the anaesthesiologist will be judged when complaints are made.

South African data are not available, but data from the USA indicate that lack of IC forms the sole basis of malpractice litigation in less than 1% of instances.⁹ However, when patients sue for negligence, an allegation of improper or inadequate IC is often added to the claim to support the alleged deviation from the required standard of care.

Given the above, what can and should I tell my patient? This should be considered from two perspectives: from a moral and from a legal/regulatory point of view.

Moral requirements

The moral dictate to obtain IC is universal, namely that we should respect patients as autonomous human beings empowered,

capable and entitled to make decisions concerning matters that affect their bodies and lives. The limitations to individual autonomy are that it should not impact negatively on other persons' lives, and should be legal and reasonable, depending on circumstances.

Respect for personal autonomy is summed up in a beautiful passage written by a doyen of British philosophy, Isaiah Berlin:¹⁰

I wish my life and decisions to depend on myself, not on external forces of whatever kind. I wish to be the instrument of my own, not other men's act of will. I wish to be a subject, not an object; to be moved by reasons, by conscious purposes which are my own, not by causes which affect me, as it were, from outside. I wish to be somebody, not nobody—a doer, deciding, not being decided for, self-directed and not acted upon by external nature or by other men.

The moral dictate regarding IC assigns no purpose to respect for autonomy and leaves open the questions of explicitness and comprehensiveness of informing. However, ethics is an aspirational endeavour, meaning that there may be no limit to what may be required of us if the end is not to tick a box but to ensure and promote patient autonomy. It is paramount that our patients have a sufficient understanding of what they are subjecting themselves to when granting consent; consent to medical treatment is *always* informed consent.

Disclosure and the understanding of all relevant information are central to the popular three-tier cascade 'paradigm' model of informed consent:¹¹ ascertaining subject competence to provide consent, adequate disclosure and freely given, un-coerced, i.e. informed, consent. A secondary 'paradigm' informs current conceptions of the power relationships that operate in the normal doctor-patient interaction.¹ This model describes the knowledge asymmetry between patient and professional as the root cause of a concomitant power differential. Consequently, patient autonomy is negated in favour of some form of paternalism. The remedy, goes the argument, is to recover the equilibrium of the relation by providing sufficient contextual information. Unfortunately to do this authentically and not just in name implies high and probably impossible demands regarding the explicitness and comprehensiveness of disclosure.¹ The question is to what extent we actually promote autonomy in the usual doctor-patient IC interaction if we accept that comprehensive and explicit disclosure is necessary, yet impossible. It may be contra-productive to focus too much of our attention on this conundrum. Even if we cannot totally level the knowledge-power playing fields, we do promote patient autonomy to the extent that is possible; and perhaps that is sufficient.¹² Beauchamp suggests that we may have placed the bar too high in expecting such high standards regarding information transfer and patient understanding. These expectations emanate from theorists and bioethicists, not practising doctors or patients. Patients can be *sufficiently* albeit not explicitly and comprehensively informed leading to *adequate autonomy*.¹² These high expectations should be replaced by a more realistic understanding of how patients internalise information. Besides, such high expectations in terms of disclosure are out of keeping with our normal, non-medical lives, e.g. when discussing repairs to a motor car or appliance. This is how we negotiate and conduct our lives in general. It can thus be argued that realistic IC *always* implies a limited, contextual waiver of information and perhaps even a measure of paternalism.¹ Both of these signal the level of trust that patients

invariably place in their physicians. Of course, we need to balance these ideas and limitations with the legal and regulatory demands of IC against which we are judged and which I discuss below.

