

Obtaining Informed Consent for Anesthesia in Elective Surgery at a Tertiary-Care Hospital: Practices and Ethical-Legal Context



Obtenção de Consentimento Informado para Anestesia em Cirurgia Eletiva num Hospital Terciário: Práticas e Contexto Ético-Legal

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ABSTRACT

Introduction: Informed consent is an active process of the doctor-patient relationship, based on ethical and legal principles. The anesthetic act has inherent risks, which should be subject of specific consent. The aim of this study was to evaluate the degree of implementation of written specific informed consent for anesthesia in the context of elective surgery.

Material and Methods: An observational prospective study, at a tertiary university hospital, in 230 patients aged 60 years or older, undergoing elective surgery between May and July 2017. Eligible patients who consented to participate were interviewed clinically on the day before surgery. In the postoperative period, the anesthetic technique and the existence of the written informed consent for the anesthetic and surgical procedures were assessed. Patients who were unable to give informed consent or those admitted in the Intensive Care Unit after surgery were excluded.

Results: Written informed consent for the surgical procedure was obtained for 225 (97.8%), while it was obtained in just 96 (41.7%) patients for the anesthetic act. There was a higher prevalence of stroke, anemia, and higher Charlson and physical American Society of Anesthesiologists scores in patients without written informed consent for the anesthetic act.

Discussion: We identified a low implementation of written informed consent for anesthesia. This situation may have important implications in the context of disciplinary, civil or criminal liability.

Conclusion: Despite its importance, the practice of written informed consent for anesthesia in this institution is not yet implemented on a regular basis.

Keywords: Anesthesia; Consent Forms; Elective Surgical Procedures; Informed Consent/ethics; Informed Consent/legislation & jurisprudence; Liability, Legal

RESUMO

Introdução: O consentimento informado é um processo ativo na relação médico-doente, assente em valores éticos e legais. O ato anestésico tem riscos inerentes, que devem ser alvo de consentimento específico. O objetivo deste estudo foi avaliar o grau de implementação do consentimento informado escrito para o ato anestésico no contexto de cirurgia eletiva.

Material e Métodos: Estudo observacional prospetivo, num hospital terciário e universitário, em 230 doentes com idade igual ou superior a 60 anos submetidos a cirurgia eletiva entre maio e julho de 2017. Aos doentes elegíveis que consentiram participar, foi realizada entrevista clínica no dia prévio à cirurgia. No pós-operatório, foi averiguada a técnica anestésica realizada, e a existência do consentimento informado por escrito para o ato anestésico e cirúrgico. Doentes incapazes de dar consentimento informado ou admitidos na unidade de cuidados intensivos após cirurgia foram excluídos.

Resultados: Em 225 (97,8%) dos doentes, verificou-se a obtenção, por escrito, do consentimento informado para o ato cirúrgico, mas apenas em 96 (41,7%) verificou-se a obtenção por escrito do consentimento informado para o ato anestésico. De entre os doentes sem registo de consentimento informado para o ato anestésico, foram mais prevalentes antecedentes de acidente vascular cerebral, anemia e scores de Charlson e de estado físico conforme à Sociedade Americana de Anestesiologia mais elevados.

Discussão: Identificámos uma baixa implementação do consentimento informado escrito para o ato anestésico. Esta situação pode ter importantes implicações em contexto de responsabilidade disciplinar, civil ou penal.

Conclusão: Apesar da sua importância, a prática do consentimento informado escrito para o ato anestésico nesta instituição não está implementada regularmente.

Palavras-chave: Anestesia; Consentimento Informado/ética; Consentimento Informado/legislação e jurisprudência; Procedimentos Cirúrgicos Eletivos; Responsabilidade Legal; Termos de Consentimento

INTRODUCTION

Providing information and clarification to patients on a medical or surgical therapeutic proposal is assumed in obtaining informed consent (IC) and patients should make the decision of giving consent based on their own value

system.¹ In order to become valid, this should be an active process of a fully engaged dialogue on making decisions regarding patient's health.² Patients should be fully aware of all the risks associated with the procedure, in a clear and

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objective way, with no discrepancies in the information provided by different healthcare professionals. Patient's decision must be recognised as a legitimate demonstration of autonomy, as long as it is a free and informed decision.³

