Never the twain shall meet? Interspecialty bioethics education and practice in relation to informed consent for surgery-related anesthesia*

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Objectives

- Identify and analyze ethical problems concerning known practices regarding informed consent for surgery-related anesthesia
- Propose solutions to these problems, with a focus on interspecialty bioethics education

Method

- A literature search of Medline OVID and of Google Scholar was conducted by using the keywords: anesthesia OR anesthesiologist AND curriculum OR education OR teaching AND ethics OR bioethics AND graduate OR postgraduate OR residency OR internship OR continuous professional AND informed consent OR consent form AND interspecialty OR interprofessional OR interdisciplinary AND legislation OR regulation OR standard AND surgery OR surgeon AND teamwork OR collaboration OR coordination OR cooperation
- Contemporary and 20th century textbooks of anesthesia and surgery and related bioethics books were also reviewed
- Collaborators from the anesthesia and surgery departments and from the postgraduate medical education office at the University of Western Ontario were approached for reference to relevant local, provincial and national guidelines

Background

Importance of informed consent

➢Informed consent must be obtained prior to performing a health care procedure - Rationale: respect for patient autonomy

➢Requirements for informed consent:

•Pertinent information is provided

•Voluntariness is secured

•The person has adequate capacity to consent

Documentation of informed consent for surgery-related anesthesia

➢Current practice varies depending on the requirements of jurisdictions and among hospitals; however, documentation of informed consent is commonly documented in one or more ways:

•Handwritten/typed note in the patient's health record

•Anesthesia specific consent form

•Reliance on surgical consent form (usually briefly referring to the requirement of anesthesia and its associated risks)

Debates concerning documentation of informed consent for surgery-related anesthesia

American Society of Anesthesiologists (ASA) (2006)

➢Debate among anesthesiologists and legal specialists on whether anesthesiologists should use an anesthesia specific consent form separate from a surgical consent form. Considerations:

•Legal protection for anesthesiologists

•Better patient care

•Logistics of patient care in hospital (e.g., time constraints)

➢ Focused mostly on better legal protection for anesthesiologists

(ASA newsletter; July, 2006)

One form, two forms, or…?

➢Reliance on surgical consent form

•Substantial informed consent process is not reflected in formal paperwork

•Less paperwork

•May provide enough legal protection for anesthesiologists by means of their progress note

•Some surgeons refuse

➢Anesthesia specific consent form

•Substantial informed consent process is directly reflected in formal paperwork

•More paperwork

•Odd for surgeons to obtain informed consent only to surgery without anesthesia, as anesthesia is definitely required

•Better legal protection for anesthesiologists (controversial)

Ethics critique of current known practice

➢ Problem may not only address one form vs. two forms, but also how the informed consent process occurs

Problems in relation to the elements required for informed consent - 1

➢Surgeons often obtain written informed consent not only for surgery, but also for surgery-related anesthesia without providing much information about anesthesia

•Not respectful of patient autonomy and involves risks to patients, as they sign a paper not reflecting the informed consent process, i.e., patients give formal consent to anesthesia without being sufficiently informed about it

•Risk for surgeons, as they obtain consent for anesthesia, which is not their specialty

Problems in relation to the elements required for informed consent -2

➢Anesthesiologists often provide substantial information (and opportunity for discussion) "Just before entering the operating room (OR)"

•Not respectful of patient autonomy, as they are given little time to understand and deliberate (tight OR schedule) before giving consent

•Risk for anesthesiologists, as they do not obtain a formal consent by themselves

Analysis, possible solutions and limitations

1. Legal aspects

Analysis

•No legal requirement for implementing a consent form signed by patients and anesthesiologists

•Law may not be specific enough to address informed consent process, e.g., how patients should be informed

Solution and limitations

•Require anesthesia specific consent form and standard of informed consent process by regulation

➢May bring immediate change regarding documentation

➢Better patient care is not necessarily guaranteed

2. *Logistics of patient care in hospital*

Analysis

•Many patients are not admitted to hospital until the day of surgery

•Tight OR schedule

•Not enough time for healthcare staff

•No desire to increase paperwork

•Pressure to cut expense

Solution and limitations

•Reconstruction of logistics of perioperative patient care

➢Difficult due to multiple factors (limitation in manpower, OR capacity, funding, and human tendency to maintain current practice despite problems)

3. Attitudes of anesthesiologists and of surgeons about this issue

Analysis

•Anesthesiologists and surgeons may not be fully aware of the problematic aspects of the current known practice regarding informed consent process and documentation for surgery-related anesthesia

Solution and limitations

•Enhance discussion among surgeons and anesthesiologists

•Relevant bioethics education for residents, and possibly for faculty

➢Not enough time?