Regulatory requirements

Consent in medical interactions is always *informed consent*, meaning specific consent after having been duly informed as required by the HPCSA Guidelines. Lawful, authentic consent can only exist where the consenting party knows and understands what is being consented to.¹³ There is general agreement in most legislations regarding regulatory and legal determinants of IC, but these have to be adapted to local guidelines, regulations and laws. For example, in 23 American states the professional standard of disclosure is practised (i.e. doctors collectively determine what should be disclosed).⁸ Australian courts favour a patient-centred ('reasonable patient') approach.¹⁴ An Australian High Court has determined that all material information should be disclosed, defined as information that may influence choices and decisions regarding treatment.¹⁵ In the UK, the General Medical Council (GMC) promotes a patient-centred, shared decision-making/partnership model. The GMC guidelines are similar to those in South Africa, particularly lucid and worth reading.¹⁶ Patients prefer this decision-making model compared with, for example, having to decide on their own, or the anaesthesiologist paternalistically deciding for them.¹⁷

The HPCSA booklets on ethical conduct have the general title 'Guidelines for Good Clinical Practice in the Healthcare Professions'. Guidelines normally have a somewhat lower hierarchical status than laws in that they are not normally legally enforceable. Regulations are the mechanisms through which laws are made to function in practice. The preamble to Booklet 4, which deals with IC, as well as to each of the ethical guideline booklets contains the following passage (emphasis added):

In essence, the practice of healthcare professions is a moral enterprise. In this spirit, the HPCSA presents the following ethical guidelines to guide and direct the practice of healthcare practitioners. *These guidelines form an integral part of the standards of professional conduct against which a complaint of professional misconduct will be evaluated.*

Thus it is clear that these guidelines are enforceable to the extent that they form part of the HPCSA standards of care. Professionals should therefore ensure that they read, understand and comply with these guidelines. The booklets are available for download from the HPCSA website.¹⁸ Professionals may be negligent if they do not comply with these principles. For negligence in clinical actions to be proven, four elements must be met:

- presence of a duty—to meet a standard of care;
- breach of duty—standard not met;
- causation—failure to meet the standard was the foreseeable immediate cause of injury;
- proof of damage—actual damage/injury occurred.

Negligence relating to the informed consent process may be deemed to occur if the anaesthesiologist provides a disclosure that is insufficient to allow a patient to make an informed decision and an injury subsequently occurs, even if the injury was foreseeable and a treatment error did not take place.⁹

In the ensuing discussion of the HPCSA guidelines, I shall integrate the relevant legal (NHA) requirements because they are fully incorporated into the HPCSA guidelines, and discuss the two as one.

HPCSA guidelines on IC

Booklet 4 outlines the HPCSA guidelines on IC. In response to the question 'What should I (as an anaesthesiologist) tell my patient?' it behoves us to examine these guidelines, concentrating on what is relevant for anaesthesiologists. The principles are presented in bullet form below, with a reference to the relevant section in parentheses, and appropriate comments/notes in italics:

Providing sufficient information

- To start off, be clear about the scope of consent being sought (3.1.5). *Consent is sought for the anaesthetic and all anaesthesia-related procedures and interventions. The validity of consent is limited to what has been disclosed to and understood by the patient, subject to the patient's preferences. Consider the possibility of perioperative events or complications which may require further or additional interventions not covered above. Discuss these as far as possible, particularly if these events/interventions are likely or profound in nature. (3.1.7) There is a self-evident limit to what can reasonably be discussed.*
- A right to be informed: Patients have a right to be informed (3.1.1). *Conceptually, rights can only be realistic, i.e. enforceable, if there are identifiable parties or entities that have corresponding obligations to honour those rights. The patient has a right to information, and according to the guidelines there rests on those who treat her/him a corresponding obligation to inform. Informing prior to consent should be seen in this light.*
- Standards of disclosure (3.1.1, 3.1.2): The guidelines promote three standards of disclosure either directly or implicitly. First, the *subjective standard*, determined by 'the patient's own wishes' (3.1.4). But, second, there are also self-evident *objective regulatory* standards of disclosure to be met. Thus the guidelines state that the quantum of information required will vary 'depending on factors such as
 - the nature of the condition,
 - the complexity of the treatment (or procedure),
 - the risks associated with the treatment or procedure.'

