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Anesthesiological Ethics: Can Informed Consent Be Implied?

Jeffrey P. Spike

ABSTRACT

Surgical ethics is a well-recognized field in clinical ethics, distinct from medical ethics. It includes at least a dozen important issues common to surgery that do not exist in internal medicine simply because of the differences in their practices. But until now there has been a tendency to include ethical issues of anesthesiology as a part of surgical ethics. This may mask the importance of ethical issues in anesthesiology, and even help perpetuate an unfortunate view that surgeons are "captain of the ship" in the operating theater (leaving anesthesiologists in a subservient role).

We will have a better ethical understanding if we see surgery and anesthesia as two equal partners, ethically as well as in terms of patient care. Informed consent is one such issue, but it is not limited to that. Even on the topic of what type of anesthesia to use, anesthesiologists have often felt subsumed to the surgeon's preferences. This commentary takes the case study and uses it as a exemplar for this very claim: it is time to give due recognition for a new field in clinical ethics, ethics in anesthesia.

Surgical ethics is an important subject, and not the same as medical ethics. There are at least a dozen issues in surgery that are different enough from medicine that surgical ethics deserves recognition as a subspecialty of clinical ethics, and there are now books on surgical ethics and chapters on ethics in surgical texts.[1] The case by Patel and Cattano[2] is a useful reminder of the easily overlooked importance of clinical ethics for anesthesiologists, which overlaps with surgical ethics.

Other fields of medicine have important, unique aspects. Thus the suggestion that obstetrics may involve "two patients," one inside the other, can help explain the ethical complexity of the field. (This is not to imply the "two patients" are of equal importance, or have an equal say; it is simply an explanation of why internists typically deal with one less level of complexity.) And the notion that pediatrics involves parents as well as children in the decision-making process explains its additional complexity.

In surgery, rather than two patients or two decision makers, we have two physicians: the surgeon and the anesthesiologist. What these examples have in common is that the usual model of a doctor-patient relationship, involving one doctor and one patient, is inadequate for *normal, everyday* situations in each field.

The case by Patel and Cattano is ethically important not because it is unusual, exotic, or new, but because it is common. Important ethical issues are often invisible to us when they have become accepted as everyday occurrences.

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It is harder to see what is wrong when something is so widely practiced; indeed, speaking up about it risks sounding naïve. Thus, for example, the use of general surgical consent forms that are interpreted as giving "implied consent" to whatever the surgeon thinks is necessary as the surgery progresses is very common, and gives far more latitude to surgeons than one finds in most *medical* consent forms.

Furthermore, the respective roles of the surgeon and the anesthesiologist are not clear in getting a patient's consent. Should one of the two attendings be allowed to get consent for the responsibilities of both? If that is a common practice, should it usually be the anesthesiologist who tells the patient about the surgery and its risks, or should it be the surgeon who tells the patient about the anesthesia and its risks? Are there risks in each case of doing a better job with your own concerns, and being less complete in covering the others' concerns?

The most likely explanation for having one consent form and letting one person talk to the patient is efficiency. One attending is spared having to talk to the patient prior to surgery. But ethically this cannot be an adequate justification. If each attending can give helpful information that the other cannot (to the same degree of precision or clarity), then having both talk to the patient should be the standard of care. For example, it is often reported that a patient comes in for surgery with low red blood cell counts, and ends up needing a transfusion. Could that have been avoided by taking daily iron supplements for the weeks between scheduling the surgery and the date of surgery?

Also, if one attending is to be privileged, there is no reason we must pick the surgeon. Surgeons and anesthesiologists have a unique relationship in the medical world, and there is no *a priori* reason that one should have greater authority than the other. In some other countries, it is often the anesthesiologist who is seen as "the captain of the ship" during a surgery, and the surgeon is more the technician. At the very least, there appears to be justification to require both to see the patient before surgery.

Conversion from a laparoscopic to an open surgical technique (that is, where one must open up the full surgical field with a large incision in order to be able to visualize and touch the involved structures) is becoming ever more common as more surgeries initially attempt to use a difficult, minimally invasive procedure first (now, increasingly, using robotic surgery). Thus more surgeries will need to consider converting to the more invasive traditional surgery while the patient is under anesthesia. This is, in many ways, just another example of how medical progress leads to a new ethical issue in need of analysis and discussion.

