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Guidelines

AAGBI: Consent for anaesthesia 2017

Association of Anaesthetists of Great Britain and Ireland

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Summary

Previous guidelines on consent for anaesthesia were issued by the Association of Anaesthetists of Great Britain and Ireland in 1999 and revised in 2006. The following guidelines have been produced in response to the changing ethical and legal background against which anaesthetists, and also intensivists and pain specialists, currently work, while retaining the key principles of respect for patients' autonomy and the need to provide adequate information. The main points of difference between the relevant legal frameworks in England and Wales and Scotland, Northern Ireland and the Republic of Ireland are also highlighted.

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- *What other guidelines are available on this topic?*
  Previous guidance was published by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) in 1999 [1] and this was revised in 2006 [2]. Guidance on consent to examination and treatment was published by the General Medical Council (GMC) in 2008 [3] and the Department of Health (DoH) in 2009 [4]. The British Medical Association and Law Society have published guidance on the assessment of mental capacity in 2015 [5].
- *Why was this guideline developed?*
  There have been a number of changes in the ethical and legal context around delivery of healthcare since the last AAGBI guidance, in particular new case law and increasing emphasis on consumerism and patient-centred care.
- *How and why does this statement differ from existing guidelines?*
  The previous AAGBI guidance has been updated and input received from intensivists and pain specialists as well as anaesthetists. In addition, some guidance is offered for the increasingly different systems in the devolved nations and in Ireland.

Recommendations

(The legal frameworks for decision-making in relation to those lacking capacity in Scotland, Northern Ireland and the Republic of Ireland are not the same as that in England and Wales, although the guiding principles are largely the same. The body of this guidance is based on the law as it applies in England and Wales; a comparative table is provided at the end to highlight the main differences (Appendix 1, Supporting Information)).

1 Information about anaesthesia and its associated risks should be provided to patients as early as possible, preferably in the form of an evidence-based online resource or leaflet that the patient can keep for future reference. Those undergoing elective surgery should be provided with information before admission, preferably at pre-assessment or at the time of booking, but the duty remains on the anaesthetist to ensure that the information is understood.

2 Immediately before induction of anaesthesia, for example in the anaesthetic room, is not an acceptable time to provide elective patients with new information other than in exceptional circumstances.

3 The amount and the nature of information that should be provided to the patient should be determined by the question: 'What would *this particular* patient regard as relevant when coming to a decision about which of the available options to accept?'

4 At the end of an explanation about a procedure, patients should be asked whether they have any questions; any such questions should be addressed fully and details recorded.

5 Anaesthetists should record details of the elements of a discussion in the patient record, noting the risks, benefits and alternatives (including no treatment) that were explained.

6 A separate consent form, signed by the patient, is not required for anaesthetic procedures that are done to facilitate another treatment.

7 Consent is an ongoing process, not a single event, and may require repeated discussion and/or confirmation, with documentation at every stage.

8 For a course of treatment (e.g. for chronic pain), consent to continue should be confirmed and documented before each individual component, and any changes to risks, benefits or alternatives discussed fully.

9 If patients insist they do not want to know about the risks of a procedure (including anaesthesia), the consequences of this should be explained; this discussion should be recorded in writing and the patient given the opportunity to change his/her mind. Patients should understand that there may be risks but should not have a detailed explanation forced upon them if unwilling.

10 The Mental Capacity Act 2005 (MCA) [6] confirms that adults should be presumed to have capacity to consent to medical treatment. If there are reasonable grounds for concluding otherwise, these must be documented. The MCA places a duty upon all those concerned with care to make efforts to reverse or minimise temporary incapacity to enable patients to make their own decisions

and, where it is not possible to do so, to treat patients lacking capacity in their best interests. Adults may make an advance decision to refuse treatment or appoint a proxy to decide upon their behalf using a lasting power of attorney (LPA). A valid and applicable advance decision or a decision of a validly appointed health and welfare LPA is legally binding, as is the decision of a court-appointed deputy with the appropriate powers.

11 Anaesthetists should be aware of the different frameworks that apply in relation to consent (and who can consent on behalf of the patient) with respect to patients aged 16 and 17 and those under 16.

12 When planning to allow trainees or others to use an opportunity presented by a clinical encounter for training in practical procedures, the anaesthetist should make every effort to minimise risk and maximise benefits, and should consider alternative ways of achieving the same end. Specific consent for such procedures may or may not be required depending on the circumstances.

A set of 'frequently asked questions' (FAQs) (relating to England and Wales and Northern Ireland, with a version adapted for Scotland and a note relating to the Republic of Ireland) is also provided in Appendix 2, Supporting Information.