Then there is a third standard. Because procedures that have a high failure rate or risk of morbidity will require more detailed information, and since the doctor is the gatekeeper to this type of information, the implication is that the professional standard of disclosure also applies. (3.1.1)

- The content of disclosure: The NHA details the extent of information to be disclosed. This section of the NHA is carried over to and is endorsed by Booklet 4 thereby forming an important section of the HPCSA guidelines and practice standards (3.1.1). Included are the following:
 - the patient's 'right to be informed of her health status' (3.1.3) *inasmuch as it would influence proposals regarding the choice of anaesthesia, the probability of risks and complications, and necessitate further preoperative and/or postoperative treatments, e.g. intensive care. The anaesthesiologist may make a new diagnosis, e.g. a heart murmur in*

a child, or hypertension, and this has to be dealt with separately;

- the range of available treatment options (3.1.3.3, 3.1.2.2), *i.e. anaesthetic options, inasmuch as they are realistic options; e.g. general vs. regional vs. neuraxial vs. infiltration, with or without sedation. It is normally unnecessary to discuss specific medications or drugs to be administered, unless an agent has specific morbidity and there are alternative options, e.g. suxamethonium vs. rocuronium/sugammadex. Electing an appropriate airway management strategy is a professional decision, therefore the various options need not be discussed, though the patient should be informed of which option is appropriate, and of the implications of that option, and consent thereto;*
- the 'benefits, risks, costs and consequences generally associated with each option' (3.1.3.5), *i.e. a risk-benefit assessment of each option that realistically applies and that can aid the patient's choice. Note the choice of the word 'generally', i.e. usually, normally, commonly, mostly. The implication is that exotic consequences need only be discussed if they are serious;*
- the patient's 'right to refuse treatment' (3.1.2.4). *In anaesthesia, this relates to refusal to accept a specific proposal, in which case the consequences of such refusal should be explained (see also cases 2.4 and 2.5 below);*
- the purposes and details of proposed procedures (3.1.3.4), *e.g. arterial and central lines;*
- details of subsidiary treatments like pain relief (3.1.3.4), *e.g. intermittent oral and/or intramuscular analgesics vs. patient-controlled analgesia or epidural analgesia;*
- details of what might be experienced by the patient including all serious and common complications (3.1.3.4, 3.1.3.5). *The guidelines do not define or quantify 'serious' or 'common' but note that legal opinions refer to 'material risks' defined as either what reasonably prudent persons are likely to want to know⁸ or what would induce them to decide against a particular option¹⁵ (3.3.2). If unsure, err on the safe side. The courts will accept the testimony of experts and/or make up their own minds in this regard. The anaesthesiologist should be careful of accepting a refusal to be informed about serious and/or likely morbidity. She/he should also have knowledge of the long list of possible complications, have an idea of incidence and prevalence, and should be able to relate this in an understandable way to the patient, as is deemed appropriate (see discussion, Cases 2.4, 2.5 and 2.7, below). Note also that neither a waiver to be informed nor any information supplied or consent by the patient can absolve the anaesthesiologist from culpability of any illegal actions, negligence or actions contrary to standards of care as generally accepted, or conflicting with the ethical guidelines as described in the HPCSA booklets.*
- If there are treatment options, each should be fully detailed to promote informed choice (3.1.2.2, 3.1.3.3), and
- details of normal monitoring and reassessment with respect to possible morbidity should be supplied (3.1.3.7).
- Patients should be given details of the treatment team and the role of each member of the team (3.1.3.8) and the extent of student involvement, if any (3.1.3.9). *Patients have a right to be treated by a 'named' professional. Consent*

for physical student involvement purely for training purposes should be obtained separately.¹⁹

