Chapter 12
Specific Considerations Regarding Consent and Communication with Patients and Family Prior to Neurosurgery

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Overview

For any medical procedure, informed consent consists of four basic elements: (1) voluntariness, (2) competence, (3) informed, and (4) comprehended (capacity). For neuroanesthesia, satisfaction of the elements may be more difficult due to both the underlying pathology and the difficult choices facing patients undergoing neurosurgery. As a result of the unique nature of neurosurgical cases, anesthesiologists need to allow more time and need to take more care in obtaining consent for the anesthetics used in those cases.

A review of the elements for valid consent is useful for understanding the challenges faced in obtaining valid consent in neurosurgical cases. The classic criteria for voluntariness was set forth in the Nuremberg Code which stated that the patient should be "able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion." Several factors may impair the voluntary nature of informed consent. First, sedation is commonly encountered among preoperative patients and may constitute a form of constraint on a patient's ability to fully evaluate and participate in informed consent. Sedation may be obvious in the case of a sleepy patient who has received a large dose of anxiolytic, or may be more subtle, such as in a patient who has received a smaller dose of analgesic medication. The environment in which informed consent is obtained may also undermine voluntariness. Addressing informed consent in the operating room may make a patient more likely

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to feel pressured to agree to a procedure. The anesthesia provider may also limit voluntariness by deliberately limiting anesthetic choices for the patient, based on the anesthesia provider's preference.

Patient competency is a legal term and designation. All adults are deemed competent unless designated otherwise by a court, and a declaration of incompetence is universally followed by appointment of a legal guardian. Patients that have been declared incompetent cannot consent, and consent must be obtained from their designated guardian.

Capacity is distinct from competency and is a determination made by the physician. The subject of informed consent should have "sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision." This requires that the patient have the capacity to provide informed consent and "implies that a patient has the ability to understand and weigh medical information and make decisions." The patient must be able to understand the medical problem and proposed treatment alternatives. For some procedures, this may be relatively simple. However, as the complexity of the medical problem and treatment increases, the patient's decision-making capacity may be exceeded. Likewise, as the complexity of the medical decision increases, so does the obligation of the physician to ensure that the patient has the capacity to understand the medical decisions and its implications.

Meeting the "informed" element of consent can be obtained by addressing the four key components of the PARQ discussion: (1) procedures, (2) alternatives, (3) risks, and (4) questions. The PARQ discussion can be utilized not only to provide information to the patient but also in determining the patient's ability to understand the concomitant risks and alternatives.

Implications for Neurosurgical Procedures

Obtaining informed consent from neurosurgical patients can be complex, due to the nature of the patient's diagnosis, the treatment options, and the increased likelihood for diminished decision-making capacity related to the neurosurgical procedure. First, voluntariness may be problematic for several reasons. Neurosurgical problems often present treatment choices without a "good" choice. For example, a patient with a brain mass must decide between surgery, which may leave the patient with a significant neurologic deficit or even death, or not having surgery and risk the tumor growing causing neurologic deficits and again possibly death. Family members may strongly support or oppose some options and may place pressure on the patient to choose a particular course.

Neurosurgical problems often compromise a patient's decision-making capacity, and any diagnosis or treatment that alters mentation may be associated with diminished capacity. Neurosurgical conditions most likely to decrease capacity include stroke and dementia. In cases of delirium, waxing and waning mental status creates a moving target for the assessment of medical decision-making capacity. Additionally, based on the degree of delirium, sedative medications may be required to maintain

the patient's safety. The intensive care unit setting itself is associated with a high proportion of patients with diminished medical decision-making capacity. Conditions among patients in the ICU can range from postoperative sedation to ICU psychosis, which interfere to varying degrees with a patient's ability to evaluate medical decisions, but interfere nonetheless. Psychiatric diagnoses can also impair capacity. Unfortunately, many physicians caring for impaired patients may not appropriately identify them as such.

Much variability can exist within a given diagnosis or even between physicians evaluating whether a patient has capacity to provide informed consent. Other instruments that may be valuable in assessing capacity include the Mini-Mental State Examination (MMSE), which has been found to correlate with clinical judgments of incapacity. A score of <19 is associated with lack of capacity. The MacArthur Competence Assessment Tool for Treatment may also be utilized and specifically incorporates information related to a patient's decision-making situation. Unfortunately, these assessments can be time-consuming; the Mac-CAT takes about 20 min to perform.

Often, obtaining surgical consent implies consent for anesthesia, although the PARQ process for each should be distinct. It is possible, however, that a patient may be able to provide surgical consent without the capacity to consent to anesthesia. Again, it is incumbent on the anesthesia provider to weigh whether the patient has medical decision-making capacity, even if surgical consent has already been obtained from the patient.

Concerns and Risks

Neurosurgical patients comprise a group at risk for incomplete and/or inadequate informed consent. Taking the necessary time to assess a patient's ability to engage in and understand informed consent is fundamental to ensure the patient's ability to provide informed consent. Failure to obtain proper consent may subject the provider to a claim of battery (the tort of an inappropriate and unconsented touching).

Key Points

- Address each element of informed consent, including voluntariness, competence, informed and comprehended (capacity).
- It is incumbent upon physicians taking care of neurosurgical patients to ensure that informed consent is obtained.
- Neurosurgical patients comprise a high-risk group of patients who may have diminished medical decision-making capacity and may required additional time.
- Maintain a heightened awareness of factors potentially interfering with obtaining informed consent.

Suggested Reading

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