Introduction

The need for consent before treatment is firmly embedded in modern healthcare. These guidelines – the third produced by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) – draw upon previous versions [1, 2] and other guidance [3–5] in the context of the particular roles of anaesthetists, intensivists and pain specialists in providing clinical care, against a backdrop of evolving legal and ethical frameworks in which they work. In light of the different legal frameworks that now apply in the devolved nations and in the Republic of Ireland, the body of this guidance limits itself to the legal framework that applies in England and Wales (although the guiding principles are largely the same). A table highlights the key differences in the legal frameworks in Scotland, Northern Ireland and the Republic of Ireland (Appendix 1, Supporting Information). (n.b. the word 'treatment' is used in this document to indicate both treatment in the usual sense, that is, something used to 'treat' (alleviate) something, and also an anaesthetic intervention such as general/regional anaesthesia, etc).

The importance of consent

Ethical aspects

Clinicians have an ethical obligation to respect patients' autonomy – that is, their right to be involved in decisions that affect them. In medicine, this is reflected in the requirement to obtain consent for treatment, which can only be valid if adequate information is supplied and the patient has the capacity to understand it and make a balanced decision, free from coercion [7]. Patients may change their minds and withdraw consent at any time, so long as these conditions still apply.

The need to respect autonomy sometimes conflicts with other obligations, such as the principle of beneficence (doing good). For example, patients may decline life-saving treatment, and this decision must be respected if they have capacity.

Professional aspects

Respect for autonomy and the need for consent is emphasised in professional guidance as being central to the doctor–patient relationship. The GMC's guidance in 2008 confirmed that doctors should tell their patients what the latter wanted to know, not what the doctors thought they should know [3].

Patients also have an interest in knowing what is going to happen to them and what they should expect during a course of treatment or other medical encounter. It is a professional obligation to explain such things to patients, to give them the opportunity to ask questions and to provide honest answers.

Legal aspects

The legal requirements for valid consent reflect the ethical ones: it must be given voluntarily by an appropriately informed patient, who has the capacity to exercise a choice – even if this choice appears irrational. Pain, illness and premedication do not necessarily make a patient incapable of consenting to treatment [7].

Touching a patient without consent or approaching him/her with a needle, irrespective of outcome, may lead to a claim of assault or battery. Far more common, although, is a claim of negligence after a complication has occurred, on the basis that had a warning been given, the patient would not have agreed to the treatment and the complication would not have occurred [8]. Case law suggests that a doctor might still be found negligent even if the patient would have undergone the treatment had he/she been warned [9, 10], reflecting the importance that the law accords to the duty to respect patients' autonomy. In addition, Articles 3, 8 and/or 9 of the European Convention on Human Rights might feasibly be invoked if consent is not sought from patients before treatment [10, 11].

The treating doctor is responsible for ensuring that the patient has consented to the treatment. For patients referred for investigations requiring anaesthesia, for example MRI, consent for the investigation should be sought by the referring doctor or local radiologist, while consent for anaesthesia should be sought by the anaesthetist providing anaesthesia.

For many decades, legal decisions concerning consent have been based on the Bolam principle [12], that is, whether the doctor seeking consent did so (i.e. provided enough information) in accordance with a responsible body of clinical opinion. The courts subsequently stressed that such a clinical opinion must be rational and stand up to logical analysis [13]. Recent case law (Montgomery v *Lanarkshire Health Board)* has confirmed that the Bolam principle no longer applies in matters of consent, and that a doctor needs to provide all 'material risks' to a patient, with materiality defined as: "*. . . whether a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor should reasonably be aware that the particular patient would be likely to attach significance to it*" [10] – thus bringing the law in line with previous *professional* guidance from the GMC in 2008 [3, 14]. There are only three exceptions to this rule: i) the patient has expressed a fixed desire not to know the risks; ii) discussion of the risks would pose a serious threat (beyond merely causing distress) to the patient (e.g. suicide); and iii) in 'circumstances of necessity' where urgent treatment is needed but the patient lacks capacity, and where the treatment that is being delivered is in his/her best interests.

Patients must be informed of alternative treatments, the risks associated with them and the option of not receiving treatment; not doing so may invalidate consent and result in a negligence claim [10, 15].

Capacity, best interests and voluntariness

Capacity

The MCA provides the legal framework in England and Wales for protecting and supporting people whose capacity may be impaired [6]. It reinforces that capacity should be assumed unless proven otherwise (Section 1(2)), sets out how to make decisions where a person does not (despite being supported) have the capacity to make his/her own decisions (Sections 1(5) and (4)) and introduced several new roles, bodies and powers (see Table 1).