- Full details of fees and costs should be supplied (3.1.3.12) (see also case 2.6 below).
- Waiving the right to be informed: 3.1.1 reiterates the patient's right to be informed and that 'the amount of information that must be given to each patient will vary according to' amongst others, 'the patient's own wishes'. *The implication is that the patient may waive the right to be informed to the extent that he or she wishes. However, 3.1.2 expressly requires treating physicians to provide a range of information. This apparent conflict presents a conundrum to the physician; clearly, both cannot simultaneously be complied with. See case 2.1 below for further clarification, and the discussion immediately below.*
- 3.1.4: 'When providing information, health care practitioners must do their best to find out about patients' individual needs and priorities.' *The GMC guidelines more explicitly warn against making assumptions about what patients may know or want/need to know, the clinical and other factors a patient might find significant, and the patient's knowledge and understanding of a proposed treatment.¹⁶*

Responding to questions

- Opportunity to ask questions and detailed responses should be provided (3.2). Patients may on occasion ask difficult questions such as 'whether any of the risks or benefits of treatment are affected by the choice of institution or doctor providing the care'. *This is unlikely to be the case due to anaesthesia alone, provided the anaesthesiologist is appropriately experienced. However, inter-institutional morbidity and mortality figures may vary with more complex surgery. Where appropriate, patients may be entitled to this information, and members of the treatment team should be able to provide data in a comprehensible way.*

Withholding information

Healthcare practitioners should not withhold information necessary for decision-making unless they judge that disclosure of some relevant information would cause the patient serious harm (3.3.1). *It is unlikely that any anaesthesia-related information will ever cause 'serious harm' and should not for this reason be withheld. However, the extent of information provided is determined by the individual patient. Note also the earlier discussion of waivers of consent and the materiality of information.*

Presenting information to patients

- Appropriate aids should be used, and the discussion should be in an understandable language using an interpreter if required, at a level commensurate with the patient's level of understanding (3.4.2). *Qualified interpreters should be provided by the institute. Patients prefer a verbal interaction to a written information sheet.¹⁷ Videos of, e.g., central line insertions or epidural procedures may be helpful.*

- The presence of a relative or friend is advised (3.4.2.3). *Patients often forget details of what has been discussed.*
- *The patient, not the anaesthesiologist, is to decide what is in her/his best interests, but can only do this with appropriate information understood appropriately. At times it may be prudent to assess understanding by asking a few pointed questions based on the discussion.*
- Consent should be voluntary and un-coerced (3.4.2.9). *Duress, coercion or undue influence to make a particular choice, even if clinically more appropriate, may invalidate consent.*

Who obtains consent?

- The healthcare professional who will provide the treatment is tasked with obtaining consent. This may be delegated to a sufficiently experienced and trained colleague. However, the actual service provider accepts responsibility for the authenticity of consent.

The right of patients to information

- 'Patients have a right to information about the healthcare services available to them, presented in a way that is easy to follow and use' (5.1). *See also the earlier discussion on standards of disclosure and the materiality requirement.*

Ensuring voluntary decision-making

- Respect for patients' autonomy implies that patients need to decide what is in their best interests, irrespective of suggestions and advice from their doctors. As has been discussed earlier, the actual scope of what the patient can realistically decide upon is limited in anaesthesia, yet should be respected as far as possible.

Children 8.5 quotes section 129(3) of the Children's Act (Act No. 38 of 2005):

- A child who is 12 years of age is legally competent to consent to a surgical operation if the child is of sufficient maturity, has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation, and is duly assisted by his or her parent or guardian.

Children can be surprisingly mature and should be involved in any discussion regarding them; children below the age of 12 also have a right to be informed in a way they can internalise, and should provide assent, even if the HPCSA guidelines makes no provision for their assent. Parental consent supersedes a child's assent provided it is in the child's best interests.

Section 14 warns that implied consent is invalid.