IC is valued under (i) the ethical perspective, as a crucial part of the physician-patient relationship and the patient's autonomy and (ii) the legal, as an instrument for patient's self-determination regarding the assumed risks and to specify the scope of physician's responsibility.⁴ IC, particularly written IC, is a legal instrument and an evidence in a legal action of medical liability and has been laid down by different legal regulations and codes of ethics, such as the Oviedo Convention,⁵ the Portuguese *Lei de Bases da Saúde*,⁶ the Regulation (*Estatuto*)⁷ and Code of Ethics (*Código Deontológico*) of the Portuguese Medical Association (*Ordem dos Médicos*),⁸ the Norm 015/2013 of the Portuguese *Direção-Geral da Saúde*,³ the Portuguese Civil Code⁹ and Criminal Code.¹⁰

Consent for anaesthesia was for a long time considered as implicit to elective surgeries. Surgeons have had an almost entirely dominant role within the operating room, with no autonomy or responsibility left for the remaining players, regardless of their differentiation. Therefore, the presentation of the proposed anaesthetic management option was usually left to the surgeon. Gradually, Anaesthesiology has become a distinctive specialty, with its own scope for action and with an autonomous role in different areas of expertise beyond anaesthesia. The relationship between surgeons and anaesthetists has become increasingly horizontal and the direct contact between the patient and the anaesthetist has claimed for the anaesthetist's personal and civil liability in a cumulative way, with a direct link to the obligation concerning the means¹¹ as well as to obtain from patients their informed and free consent for the techniques that are proposed.

The anaesthetist's autonomy over the remaining operating room staff members has been laid down by the Code of Ethics of the Portuguese Medical Association (*Ordem dos Médicos*)⁸: "physicians, in exercise of their profession, are technically and ethically independent and are responsible for their actions" ("*o médico, no exercício da sua profissão, é técnica e deontologicamente independente e responsável pelos seus atos*"). Nevertheless, the studies by Tait *et al.* and Zarnegar *et al.* have shown that more relevance is still assigned by patients to their consent for surgery than for anaesthesia, more aware of the information discussed on surgery itself.^{12,13}

The anaesthesia has specific aims, benefits, alternatives and risks that must be specifically discussed and leading to a specific consent. Only the anaesthetist has the necessary skills and knowledge to design and discuss the anaesthesia plan and its specific characteristics. Therefore, discussing and obtaining consent for anaesthesia must be an ethical and legal obligation of the anaesthetist rather than of any other healthcare professionals. Different authors have found that understanding the anaesthesia procedures, their benefits and adverse effects, as well as the role of the

anaesthetist is improved by obtaining an adequate IC for anaesthesia.^{14,15}

The adequate practice for information transmission and documents leading to IC, according to current literature, has been recommended by the Portuguese *Direção-Geral de Saúde*.^{3,16,17} In addition, written IC are also recommended, by use of a specific form, for elective surgeries in which any kind of anaesthesia technique is used. A specific form represents a straightforward record of the patient's decision.

This study was aimed at assessing written IC for anaesthesia in elective surgeries by patients aged 60 and older attending a tertiary university hospital.

MATERIAL AND METHODS

This was a prospective observational study carried out at the department of Anaesthesiology of a Portuguese tertiary university hospital following the approval by the ethics committee of the institution.

The study was aimed at elderly patients submitted to elective surgery, due to its increasing prevalence, patient comorbidities, quality of life and surgical outcomes. Patients aged 60 and older having undergone an elective surgery in General Surgery, Urology, Gynaecology, Plastic Surgery, Vascular Surgery, Orthopaedics and Oral and Maxillofacial Surgery between May and July 2017 were included in the study. Patients postoperatively admitted to the Intensive Care Unit were excluded from the study, in addition to patients unable to understand the Portuguese language or to give IC for the participation in the study.

Patients attended a clinical interview the day before surgery, where the following data were collected: proposed surgery procedure, demographic data, medical history, usual medication, American Society of Anesthesiologists (ASA) physical status, Charlson index, clinical frailty scale (CFS) and cognitive ability as assessed by the Montreal Cognitive Assessment (MoCA). Charlson index is an outcome indicator for the classification and assessment of comorbidities aimed at obtaining a 10-year estimated mortality.^{18,19} CFS score is a strong predictor of postoperative adverse events and patients are classified according to the level of vulnerability.^{20,21} Montreal Cognitive Assessment (MoCA) is an early detection method of cognitive impairment, which has already been adapted to the Portuguese population.²²⁻²⁴ The presence of cognitive impairment is considered below the score of 26 which has been established as clinical cut-off.