Those over 16 years have the legal capacity to consent to a medical procedure if they are able to understand, retain, use and weigh the relevant information, and communicate their decision [3, 6, 16]. In most instances, it is for the person treating the patient to decide whether the patient has the capacity or not. Assumptions relating to capacity based on age,

Table 1 Summary of the Mental Capacity Act (2005)'s main features and provisions [6].

Statutory principles	A person must be assumed to have capacity unless proved otherwise A person must be given all practicable help to make his/her own decision before being treated as lacking capacity A person must not be treated as lacking capacity merely because he/she makes an unwise decision An intervention or decision made on behalf of a person lacking capacity must be in his/her best interests. The intervention or decision made on behalf of a person lacking capacity must cause the least restriction of his/her rights and freedom of action to achieve the stated purpose
Roles/institutions created	Court of Protection Lasting power of attorney Independent Mental Capacity Advocates Deputies
Other	Advance decisions to refuse treatment confirmed in law Applies to anyone over 16 years old

appearance or behaviour must not be made [3, 17], and nor should they be made about a patient's capacity to make decisions on the basis of a particular condition, for instance a learning disability. Furthermore, patients cannot be treated as lacking capacity to consent to or refuse medical procedures unless all practicable steps to support them to do so have been taken without success [6].

The decision made by the patient does not have to be sensible, rational or well considered. Furthermore, a patient should not be treated as being unable to make a decision merely because the decision that he/she makes is one that appears unwise to the treating professionals [6]. However, a highly irrational decision that is based on a persistent misinterpretation of the information presented may indicate that the patient does not, in fact, have the capacity to make the decision within the meaning of the MCA (in practice, determining incapacity on the grounds of irrationality is fraught with difficulty; in such a situation, legal advice should be sought). Under the MCA, the patient's inability to make the decision must be because of an impairment of or disturbance in the functioning of their mind or brain, in the absence of which he/she has the capacity no matter how impaired his/her reasoning process is. (See also *Voluntariness*, below, in relation to concerns that a patient's decisions may be made under duress).

Refusal of treatment by an adult with capacity is legally binding, even if refusal is likely to result in the patient's death [18]. The position in relation to 16- and 17-year-olds is addressed below.

Capacity is issue-specific: patients may have capacity to consent to simple procedures but not complex ones [19, 20].

A lack of decision-making capacity may be the predictable result of a condition (e.g. Alzheimer's disease, Huntingdon's dementia), the temporary result of an event (e.g. unconsciousness following intoxication, head injury or during general anaesthesia), or the permanent result of an event (e.g. perinatal brain damage or persistent vegetative state).

Mental illness may impair a patient's capacity to provide valid consent for treatment. However, a person receiving treatment for mental illness (even if he/she is detained under the Mental Health Act 1983 (MHA)) should not be assumed to be incapable of providing valid consent for medical, surgical or dental treatment. The consent of a patient detained under the MHA is not required for any medical treatment of the patient's mental disorder if that treatment is being given under the provisions of Part 4 of the MHA. However, the patient's consent, or a second opinion, is required before the administration of electroconvulsive therapy (ECT), which also cannot be given where the patient has made an advance decision refusing ECT, or a health and welfare attorney or court-appointed deputy refuses the treatment. When the patient is not capable of consenting, or refuses treatment, ECT can be given in an emergency if the authorised practitioner certifies the patient's lack of capacity or refusal, and that the treatment is likely to alleviate or prevent deterioration in the patient's condition. Licence to treat in this way in an emergency would also extend to the use of general anaesthesia for administering ECT [21].

Best interests

If a patient lacks capacity, practitioners must make a clear record of the grounds on which they have reached this decision, the treatment that will be undertaken, and how this treatment will be in the patient's best interests. The courts have made clear that 'best interests' for these purposes involve consideration of the patient's '*welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be*' [22]. The process of best interests decision-making is designed to ensure that the decision that is made is right for the patient 'as an individual human being', which may or may not accord with the decision that appears wise to the treating professionals [22, 23]. The MCA stresses that family members (and where appropriate, other persons close to the patient) must be consulted when considering patients' best interests [6], but failure to do so should not compromise care in an emergency. If a

patient lacking capacity is to undergo serious medical treatment (defined in the context of a fine balance between risks and benefits, or of the 'serious consequences' that may arise) but no family members or close friends are available, consultation with an Independent Mental Capacity Advocate should be sought, under Sections 35-37 of the MCA [6].

Patients who are aware that they are likely to lose capacity to make decisions, either temporarily or permanently, may choose to prepare an 'advance decision' (often known as 'advance directive' or 'living will'), stating which treatments they would refuse in the event that their treating team consider them indicated (see below).