Finally, a note on written consent: in the present litigious societal ethos and given the profound nature of anaesthesia, written consent should always be obtained. A pre-printed information leaflet and consent form may be used, but space should be left for notes or options to be deleted/encircled to confirm that a meaningful contextual discussion actually took place.¹¹ Leaflets should not be too voluminous, and the content should be briefly discussed with the patient to assess comprehension. Fine print and a form stuffed in the hand of an anxious patient do not equate to meaningful IC, and will not be so judged. Litigation or

HPCSA complaints may take years to finalise and it is both inappropriate to rely on one's memory, and difficult to convince of the details of a discussion without a written record.

See also South African Society of Anaesthesiologists (SASA) Practice Guidelines 2012: Part 2:5: Consent and explanation, available on their website (http://129.232.161.218:40003/Document/SASA%20Practice%20Guidelines%202012%20Revision_636052813331828299.pdf)

Conclusion

The migration of patients to day-care facilities and admission on day of surgery limit the time available for fruitful interaction between patient and anaesthesiologist. It is nevertheless important that we dedicate the little time available to the subject of our interaction; a patient-centred approach goes a long way to ensuring that the interests of the patient predominate.

Addendum

(1) Example of a proposed IC discussion

- Introduce yourself and explain your role as a member of the team. Consider shaking hands with the patient and spouse/parents to promote a sense of your personal involvement to build personal rapport. Mention that you will be present in the operating room at all times during the procedure and will monitor (take care of) the patient constantly, using all the available technology as indicated. Although this falls outside of your responsibility, ask the patient what procedure is envisaged. This has the risk of being drawn into a lengthy discussion; patients often claim not to be sure of the details. If this is true, it is disconcerting what patients will consent to apparently without understanding the content of their consent. This may be indicative of the level of trust that patients place in their doctors.
- Explain why a preoperative assessment is important, elicit an appropriate history and do an appropriate physical examination after getting verbal consent; this can be done in a very informal way ('I need to examine your heart and lungs, is that OK?'). Avail yourself of the results of side room and special investigations, and request new tests as indicated, and explain why you are doing it (touching a person without explicit consent may be deemed as assault).
- Once you have all the information you require, discuss salient points in the patient's history and examination, and the proposed anaesthetic management. Start off by explaining that there are moral, legal and regulatory requirements for you to inform the patient, but that you need guidance to understand to what extent the patient wants to be informed regarding the anaesthesia and risks: just the basics including likely complications/risks/side effects, or a full explanation of all risks, or somewhere in between. Balance this with the requirements discussed above.
- It is appropriate to detail everything that will be experienced up to the point of losing consciousness under a GA, e.g. premedication, transport, holding area, something about the OT and recovery environment, connection of monitors, putting up an infusion, pre-oxygenation, the induction process. Patients

usually want to know about the envisaged duration of anaesthesia and the process of recovery. Explain how the depth of anaesthesia is monitored and ask if the patient requires more information about the period of unconsciousness. Airway management should always be discussed to the extent that the patient requires, as well as the rationale and implications of any additional monitoring that may be or may become necessary (e.g. central and arterial lines), and consent obtained therefor. Any specifically expected difficulties should be discussed, such as the difficult airway. Information that the anaesthesiologist deems essential to the patient may override the latter's choice of minimal information, and a sincere attempt should be made to impart such information without alarming the patient.

- A short explanation of what might be expected postoperatively is appropriate: sore throat, nausea and vomiting, pain and its management, postoperative care from the anaesthetic point of view, including pain management, and when a return to normal activity can be expected. Alternatively, if not yet done, a question concerning the required level of information on risks and complications can be added here: 'I've told you about the usual side effects you can expect, but you are no doubt aware that anaesthesia carries many other risks and complications, some of which we can't predict and some of which can have serious consequences. Would you like me to tell you about them?' It is also helpful and reassuring to explain the association between pre-existent morbidity and intra- and postoperative morbidity and complications. In the absence of pre-existent morbidity it is desirable to emphasise that complications are unlikely. You may want/need to provide simplified incidence data, relating statistics to references from our normal lives. A useful example is Calman's verbal scale, using descriptions like:
 - *very high* where risk > 1:10, as in postoperative nausea and vomiting or sore throat;
 - moderate when risk prevalence is 1:100–999: e.g. awareness without pain;
 - very low, prevalence of 1:10 000–99 999: e.g. anaphylaxis;
 - and negligible, incidence of 1:1 000 000–9 999 999: e.g. spontaneous epidural haematoma.