➢Other resources missing: instructors, teaching materials, funding

Informed consent for surgery-related anesthesia is an interspecialty issue

•As anesthesia is required for most surgeries, obtaining informed consent for surgery-related anesthesia is important not only for anesthesiologists, but also for surgeons

•Surgery and anesthesia are distinctly different specialties which must function collaboratively during the perioperative period

Results of literature search on an interspecialty approach to this Issue

•We found no published scholarly writings or formal local guidelines on interspecialty education or teamwork of residents or specialists in anesthesia and in surgery regarding informed consent for surgery-related anesthesia

Interspecialty education: a proposal

Interprofessional education

•*WHAT is it*?: Occasions where two or more professions (in health and social care) learn with, from and about each other to improve collaboration and quality of care

•*WHY promote it*?: Interprofessional education can produce positive changes, e.g., collaborative professional practice and a more wholistic understanding of patients/clients

•*WHEN should it happen*?: Interprofessional education may be undertaken before and/or after qualification

(Freeth, Hammick, Reeves, Koppel & Barr, 2005)

Interspecialty education as interprofessional education?

•Specialty is a subdivision within a profession. Specialties in medicine have proliferated (Barr et al., 2005)

•Interspecialty education and interprofessional education are similar in that they address issues across practices that may be fundamentally different from each other, at least in part

•Interspecialty education and interprofessional education may be different to some extent, as there are important common understandings and shared values within a profession

Empirical evidence on the outcomes of interprofessional education

➢Review of 107 studies searched from: Medline (1966-2003), CINAHL (1982-2001), BEI (1964-2001), ASSIA (1990-2003)

➢Reported Outcomes of Interprofessional Education

-Level of Outcome-	-Positive-
• Reaction to this education experience	45 (42%)
• Modification of attitudes/perceptions	21 (20%)
• Acquisition of knowledge/skills	38 (36%)
• Behavioural change	21 (20%)
• Change in organizational practice	37 (35%)
• Benefits to patients/clients	20 (19%)

(Barr, Koppel, Reeves, Hammick & Freeth, 2005)

Proposal: joint bioethics education for in surgery and in anesthesia

•Content: informed consent process and its documentation

•Process: lecture, case discussion, role play, demonstration of various types of documentation

➢Interprofessional education is focused on interaction between participating professionals (Freeth et al., 2005)

➢Learning processes are as important as learning outcomes; thus, greater emphasis is put on active participation of the learner and on the context where learning takes place (Lord & Young, 2008)

Proposal: joint bioethics education for specialists in surgery and in anesthesia

•Compared with resident education, this may be less feasible to implement as a requirement; however, it should not be considered less important because:

➢Interprofessional education may be undertaken at any stage of qualification (Freeth et al., 2005)

➢Through interaction with others and working collaboratively, continuous interprofessional education provides transformative learning, i.e., creating new learning which is not a mere extension of what is taught and learned (Sargeant, 2009)

Evaluation of outcomes

•Education evaluation should be considered at the early stage of education planning (Freeth et al., 2005)

•Framework for evaluation (Kirkpatrick-Barr et al. , 2000)

1.Learners' reactions/views on their learning experience

2.Learning (modification of attitudes, acquisition of knowledge/skills)

3.Behavioral change (application of learning to practice)

4.Change in organizational practice and benefits to service users (Carpenter & Dickinson, 2008)

➢Learning and behavioral change of surgery and anesthesia residents/specialists are important; however, the most important of all should be benefits to patients for being adequately informed before giving consent

Perhaps not joint education: a possible objection to address

•Bioethics education regarding informed consent for surgery-related anesthesia may be done separately for each specialty; however, it may be more effective to do it together considering the nature of this issue

•Interprofessional education and uni-professional education (separately done for each profession) complement one another; there is an effective balance between these two (Freeth et al., 2005)

➢Further empirical research is required to determine which – separate, joint or balanced – education is more effective and less costly in this context

Conclusion

➢Current known practice regarding informed consent for surgery-related anesthesia is ethically problematic as it does not fully include the elements required for informed consent process:

1. Formal consent is often obtained by surgeons and not by anesthesiologists who must provide information and opportunity for questions and discussions

2.Patients often receive information about anesthesia "just before entering the OR"

➢Such problems may be related to (1) lack of legal requirements, (2) difficult logistics of patient care, and (3) inadequate understanding about informed consent among anesthesiologists and surgeons

➢Obtaining informed consent for surgery-related anesthesia may be better addressed as an interspecialty issue, as both specialties are involved

➢Joint bioethics education for residents and for specialists in surgery and in anesthesia may be conducive to such informed consent