A patient may also have made an LPA. This is a legal document that allows patients to appoint another person(s) to make decisions on his/her behalf in the case of incapacity. Two types of LPA exist (health/welfare and property/financial affairs), and they must be registered with the Office of the Public Guardian for them to have effect (this process may take up to several weeks; if needed more urgently an application may have to made to the Court of Protection). Only an attorney under a health and welfare LPA can have any power to make decisions in relation to medical treatment, and an attorney has no power to refuse life-sustaining treatment unless the document contains specific provision to that effect (a health and welfare deputy can never have the power to refuse life-sustaining treatment). Enduring powers of attorney (EPA), which can no longer be made but many of which are still used, could only give the attorney power to make decisions in relation to property and financial affairs; an attorney under an EPA can therefore never make healthcare decisions on behalf of a patient. In some circumstances, a patient lacking capacity to make decisions may have a court-appointed deputy, who may (depending on the terms of their appointment) have powers to make some healthcare decisions, but will never have the power to refuse life-sustaining treatment.

Voluntariness

For a decision by an individual to be valid, it must have been taken voluntarily, that is, without coercion [3, 7]. In general, it is good practice for the clinician who is seeking consent to indicate whether he/she favours one therapeutic option over another, but the imbalance of power and influence in the doctor–patient relationship means that the vulnerable patient may feel coerced by the doctor's enthusiasm. Anaesthetists seeking consent should be aware of this and not allow their preferences to override the patient's autonomy [4].

Coercion can occur when patients are influenced by the beliefs or preferences of friends or relatives. This is more likely to arise where a child with capacity is accompanied by a parent, in areas where both parties have a major stake in the outcome, such as obstetrics, or in certain cultures. Where such a situation is suspected, anaesthetists should seek to speak to the patient away from a potentially coercive influence. Legal advice should be sought where anaesthetists are not clear whether a patient's inability to make decisions about his/her medical treatment is down to an impairment or disturbance in the functioning of his/her mind or brain, or the duress to which he/she may be being subjected by family members or friends [7]. Such situations must be handled very carefully, particularly if English is not the first language of any participant. A 'whole team' approach is always best, but is essential in obstetric and/or paediatric cases, with early consultant involvement.

Information and the consent process

Information about anaesthesia and related procedures is not exclusively provided by anaesthetists, but the anaesthetist caring for the patient is responsible for the discussion with the patient regarding that procedure. This can be delegated to someone else, providing that the person is suitably trained and qualified with adequate knowledge of what is planned, including an understanding of the risks. He/she must also act in accordance with the GMC's guidance [3].

Timing

Information about anaesthesia and its associated risks should be provided to patients as early as possible, preferably in the form of an evidence-based online resource or leaflet that the patient can keep for future reference (see e.g. http://www.labourpains.com/UI/Content/Content.aspx?ID=5; http://www.aagbi.org/news/information-public/information-about-anaesthesia-adults). Those undergoing

elective surgery should be provided with information before admission, preferably at pre-assessment or the time of booking, but the duty remains on the anaesthetist to ensure that the information is understood. This is particularly important for patients admitted on the day of surgery – increasingly the norm in modern surgical practice – where the opportunity for prolonged discussion is limited. Patients should be informed that they will meet the anaesthetist before their operation, so that further queries and discussions can take place before finally consenting to anaesthesia. Consent can only be valid if the patient is sufficiently informed and understands the broad nature of the procedure [4, 24, 25].

The anaesthetist must be satisfied that patients have been given sufficient time to come to a considered view after they have been provided with relevant information about their treatment, and have had the opportunity for adequate discussion, even if admitted on the same day as surgery. The time required for this will depend on the patient and the nature of the procedure. Immediately before induction of anaesthesia, for example in the anaesthetic room, is not an acceptable time to provide elective patients with new information other than in exceptional circumstances. The importance of allowing sufficient time for the consenting process is illustrated by a recent case in which it was held to be unacceptable to inform a patient who had specifically arranged to have surgery performed by a particular surgeon, as she was about to enter the operating theatre, that her surgery would be performed by a different surgeon, since there was insufficient time for her to make an informed and free decision [26].

Standards for provision of information

Sufficient time must be allowed for the process of consent to take place during the pre-operative visit.

The amount and the nature of information that should be disclosed to the patient should as far as possible be determined by the question: 'What would *this particular patient* regard as relevant when coming to a decision about which – if any – of the available options to accept?' [4].