To these, Jenkins and Barker have added community groupings, i.e. relating the probability of an event to, e.g., respectively, siblings (incidence of 1:3), street (1:20), small town (1:5000), city (1:500 000).¹⁵

- I use a detailed information and consent form that mentions most of the serious complications, and always specifically ask patients if they have read and understood the information, make additional notes as appropriate and sign/date the form to confirm that a discussion has taken place.
- Choices: if and when choices exist, these have to be detailed in terms of the 'benefits, risks, costs and consequences generally associated with each option', followed by an honest and sincere recommendation. Explain why you make a particular recommendation and the implications of not consenting to a proposed course. Options should be discussed even if you have already decided on a particular route if the options are realistic; the patient may have different preferences.
- Finally, do not omit a discussion of the fees you intend charging for your services.

In the next section I analyse a number of typical cases, both fictional and real, in order to develop some of the thoughts expressed above.

(2) Case analyses

- 2.1 **'Please, don't tell me anything, just put me out!':** The patient is a 70-year-old male and the proposed procedure is correction of bilateral ectropion with skin grafting. The patient refuses any discussion because of anxiety and says he suffers from claustrophobia. He allows the anaesthesiologist to examine him physically and is quite fit apart from reasonably controlled hypertension. He refuses to entertain the proposal of local anaesthesia plus sedation.

This is a relatively common scenario and illustrates three issues:

- the right of the patient to limit the information he or she requires;
- the patient's right to make a choice not advised by the anaesthesiologist; and
- the anaesthesiologist's double conundrum:
 - (i) trying to satisfy both the guidelines discussed here and the patient's right to limit the information required; and
 - (ii) having to provide treatment not in accordance with professional advice.

Patients quite commonly limit the discussion they are prepared or are able to undertake. All patients are anxious and vulnerable, and forcing information on them is as much a psychological assault as doing surgery without consent is a physical assault. But the difference is that the patient makes the decision to exercise his/her free and autonomous will to waive his/her right to be informed. This should be respected with some provisos: this cannot legitimise illegal, unethical, experimental or highly risky procedures. Care should also be taken to affirm the patient's competence and choice and that he/she understands the implications of this choice. Comprehensive notes should be kept. Since full and explicit informing is hardly ever possible, one may argue that a limited and contextual waiver is built into every instance of IC.¹² However, information of a profound nature (e.g. a significant risk of mortality) should at least be imparted to a relative if the patient remains steadfast. The second conundrum is discussed in Case 2.4, below.

- 2.2 **'You didn't tell me my lung is going to collapse!':** Your patient is a 60-year-old male who undergoes a radical prostatectomy. You consider that a central venous line is routine for this procedure and do not inform your patient accordingly. You have some difficulty in locating the internal jugular vein, but at the third attempt you succeed. The operation proceeds uneventfully, but in recovery the patient is clearly uncomfortable. You eventually call for a mobile chest X-ray, to find a significant right-sided pneumothorax that requires underwater drainage. The patient recovers well, and six weeks later you get a letter from his legal representative who accuses you of not informing him that a CV line was to be inserted, or of the associated morbidity.

The NHA/HPCSA guidelines require you to discuss treatment options including the 'benefits, risks costs and consequences generally associated with each option', the purposes and details of proposed procedures, details of subsidiary treatments, details of what might be experienced by the patient including all serious and common complications, and details of monitoring with regard to possible complications (3.1.2, 3.1.3). The patient is entitled to be aggrieved since you did not honour these practice standard requirements and are technically guilty of assault. A subsidiary question arises about the use of aids like ultrasound.

