SECTION 1

Perioperative care

Consent and medico-legal considerations

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Individuals have a fundamental right to determine what happens to their own bodies. It is unlawful and unethical to carry out a medical procedure without first obtaining valid consent. Legal aspects of medical practice are subject to continuous change and it is necessary for health professionals to keep abreast of developments in medical law. In particular the Mental Capacity Act 2005 is likely to have a profound influence on current practice.

What is consent?

While there are various definitions of consent, essentially it identifies the agreement between patients and health professionals to provide care. For consent to be valid one must appreciate the essential principles of valid consent. This requires that the patient must be adequately informed, have the capacity to make the decision for him/her self and make the decision voluntarily. Nobody can give or withhold consent on behalf of a competent adult.

Capacity

Capacity is the decision-making ability of an individual in relation to a specific matter at the material time, which is not impaired due to a disturbance in functioning of the mind or the brain either temporarily or permanently.

All registered medical practitioners are eligible to assess capacity. Adults are always assumed to have capacity unless demonstrated

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otherwise. Capacity assessments are decision-specific and may fluctuate over time. Patients with mental illness may have capacity to consent to treatment for physical illness even when psychiatrically unwell or vice versa.

Prior to a capacity assessment an individual must be provided with all the relevant information including the nature and purpose of the proposed intervention, the risks associated with accepting or refusing the intervention and other available options. Any adult has capacity to consent (or refuse) medical treatment if he/she can satisfy the four legal criteria:

1. Understand and retain the information relevant to the decision
2. Believe the information
3. Use the information and weigh it in the balance to arrive at a decision
4. Communicate their decision (does not have to be verbal).

Case example

Mr C was a patient suffering from paranoid schizophrenia and was being detained in a psychiatric hospital when he developed gangrene in his right foot. He held a delusional belief that he was an eminent surgeon and refused to consent to a below-knee amputation. He sought an injunction to prevent surgeons from carrying out the amputation. Justice Thorpe granted the injunction and held that Mr C understood the nature, purpose, and effects of the proposed amputation. Hence he retained the capacity to make a decision regarding his treatment. This has subsequently been cited in various cases and is known as the 'Re C Test'.

Refusal of a medical procedure

Any adult patient of sound understanding has the right to accept or refuse treatment, even if the choice appears irrational, insensible or ill considered. If a patient has refused to consent to treatment, doctors must make a careful assessment of the patient's capacity at the material

time. The more serious the decision the greater the capacity required. In cases of uncertainty advice should be obtained from senior colleagues. It may be necessary to consult Trust solicitors or seek a declaration from the court.

If the patient lacks capacity to consent to treatment, doctors have a duty of care to act in the best interests of the patient. Under the common law doctrine of 'necessity', treatment can be given to save life, ensure improvement or prevent deterioration of physical or mental health and should be accepted by a responsible body of medical opinion. It is good practice to seek a second opinion in such cases.

When determining the best interests of the patient, the responsible clinician should consider not only the most appropriate clinical care, but also other factors such as the wishes and beliefs of the patient when competent, and their current wishes. It is wise to involve people close to the patient in the decision-making process to gain additional information about the patient's wishes and values.

Jehovah's Witnesses

Jehovah's Witnesses are entitled to accept or refuse any proposed treatment and have the right to change their mind at any stage. Detailed advance directives are often prepared and doctors may be found guilty of assault if they knowingly breach the directive. In life-threatening situations where consent cannot be obtained and the individual's views are not known, blood transfusion should not be withheld. The views of relatives and friends may be sought but they cannot refuse transfusion on the patient's behalf.

Detention under the Mental Health Act 1983

The Mental Health Act may only be used to assess or treat mental illness. Physical disorders cannot be treated under the provisions of the Act.

Inpatients requiring detention in hospital when a mental illness is suspected can be detained under Section 5(2) of the Mental Health Act 1983. The Responsible Medical Officer or his/her nominated deputy is responsible for applying the section. In Acute Trusts this will usually be the Surgical Consultant or Registrar, although the psychiatric team should be notified immediately. Section 5(2) is not applicable in Accident and Emergency (A&E) or Outpatient (OPD) Departments.

Documentation

The professional seeking consent must be competent to do so. In practice this is usually the person carrying out the procedure. However it may be appropriate for professionals who have received specialist training in advising patients about a procedure to do so. Responsibility for gaining informed consent in law lies with the professional carrying out the procedure.

It is essential to document clearly the patient's agreement to the intervention and the discussions that led up to the same. A consent form may be used or oral consent may be documented in the patient's notes. It is good practice to seek written consent, although it is rarely a legal requirement. While it is not necessary to document a patient's consent for routine and low-risk procedures, it is good practice.

Children and adolescents

The competency criteria for valid consent are similar to those for adults. Professionals need to be extra vigilant so as to ensure that information is provided in an appropriate pace and form, in a non-coercive environment that respects privacy and dignity. This may include discussion in the absence of the parents.