Individual anaesthetists and departments may wish to use nationally available written information or to produce their own (e.g. see http://www.rcoa.ac.uk/document-store/you-and-your-anaesthetic; https://www.rcoa.ac.uk/node/428; http://www.labourpains.com/UI/Content/Content.aspx?ID=5). Written information should be available in languages commonly read by local patients. Braille and large-print versions should be available for situations where impaired vision is likely (e.g. information about local anaesthesia for cataract surgery). Translators or readers must be available for those patients unable to read the written information provided. If the patient does not speak English then consent must take place with the use of an interpreter, and must not rely on family members or friends to translate, ensuring the accuracy of the information provided and reducing any coercive influence.

Information may only be withheld if providing it would pose a serious threat to a patient's health, not just because the anaesthetist feels it may make a patient anxious or deter him/her from undergoing a beneficial procedure. Conversely, any information that might lead a patient to cancel or defer a procedure should be considered significant. If patients insist they do not want to know about anaesthesia or a procedure, the consequences of not understanding the procedure/anaesthesia should be explained, particularly as it may mean their consent is not valid. This discussion should be recorded and the patient provided with the opportunity to change his/her mind. Basic information about the nature of the procedure should always be provided; however, detailed information should not be forced upon patients who have repeatedly indicated that they do not want to hear it [27].

In broad terms, patients must understand to what they are consenting. Therefore, anaesthetists should tell the patient: i) what procedures are intended, and why; ii) what the significant, foreseeable risks of these procedures are, and their consequences; and iii) what the alternatives are, including having no treatment. When deciding how much information to provide, anaesthetists must consider the relevance of information from their judgement of the patient's perspective, and mention significant hazards. A broad summary of what should be included in most cases is provided in Table 2, although the information given should always be according to what a particular patient wants to know and the likelihood of outcomes in that specific case, given the patient's medical history, the nature of

Table 2 Broad summary of information appropriate for patients during the consenting process (n.b. the anaesthetist should be guided by what each particular patient wants to know, rather than a proforma list, and with consideration of what the incidence of risks might be in that patient).

Common components of anaesthetic technique	Fasting; administration and effects of premedication; transfer from ward to anaesthetic room; cannula insertion; non-invasive monitoring; induction of general and/or local anaesthetic; monitoring throughout surgery by the anaesthetist; intra-operative drugs/fluids; intra-operative discomfort/awareness of the procedure/surroundings, etc, if awake/sedated; transfer to recovery area; return to ward; postoperative analgesia/anti-emetics/fluids; techniques of a sensitive nature, e.g. insertion of an analgesic suppository Alternative techniques where appropriate, including if one technique fails (e.g. general anaesthesia for caesarean section as an alternative to regional anaesthesia, or if the latter is inadequate)
Specific aspects related to procedure or condition	Invasive monitoring and associated risks; recovery in a critical care environment; sedation; intubation/tracheotomy
Common/significant side-effects	Nausea and vomiting; sore throat; damage to teeth/lips; cognitive dysfunction; numbness/weakness/return of pain after local anaesthetic techniques; suxamethonium pains; post-dural puncture headache
Serious side-effects	Nerve/eye damage; awareness during anaesthesia; death

the surgery and its urgency. It is the anaesthetist's responsibility to make reasonable efforts to judge what would be particularly significant risks or complications to his/her patient, for example the risk of vocal cord damage from general anaesthesia if the patient is a professional singer. Where possible, estimates of the incidence of risks should be given and the discussion recorded (see below).

All patients should be given the opportunity to ask questions and honest answers should be provided. The courts have emphasised the importance of medical professionals' recognising that they are engaged in a dialogue with the patients they are treating, and tailoring that dialogue to the needs of the individual patient [10].

Many questions relate to the operation itself. The anaesthetist should not provide information about the surgical procedure beyond his/her capability.

Documentation

As in previous versions of this guidance, the Working Party's view continues to be that a signed consent form is not necessary for anaesthetic procedures that are done to facilitate another treatment, since it is the process of consent itself that is important; a signed form is evidence that a consent process has been undertaken but does nothing to validate or invalidate the consent. Furthermore, the anaesthetic can be considered a component of another treatment (e.g. anaesthesia for surgery) or as part of a larger and interrelated process (e.g. epidural pain relief for childbirth), rather than a treatment in itself (see FAQs, Appendix 2, Supporting Information).

Whether consent is oral or written, it is essential for anaesthetists to document clearly both a patient's agreement to the intervention and the discussions that led up to that agreement, including the patient's questions and the responses given. This can be done on a standard consent form, on the anaesthetic record or separately in the patient's notes. Anaesthetic departments may wish to design anaesthetic records to document the discussions and agreement to specific modes of anaesthesia and interventions. A proforma may be useful – but as a guide to the conversation, not as a checklist to be ticked off without recording further detail. Documentation is particularly important where a patient wishes to reverse a previously documented decision, or circumstances when the patient's decision goes against the anaesthetist's advice, for example if a patient wishes to convert to general anaesthesia during apparently effective regional anaesthesia, or alternatively to continue with regional anaesthesia despite suboptimal anaesthesia in the view of the anaesthetist.