2.3 'I can't open his mouth!': You are a registrar at a tertiary hospital and your patient is a frequent client of the hospital's trauma unit. This time he has a compound fracture of his tibia and fibula requiring emergency debridement and suturing under a general anaesthetic. You rush from just finishing an emergency Caesarean section. The orthopaedic registrar says the patient is 'A-OK' but ate a pie after his accident. Apart from a quick stethoscope on the chest you do not examine him but plan a rapid sequence induction. After the suxamethonium fasciculations subside you attempt an intubation—only, to your horror, to find his jaws to be wired. It later turns out that his last visit 10 days prior was for a mandible fracture.

A similar incident happened to a colleague when I was in training and I use this to illustrate just one point: No attempt was made to obtain informed consent, and thus a golden opportunity was missed.

2.4 'You're not going to stick a needle into my eye, I want to sleep!': Your patient is a 68-year-old female with severe chronic obstructive airways disease who refuses to have cataract surgery done under an eye block and sedation.

Your responsibility is to ensure that she is aware of and understands the reasons why you propose the latter: that a general anaesthetic exposes her to significant risks and that she may require postoperative ventilation and intensive care with attendant risks, more prolonged hospital stay and additional costs. If she remains adamant you have two options: accede to her request or, if you consider the attendant general anaesthesia risks too daunting, explain that you are not prepared to put her well-being at risk and decline to be involved. This would not constitute abandonment in the absence of an emergency, though it would make you unpopular with your surgeon.

2.5 'You didn't tell us that this could happen!': You anaesthetised a 28-year-old provincial rugby player who required an endoscopic repair of a rotator cuff injury. The operation was performed in a beach-chair position with mild hypotension. Postoperatively the patient has marked cognitive impairment. His girlfriend was present at the preoperative interview and accuses you of not highlighting this risk.

This case highlights two points; first that no level of informed consent can justify procedures exceeding the bounds of the standard of care in a given situation. Second, the question of what would be material for a patient to know. It is likely that any reasonable (prudent) person in the patient's situation would have wanted to know that hypo-perfusion brain damage is a distinct risk in the beach-chair position, particularly when combined with controlled hypotension. You should also have known this and have informed the patient. (Note: I deliberately omit reference to the use and limitations of cerebral function monitors.)

2.6 'Your fee is exorbitant! You didn't tell me you charge contracted out fees!': You are rushed to start an afternoon list and because of time constraints omit to discuss fees with an anxious parent whose child is booked for an outpatient myringotomy. Your bookkeeper applies your usual private fee equating to 1.5 times medical aid tariffs. An irate father calls you and refuses to pay anything above his medical aid tariff, and threatens to report you to the HPCSA. Like so many members of the public, he knows that you have acted unethically by not discussing fees with him.

Complaints regarding professional fees make up a large proportion of complaints of unethical behaviour handled by the HPCSA. Full details of fees and costs should be supplied, and this is one item you should not omit from your list of IC topics. If you use a pre-printed form with, amongst others, details of your fees you should not presume that the patient/responsible person has read and understood it without confirmation of some sort. Discussing money when patients are anxious may seem callous and may make one feel uncomfortable, but it is a defensive habit we should simply acquire.

2.7 'I heard you talking to the surgeon, I couldn't move!': Your patient is a young man who had impacted wisdom teeth removed under GA. As usual, you used a totally intravenous (TIVA) technique combined with non-depolarising relaxants, and did explain this preoperatively, though you omitted the fact that the incidence of awareness may be higher under TIVA plus relaxants, and did not offer an alternative.²⁰ Neither did you mention the possibility of awareness during GA (in one study, 25/19 575 cases or 1–2/1 000, plus 45 possibly aware²¹).

Usually the choice of anaesthetic agents and ancillary drug is left to the professional. However, if there are data that may influence choices by patients if they had been informed, these are material and should be shared with the patient and a shared decision made.

Note: Some of the inferences made above may be controversial but are nevertheless made for the sake of the examples.

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