

EDITORIAL

## Informed consent to anaesthesia

Interest in informed consent to anaesthesia is growing, and directives have been proposed at both Italian national and European levels. Patients must be aware of any risks specific to their particular condition, but anaesthetists are also obliged to inform patients about the anaesthetic procedures to which they will be subjected and the risks of those procedures. The Hippocratic idea of consent is for 'the good of the patient', with its implicit medical paternalism; the idea of informed consent is underpinned by the principle of the autonomy of patients, and thus patients' right to information.

There are published surveys of patients' need for information but not, as far as we are aware, from Italy [1–3]. In a survey approved by our local research ethics committee, we investigated patients' desire for information and their attitudes towards informed consent to general anaesthesia. Our sample was of consecutive eligible patients due to undergo either general or otorhinolaryngoscopic surgery for benign or malignant conditions. We included patients only if they were free of pain before surgery, and were able to read and answer our questions. Before the preoperative visit, patients were given a form containing six questions, designed after reading the literature [1] and from our personal experience. The questions related to the duration of the anaesthesia, the likely nature of the postoperative pain and type of pain relief, details about the anaesthesia and where anaesthesia would be induced, the most common complications of general anaesthesia, where and how they would awaken from general anaesthesia and a question about the nature of artificial breathing during general anaesthesia. Each of these six questions was preceded by four statements: 'I prefer not to know'; 'I would like to know'; 'I have a right to know'; 'I have a right to know but prefer not to know'. All statistical comparisons were

by chi-squared test, taking a probability of  $< 0.05$  as significant.

A total of 107 people (52 women) took part, 24 were undergoing surgery for cancer. Patients were aged 16–83 years (mean 49.5 years, SD 17.7 years; median 49 years, interquartile range 35–65 years).

Over two-thirds answered all six questions by indicating that they had a right to the information or wanted to know the information. The demand for information about pain was particularly high (85%). In general, patients preferred 'I would like to know' to 'I have a right to know', but were more likely to demand the right to know when considering complications and pain. Fewer than one in 20 patients, although slightly more than this for information about types of anaesthesia, chose 'I have a right to know but prefer not to know'.

We took the responses 'I have a right ...' and 'I would like ...' to indicate a wish to know, and this wish was not affected by gender or whether the illness was benign or malignant. Wish to know was, however, consistently affected by age: 90% of those aged less than 35 years wished for information, and this wish was consistent for all six questions; about 55% of those aged more than 65 years wished for information, a wish less consistent across the questions; with the patients aged 35–64 years coming in between. Five patients, whose mean age was 72 years, left all six questions unanswered; four of these patients had had no schooling above the elementary level.

The doctor–patient relationship is changing. Statements from official organizations such as the Parliamentary Assembly of the Council of Europe [4] are expressions of these changes. Doctors are being asked to inform patients and obtain from them a specific consent to every medical act. How these changes evolve will be different in each country and also for each medical and surgical speciality.

The obtaining of informed consent to anaesthesia has some difficulties common to consent to any medical or surgical procedure, i.e. patient autonomy conflicting with the traditional sense of duty, but some

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difficulties that are peculiar to anaesthesiology. Although patients understand that anaesthesia is a necessary prerequisite for surgery, they often have little idea of what anaesthesiologists do. Only 5% of patients realize that anaesthesiologists are responsible for looking after the heart and circulation during an operation [5]. As many as 35% of patients undergoing surgery do not realize that anaesthesiologists are medically trained specialists. Often, during preoperative visits from anaesthesiologists, patients ask questions about the operation or, by their questions or responses, indicate that they have little idea of how intercurrent illnesses could be affected by anaesthesia, could affect the type of anaesthesia necessary or could affect the course or outcome of the surgery itself [6]. Making this information available to patients in a way they understand, information about the patients' general condition and about anaesthetic techniques and monitoring, is therefore very important.

Most of the patients we studied indicated that they 'would like to know' but did not know that they had 'a right to know'. This finding has been reported before [1,2] and taken as deference to doctors' judgement of what is best for patients. For our patients, the belief in a right to know increased for questions about pain and complications after surgery. Perhaps this is not surprising, as these are subjects that directly and consciously affect the patients.

In Italy, as elsewhere [1–3], the desire is growing for information about general anaesthesia for surgery, and this desire is becoming a demand among the younger generations. The increase in patients who wish for or need to be given information, whether interpreted as rational (information to the patient as a part of 'decision making') or as medico-legal (informed consent as protection for anaesthesiologists), emphasizes the changing relationship between doctors and patients and medical procedures, discussed above [7,8].

Internationally, informed consent has recently been defined as a 'transition concept' [9], which, when interpreted radically, does not actually apply to real-life doctor–patient relationships. However, it can be useful as a means of renewing the relationships and shared values of doctors and patients.

In Italy, there are socio-political and cultural reasons why the 'Latin world is more comfortable with an ethic that is not centred on the autonomous individual and

the defence of that individual's rights but rather on taking care of each other as a primordial structure of human existence' (translated from Ref. 10). Thus, the purely rational idea of informed consent, which emphasizes the patient as an agent making rational decisions about the medical act, comes up against a network of values still rooted in medical practice in Italy. This risks a loss of motivation in the doctors and a loss of faith on the part of the patients. Other societies may also suffer these losses, and ethicists who make pronouncements remote from the actual practice of medicine must be cautious.

For anaesthesiologists, it is important to remember the difficulties for patients trying to get their bearings in a highly specialized medical field and for us to understand the state of mind of patients at the preoperative visit. Patients want a satisfying doctor–patient relationship, from both the professional and the human perspective, that will give them adequate psychological support more than a defensive stance about their rights in the choice of anaesthesia. A need for reassurance is suggested by reports, for example, that 37–55% of patients had a fear of not waking up, and 69% of patients expressed the desire 'not to see or hear anything' [5,11]. Consistently, patients awaiting surgical intervention are very anxious [3].

Perhaps one way to advance the idea of informed consent is to allow space and time for reciprocal communication between doctors and patients, in which both parties speak and both parties listen. The main objective is not to make the patient express a rational decision, even less to protect the doctor from accusations of malpractice. The main objective is rather to lay the foundations of renewed trust in the doctor, not just because 'doctor knows best', but by making complete, understandable, information available to the patient and by creating a space in which the doctor can listen to the patient and hear their point of view on the medical procedures that they are about to undergo and on the choices that still remain open to them.

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