Sometimes, the anaesthetic procedure is the primary therapeutic intervention. Examples include invasive procedures for the treatment of chronic pain, epidural blood patch for the treatment of post-dural puncture headache or placement of a central line for chemotherapy or parenteral nutrition. In these circumstances, and

especially when the procedure is carried out in the operating theatre complex, many Trusts insist that a DoH consent form be completed and signed by the patient as evidence that consent has been given, and the Working Party's advice is that local procedures should be followed. For a course of treatment (e.g. repeated nerve blocks), consent to continue should be confirmed before each individual component, with any changes to the risks, benefits or alternatives discussed fully [28].

Qualified consent

Some patients, for religious or other personal reasons, may qualify their general consent to treatment by refusing specific aspects of that treatment. Doctors must respect these wishes as far as possible.

Jehovah's Witnesses, for example, may differ in their interpretations of the acceptability of blood transfusions. Most Jehovah's Witnesses will refuse homologous blood transfusion; however, some will accept autologous or cell-salvaged blood. Cardiopulmonary bypass with non-haematogenous primes and organ transplantation are usually regarded as acceptable [29].

If a patient gives qualified consent, a record should be made in the hospital notes indicating that the patient has been informed of the likely consequences of this decision, together with the reasons why such a treatment was proposed in the first instance. If the patient remains adamant, attention should be drawn to the clause on the consent form that specifies the patient's right to list procedures for which consent is not agreed. The doctor should also make a note of the precise nature of the restriction that has been imposed by the patient and the explanation of risks that took place.

Qualified consent does not remove a patient's right to reasonable and proper care, including provision of all other forms of treatment that are appropriate in the circumstances. If an individual anaesthetist does not feel capable of providing proper care consistent with the patient's wishes, then he/she can refuse to treat the patient, provided that no additional harm is likely to result from that refusal, and make reasonable attempts to find a different anaesthetist who is willing to treat the patient. However, in an emergency when treatment is immediately necessary, the anaesthetist should attempt to comply with the wishes of a patient who has capacity.

Advance decisions ('advance directives', 'living wills') and 'Do not attempt resuscitation' decisions

Adult patients with capacity who anticipate future incapacity through illness may indicate their preferences for future treatment by completing an advance decision, to take effect if they do not have the capacity to consent to or refuse specific medical treatments. For example, patients may indicate that they do not wish to undergo life-saving surgery if they suffer from dementia when they are older. Many Jehovah's Witnesses carry with them an advance decision forbidding the administration of blood or blood components.

Although an advance decision to refuse routine treatment does not have to be in writing, one to refuse life-sustaining treatment must be in writing, must be witnessed, and must make clear that it is to apply to the treatment even if life is at risk [6]. An advance decision that is valid and applicable to the treatment in question is legally binding [6]. Wherever possible, anaesthetists should check whether a patient has made a relevant advance decision to refuse treatment.

When a situation falls fully within the terms of the advance decision, clinicians should respect the terms unless there is good evidence that the patient did not have capacity to make the advance decision, or that the patient has changed his/her mind since signing it [30].

Advance decisions cannot authorise doctors to do anything outside the law, or compel them to carry out a specific form of treatment, for example continue life-sustaining treatment that is not in a patient's best interests, or provide a treatment the primary intention of which is to hasten death [22].

'Do not attempt resuscitation' (DNAR) decisions are not advance decisions. Consideration as to the likely appropriateness of resuscitation must, however, be based wherever possible on discussion with the patient (or, where the patient is unable to take part in the discussion, those close to the patient). Further guidance on DNAR decisions is available elsewhere [27]. The Working Party is aware of current work being done to produce similar guidance encompassing wider emergency treatment, beyond DNAR alone (Recommended Summary Plan for Emergency Care

and Treatment (previously Emergency Care and Treatment Plan); see https://www.resus.org.uk/consultations/respect/).

Special circumstances

Obstetrics

Drugs, fatigue, pain or anxiety may compromise the capacity of an adult parturient, but do not necessarily lead to incapacity unless the degree of compromise is severe.

Labour is the wrong time to burden women with excessive information. Every obstetric unit must provide, in early pregnancy, advice about pain relief and anaesthesia during labour and delivery [31]. An anaesthetist must be involved in preparing this information and approve the final version. Any patient who wishes to discuss techniques with an anaesthetist must be able to do so. Nevertheless, the patient must still be provided with appropriate information at the time of the procedure, the details of which must be documented.