Data on anaesthesia and written consent for anaesthesia and surgery were postoperatively obtained from the patient's clinical record. Even though not recommended, an initial contact of the anaesthetist with patients in the immediate preoperative period is still currently the usual procedure, a moment in which a written IC should be obtained. For this reason, the presence of a written IC was only postoperatively checked.

Patients were grouped according to the presence/absence of written IC for anaesthesia, allowing to check for

the presence of any conditions of the patients or the anaesthesia procedure associated with the absence of written IC.

Mann-Whitney test was used for continuous variables and Pearson's chi-squared, linear by linear association and Fisher's exact tests were used for categorical variables. Differences were considered as significant with $p < 0.05$. Statistical analysis was carried out by using IBM's Statistical Package for Social Sciences (SPSS Inc. Chicago, IL), version 24.0 software.

RESULTS

A total of 230 patients were included in the study (53.9% female, mean age 70.92).

A record of written consent for surgery was found in 225 patients (97.8%), while a similar consent for anaesthesia was only found in 96 patients (41.7%) and none of the latter was due to patient's informed refusal.

The absence of written IC for both procedures was found in five patients (2.2%).

The absence of written consent for anaesthesia has been associated with a higher prevalence of stroke ($p = 0.021$) and anaemia ($p = 0.028$), as well as higher Charlson scores¹⁹ (0.017) and ASA physical status scores ($p = 0.046$). No significant association has been found with the remaining variables or with patient's history of neurological, psychiatric or cardiovascular pathology, as well as with higher CFS score. The results are shown in Table 1.

The distribution of patients by the different departments is shown in Table 2 and no significant differences were found.

DISCUSSION

The presence of written consent for anaesthesia was only found in 96 (41.7%) patients and for surgery in 225 (97.8%). These results are in line with previous studies showing a higher implementation of consent for surgery when compared to anaesthesia.^{12,26} The absence of written consent for anaesthesia does not reflect the absence of patient's autonomy, as patients have given their consent for surgery, but possibly the lack of awareness of anaesthetists for this procedure.

A higher prevalence of patients with a history of anaemia and stroke, in addition to higher ASA physical status score and Charlson score were found in patients in whom the absence of written consent for anaesthesia has been found. An increased risk of specific complications must be discussed with patients at the time when IC for anaesthesia is obtained.

Patients with a history of stroke present with impaired cerebral vascular territories and are particularly prone to the possible complications associated with intraoperative episodes of cerebral hypoperfusion, namely a new cerebral ischaemic episode and postoperative cognitive dysfunction.²⁷⁻²⁹

Preoperative anaemia is an independent risk factor of

adverse perioperative outcomes³⁰⁻³² and the need for perioperative blood transfusion.^{33,34} These outcomes may be potentiated by iatrogenic haemodilution itself, in addition to sympathetic and cardiac depression induced by anaesthesia.^{32,35} Specific factors that can contribute to choose a certain anaesthesia technique must be taken into account in proposed anaesthesia, including (i) the severity and type of anaemia, (ii) the level of physiological compensation and (iii) the expected blood loss. A possible indication for perioperative blood transfusion must be discussed with the patient, complying and adequately recording the patient's will.

Poorer physical condition and more comorbidities are globally presented by patients with higher Charlson¹⁹ and ASA physical status scores, corresponding to a group of patients more likely to present with perioperative complications, with the need for unplanned interventions and late-term complications with varying levels of severity. Therefore, these patients should be adequately informed on their condition, risks and alternatives and this should be a systematic approach aimed at adjusting the information to the patient's cognitive ability or, when adequate, providing the adequate information to the patient's legal representative and obtaining consent.