In these cases, an explanation for letting there be one ultimate decision maker might be that the patient is incapacitated when decisions must be made, and so cannot act as the final arbiter if there is a disagreement between the two attendings. But clearly this only is an indication for better advance planning; discussing with the patient preoperatively any scenarios that occur with sufficient regularity. We might propose, minimally, getting explicit consent (or refusal) for events with more than a 5 percent probability. This prior consent could be for either serious events with potential to cause lifelong disabilities, or simply events requiring much longer general anesthesia. (The latter might be more controversial, but if a patient is on a heart-lung bypass that means a greater risk of "pump head," that is, mental disability that is an indirect result of the anesthesia.)

There are other situations in which the input of the anesthesiologist should not be hidden behind the surgical drapes. There have, for example, been many innovations in "regional anesthesia" where a "block" of one region of the body makes surgery possible while the patient remains conscious. Not all anesthesiologists are equally well trained for such blocks, nor are all surgeons equally comfortable working with the patient awake. But informed consent requires that the patient should at least be informed of all of the reasonable options.

If a surgery can be done with regional anesthesia, then a patient should know of that option, even if the surgeon would rather not perform the surgery. It should be the option for a well-informed patient to find a different anesthesiologist or a different surgeon in such cases,

as techniques such as minimally invasive surgeries can offer distinct advantages to a patient, such as length and difficulty of recovery and rehabilitation.

CONCLUSIONS

There may be no more important ethical doctrine than informed consent. It has been the centerpiece of American health law for nearly 100 years, having been firmly established in importance in the *Schloendorff* case in 1914, when Justice Benjamin Cardozo wrote, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."[3] Much of medical ethics of the intervening century can be seen as interpretations of this succinct statement. It is the legal buttress for the principle of autonomy, yet also makes clear the responsibilities of the physician; thus it can equally be seen as the progenitor of a joint decision-making model. Properly exercising this responsibility is an important ethical duty of every physician.

Thus, for example, in the setting of the intensive care unit, where most ethics consults tend to occur, it has become common of late to require consent for blood transfusion. This is in part because we have realized that blood transfusion carries more risk than was known 10 or 20 years ago. But it is also because ethics has worked its way deeper into medical practice, and the idea that the physician knows best, and does not need the patient's consent, has slowly loosened its hold, first in general practice, then in hospital practice, and now—I would hold—in surgical practice.

Not long ago we were content to let a vague "general consent" or "implied consent" cover many aspects of care throughout the perioperative period, and possibly for days post-op (so long as a patient was in the post-anesthesia care unit, for example). Perhaps we *assumed* that the care team knew what patients wanted, or perhaps it was assumed that patients were obligated by surgical consent to continue treatment. But, as the great Felix Unger (of *Odd Couple* fame) said, "When you 'assume' you make an 'ass' out of 'u' and 'me'." (Some ascribe this to Oscar Wilde, but I have yet to find that reference.)

We are becoming less comfortable making assumptions that we know what patients want, and that is good, for not all patients want the same thing, and there is no way to know other than to ask. Similarly, unless a Ulysses contract is made explicit at the beginning, we cannot deny a patient who has capacity that right. (In such a contract, a patient waives the right to change his or her mind—like Ulysses, who had himself tied to the mast while it sailed past the Sirens, with orders that if he begged to be untied, he should be bound tighter.) In a similar way, we can have patients make decisions prior to predictable events, to give them more control over their outcome or destination.

There is a movement—early in its development—to have two separate consent forms as the standard in surgery, one to cover all the surgical issues and one to cover all the anesthesia issues. Both are probably best introduced the day the surgery is being decided and scheduled, not on the day of surgery (when it would be inconvenient for a patient to decide against surgery, or might feel coerced into consenting).

It shouldn't be surprising that anesthesiologists have come to see their own ethical duties in the informed consent process as something separate from those of surgeons. Each professional has duties to patients; hence, each ought to have a role in explaining his or her role to patients and obtaining assurance of patients' understanding and agreement. This exemplary case introduces an emerging ethical field, ethics in anesthesiology, to clinical ethics.

NOTES

1. L.C. McCullough, J.W. Jones, and B.A. Brody, ed., *Surgical Ethics* (Oxford: Oxford University Press, 1998); J.W. Jones, L.B. McCullough, and B.W. Richman, *The Ethics of Surgical Practice: Cases, Dilemmas, and Resolutions* (Oxford: Oxford University Press, 2008); J.P. Spike, "Common Ethical Problems in Acute Care Surgery," in *Common Problems in Acute Care Surgery*, ed. L. Moore (Dordrecht, the Netherlands: Springer, forthcoming, 2012).

2. C.B. Patel and D. Cattano, "Intraoperative Conversion to Open Technique: Is Informed Consent Implied?" in this issue of *JCE.*

3. *Schloendorff v. Society of New York Hospital*, 211: New York Court of Appeals; 1914.4