Birth plans often include references to analgesia and anaesthesia. If a woman loses capacity during labour, the birth plan should be treated as representing an advance decision, and any documented refusal of therapy must be respected. However, a presumption of capacity remains in these circumstances. Therefore, women who have capacity and who request epidural analgesia during labour, despite recording a refusal in their birth plan, must have their request respected, and the decision documented as above.

In law, a pregnant woman with capacity can refuse any treatment for any reason, even if this puts the unborn child at risk of harm or death. An emergency court order to authorise treatment may be requested in such circumstances, but will only be granted if the court concludes that the woman lacks the relevant decision-making capacity and that the treatment is in her best interests.

In general, 16- and 17-year-old parturients are to be regarded as adults from the point of view of making decisions about interventions, and children younger than this may be considered as having capacity depending upon the circumstances (see below). Units should therefore have guidelines in place to ensure that these patients receive age-appropriate information and advice and access to an anaesthetist if needed.

Critical care

The principles of consent for patients receiving critical care are the same as in the general population; however, many will lack capacity because of their underlying condition or essential therapy (e.g. sedation).

Chronic pain

Anaesthetic interventions for patients with chronic pain are often primary in nature – that is, the intervention is intended to be therapeutic, rather than facilitating a more definitive procedure to take place. When this is the case, written, signed consent on conclusion of the consent process is recommended, and is often a Trust requirement. Guidance is available from the Faculty of Pain Medicine at the Royal College of Anaesthetists for specialists performing specific interventional procedures (see http://www.rcoa.ac.uk/faculty-of-pain-medicine/guidelines).

16- and 17-year-olds

In England and Wales, 16- and 17-year-olds (often referred to as 'young people') are covered by the MCA and are presumed to have the capacity to consent to treatment, including the administration of an anaesthetic, as if they were adults. Where a capable young person has given consent, it is not then necessary to obtain consent from his/her parent or guardian. Consent can also be given by those with parental responsibility (see https://www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility; https://e-justice.europa.eu/content_parental_responsibility-302-IE-en.do?clang=en) for the young person, whether or not he/she lacks capacity. The closer the young person is to the age of maturity and the more that he/she objects to the proposed treatment (especially if it is invasive or serious), the more cautious healthcare professionals should be about relying upon the consent of a person with parental responsibility; rather, consideration should be given to applying to court. The court can override the refusal of treatment of a capable young person if he/she is likely to suffer irreversible harm as a result of his/her refusal.

Children

Children (for these purposes, those under the age of 16) are not presumed to have capacity to consent to

treatment, unless the doctor decides that the child 'has sufficient intelligence and understanding to appreciate fully what is proposed' (i.e. '*Gillick* competence' [20]). The degree of understanding they will need to show will vary depending upon the nature of the procedure and the severity of the condition being treated. A capable child should understand the treatment and its effects, and the consequence of non-treatment. If capacity fluctuates, the child should be considered as lacking capacity. Capable children should be encouraged to inform their parents about treatment, but the doctor must still respect their right to confidentiality and a refusal to permit disclosure to the parents.

Consent may be provided for children lacking capacity by a person with parental responsibility, provided the treatment for which the consent is given is in the child's best interests. Usually, parents (or those with parental responsibility) will make the decision, although they themselves must be capable of making the decision and it must be made in the child's best interests. Either parent may give consent; but other family members cannot give consent on behalf of the parents. If there is disagreement between the parents, the courts may limit the power of one parent to refuse treatment that is in the best interests of the child. If both parents refuse, an application may be made to the court to overrule the parents. Where a *Gillick* competent child refuses treatment, healthcare professionals can, in principle, rely upon the consent of a person with parental responsibility, but they should always consider whether it is necessary to obtain the authority of the court.

In life-threatening situations, parental authorisation should be obtained if possible and, in default, application should be made to the court if necessary. Whatever happens, the best interests of the child must be put first and treatment that is immediately essential to safeguard the child's life or health should not be denied in the absence of parental authorisation, even if there is no time to get court authority (although it should be noted that it is usually possible to find a judge within an hour).

Individual judgment must be exercised in determining the degree of restraint that is acceptable to achieve induction of anaesthesia in an uncooperative child, even when the parents appear to consent to have the child restrained. When faced with a child who is uncontrollable for whatever reason, the anaesthetist should consider ceasing treatment, giving an appropriate explanation to the parent or representative, and arranging necessary future treatment for the child.