In England and Wales, individuals above the age of 18 are presumed competent. Young people between the ages of 16 and 18 and deemed to be competent may consent to treatment, but unlike adults cannot refuse

life-saving treatment. Individuals under the age of 16 can legally consent provided they satisfy the competency criteria (*Gillick* v. *West Norfolk and Wisbech Area Health Authority* [1985]: legal reference: 3 All ER 402 HL). Additionally parents, individuals or local authorities with parental responsibility, or courts can give consent for treatment on behalf of the individual.

If a competent young person refuses treatment or if parents dispute the treatment, resolution should be sought through discussion and compromise. If the issues cannot be resolved then the courts can be involved in the best interests of the individual.

The following are common questions that patients expect to have answered during the process of consent for a surgical procedure (taken from www.doh.gov.uk/consent):

What are the main treatment options?
What are the benefits of each of the options?
What are the risks, if any, of each option?
What are the success rates for different options – nationally, for this unit or for you (the surgeon)?
What are the complication rates for the procedure in question – nationally, for this unit or for you (the surgeon)?
Why do you think an operation (if suggested) is necessary?
What are the risks if nothing is done for the time being?
How can the patient expect to feel after the procedure?
When should the patient expect to be discharged and be able to get back to work?

Questions may also be about how the treatment might affect the patient's state of health or quality of life, for example:

Will they need long-term care?
Will their mobility be affected?
Will they still be able to drive – if so, when?
Will the procedure affect the kind of work the patient does?
Will it affect their personal/sexual relationships?

Will they be able to take part in their favourite sport/exercises?
Will they be able to follow their usual diet?

Further information

The Department of Health and General Medical Council have issued a number of documents on consent. These can be found at www.dh.gov.uk./consent and www.gmc-uk.org/guidance/library/consent.asp.

Elective surgery

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Aims

To assess and optimize co-existing medical conditions prior to surgery

To anticipate potential problems, inform the relevant people, and address these prior to admission, e.g. requires ICU (Intensive Care Unit) bed.

History

1. CARDIOVASCULAR (CVS)

History of hypertension? On antihypertensive medications?

MI: when? What treatment? Cardiology follow-up? If less than six months ago postpone elective surgery

Angina: stable/unstable? How frequently requires GTN spray? Exercise tolerance

Any symptoms of PND (paroxysmal noctural dyspnoea) or orthopnoea? How many pillows does patient sleep on at night?

Past history of rheumatic fever: has patient ever been diagnosed with 'leaky valve'?

Any symptoms of palpitations, syncope, dizziness, blackouts, unexplained falls?

2. RESPIRATORY

History of asthma or COPD?

Episodes of bronchitis? If so, how frequently? Sputum production and colour of sputum

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Inhalers? Home nebulisers? Home oxygen therapy?
Any hospital admissions with respiratory problems? If so, any ICU admissions?
Severity of dyspnoea, exercise tolerance
Current or past history of smoking? How many per day for how many years?

3. ABDOMINAL

History of indigestion or reflux?
Any past episodes of jaundice? Does patient have a diagnosis of chronic hepatitis?
Is there a history of renal disease? What is the cause?
Does patient require dialysis? If so, liaise with renal team prior to setting date for surgery
Does patient have a fluid restriction regime?

4. NEUROLOGICAL

History of CVA?
Epilepsy: how well controlled? When was last seizure?
If frequent seizures, refer to neurology team for optimization preoperatively
Rare conditions, e.g. myasthenia gravis, Duchenne's muscular dystrophy, myotonic dystrophy, multiple sclerosis – take full history of progression of disease.

5. ENDOCRINE

Thyroid problems: is function regularly checked? Does patient have symptoms of stridor, dysphagia, dyspnoea?
Diabetes: enquire about details of current regime and systemic implications of diabetes
Steroid replacement: reason for steroids, length of course, current dose.

6. HAEMATOLOGY

Coagulopathies
Sickle cell disease: enquire about systemic complications, e.g. splenic infarct, sickle cell chest, CVAs, cholecystitis
Thromboembolic tendency
Chronic anaemia: cause?

7. MUSCULOSKELETAL

Rheumatoid arthritis: is the neck affected? Symptoms of cervical cord compression? Any associated symptoms, e.g. dyspnoea? Drug treatment?

8. ANAESTHETIC

Any previous anaesthetics?
Any problems, e.g. unexpected admission to ICU?
Any family history of problems with anaesthetics?

9. DRUGS

Full history of all current medications
History of any allergies to medications
Is there a history of latex allergy? An increasing problem, inform theatres if necessary
Does patient use recreational drugs? Has patient used cocaine in previous 48 hours? If so, advise strongly against using prior to surgery.

10. SOCIAL

Does patient mobilize independently or need aids?
Smoker: how much, what and for how many years?
Alcohol: what exactly and how much?