Research and audit

The need for participants' consent and for review by an independent Research Ethics Committee is no different in anaesthetic and related research to that in any other area of medical research, and anaesthetists are referred to the copious guidelines and regulations that already exist (e.g. at http://www.hra.nhs.uk/research-community/). Particular considerations apply in relation to patients who do not have the capacity to consent to participation in research studies; in such cases, a relative or other person may be appointed as a 'consultee' to advise researchers as to the patient's preferences, and patients may be recruited into emergency research without prior consent if specific criteria are met [32].

Learning/maintaining practical skills

Although practical procedures can be rehearsed and practised on manikins – and, to a lesser extent, volunteers – most learning and maintaining of practical skills occurs during patients' care (unlike research, in which the process is usually extra to care).

It may be difficult to define what constitutes a single 'procedure' since most can be separated into several components. In addition, practitioners learn from every procedure they do. It is therefore impossible to seek patients' consent for every aspect of every 'procedure' in which there may be a learning component. The Working Party endorses the following approach [33]:

- The risks and benefits of each procedure and its components, both to the patient concerned and to society in general, must be considered.
- The harms should be minimised as much as possible, for example by close supervision, prior practice on manikins, etc.
- The benefits should be maximised as much as possible, for example by close supervision, and targeting skills to practitioners most likely to use them in the future.
- Alternatives should be considered, for example other ways of learning/maintaining skills, other techniques.

In some cases, for example an anaesthetist inexperienced in fibreoptic orotracheal intubation wishing to learn the technique unsupervised during general anaesthesia, patients' specific consent should be sought since there may be additional risks from inexperienced use and there are limited benefits to the patient. In other cases, for example an experienced endoscopist using the fibrescope as part of his/her routine technique, specific consent would not be required since the risks have been minimised and the benefits maximised, and the technique constitutes part of the general procedure of 'orotracheal intubation' (so long as the associated risks remain equivalent to or less than the alternatives). However, if a particular patient wishes to discuss intubation, for example if he/she is especially concerned about damage to teeth or sore throat, the anaesthetist should provide more details, as for any other aspect of anaesthesia – upholding the principle that disclosure of information should be flexible according to what the individual patient wants to know. It should also be remembered that patients have the right to know who is doing what to them, and how qualified they are [3, 34]. This right is not diminished by the fact that they may be under the influence of anaesthesia at the time of the intervention.

The same principles apply to supervision of others: the supervising anaesthetists should include trainees' and their own experience as part of their assessment of overall risks and benefits, including the need to minimise the former and maximise the latter, as described above.

Sometimes anaesthetists are approached by medical students and paramedical staff wishing to learn/maintain skills, for example in airway management. Such individuals are not only less skilled than anaesthetists but also not medically qualified, making the risk/benefit assessment even more important. The Department of Health's guidance states that patients' specific consent is not required for procedures done by students if such procedures are part of patients' normal care. However, the Working Party considers that this depends on the student's competence and the risks involved. For example, while it would be acceptable for a novice to hold a facemask under supervision without specific consent, since the risks are minimal, tracheal intubation is more invasive and requires a greater level of competence before the patient's specific consent is no longer required. In particular, the Working Party strongly opposes the practice whereby students or paramedics move between anaesthetic rooms to 'do' intubations, with no consideration of these issues.

The above approach is equally applicable to patients who lack capacity to give consent, so long as it is concluded that specific consent would not be required. If the patient may lack capacity to give specific consent to a procedure, the same considerations set out above under *Capacity, best interests and voluntariness* should be applied. There is no necessary bar to a student carrying out such a procedure but particular care will need to be taken by those supervising them.

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Competing interests

SMY, AH, DGB and THCB have provided expert witness reports for the court on the instructions of both claimants and defendants, and/or HM Coroner. SMY was a member of the working group that wrote the GMC's guidance on consent [6]. AH is his Trust's Lead Clinician for the MCA, and has written and

broadcast on issues related to capacity and consent. ARK regularly acts in proceedings before the Court of Protection involving the MCA, and has acted in proceedings on the instructions of the FICM/ICS. He is on the FICM/ICS Legal and Ethical Policy Unit, and has provided assistance to the Resuscitation Council (UK)/British Medical Association/ Royal College of Nursing on their *Guidance on Decisions relating to Cardiopulmonary Resuscitation* [27].

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Supporting Information

Additional Supporting Information may be found in the online version of this article:

Appendix S1. Summary of the main differences in the legal framework for decision-making in relation to those lacking capacity in England and Wales and those in Scotland, Northern Ireland and the Republic of Ireland.

Appendix S2a. Frequently asked questions regarding consent (England and Wales and Northern Ireland).

Appendix S2b. Frequently asked questions regarding consent (Scotland).