No written IC both for surgery and anaesthesia was obtained in five out of the 230 patients included in the study (2.2%), in non-compliance by physician and nursing team with the indications for safe surgery by the World Health Organization and the Norm 002/2013 of the DGS.^{36,37} Significant constraints may arise from this situation regarding the clarification of surgery's lawfulness, as only free and IC allow for the transfer of risks to the patient, which would be supported by physicians otherwise.⁴

IC is currently a legal prerequisite in any medical intervention and crucial to its legitimacy, which has been laid down by different legal and ethical norms, particularly by the Code of Ethics (*Código Deontológico*) of the Portuguese Medical Association,⁸ the Civil Code⁹ and the Penal Code,¹⁰ allowing to specify the scope of liability of physicians and patients^{38,39}; with consent, there is a conscious awareness of the risks to which patients are previously informed.⁴⁰ The duty to inform is advocated both by disciplinary proceedings and by law. The areas of liability of anaesthetists are clearly defined and therefore directly and personally responds for hypothetical medical malpractice.¹¹

In Portugal, medical liability is ruled by the *Estatuto Disciplinar Médico*⁴¹ in addition to the Code of Ethics (*Código Deontológico*) of the Portuguese Medical Association⁸; these instruments of regulation are mandatory for all the physicians registered with the Portuguese Medical Association and aim to ensure the adequacy of the clinical practice to the required quality parameters. The obligation of obtaining the IC is advocated by the *Estatuto*⁷ (art. 135º) and the Code of Ethics of the Portuguese Medical Association⁸ (art. 19 and 20). Disciplinary action shall be invoked in case of violation (by action or omission) of specific duties and rules of conduct of physicians and is of the exclusive responsibility of the Portuguese Medical Association.⁴²

Table 1 – Demographic and clinical characteristics (n = 230)

Variable, n (%) or median (IR)	Total n = 230	With written IC for anaesthesia n = 96 (41.7)	Without written IC for anaesthesia n = 134 (58.3)	p-value
Gender				
Female	124	54 (43.5)	70 (56.5)	p = 0.547 [†]
Male	106	42 (39.6)	64 (60.4)	
Age	230	69.0 (65.0 – 77.0)	70.0 (65.0 – 77.0)	p = 0.863 [*]
ASA status				
1	10	6 (60.0)	4 (40.0)	p = 0.046 ^{†*}
2	125	56 (44.8)	69 (55.2)	
3	85	32 (37.6)	53 (62.4)	
4	10	2 (20.0)	8 (80.0)	
Charlson score	230	5.0 (3.0 – 9.0)	7.0 (4.0 – 10.0)	p = 0.017 ^{**}
MoCA score	230	22.0 (18.0 – 26.0)	22.0 (18.0 – 26.0)	p = 0.976 [*]
Clinical frailty (CFS) score				
Very fit	24	11 (45.8)	13 (54.2)	p = 0.844 [†]
Well	46	21 (45.7)	25 (54.3)	
Managing well	71	27 (38.0)	44 (62.0)	
Vulnerable	39	14 (35.9)	25 (64.1)	
Mildly frail	16	9 (56.2)	7 (43.8)	
Moderately frail	21	9 (42.9)	12 (57.1)	
Severely frail	13	5 (38.5)	8 (61.5)	
Acute myocardial infarction				
Yes	16	6 (37.5)	10 (62.5)	p = 0.721 [†]
No	214	90 (42.1)	124 (57.9)	
Stroke				
Yes	15	2 (13.3)	13 (86.7)	p = 0.021 ^{†*}
No	215	94 (43.7)	121 (56.3)	
Dementia				
Yes	6	2 (33.3)	4 (66.7)	p = 0.508 [†]
No	224	94 (42.0)	130 (58.0)	
Neurological pathology				
Yes	17	8 (47.1)	9 (52.9)	p = 0.644 [†]
No	213	88 (41.3)	125 (58.7)	
Psychiatric pathology				
Yes	33	15 (45.5)	18 (54.5)	p = 0.640 [†]
No	197	81 (41.1)	116 (58.9)	
Anaemia				
Yes	47	13 (27.7)	34 (72.3)	p = 0.028 ^{†*}
No	183	83 (45.4)	100 (54.6)	
Congestive heart failure				
Yes	18	7 (38.9)	11 (61.1)	p = 0.798 [†]
No	212	89 (42.0)	123 (58.0)	
Ischaemic heart disease				
Yes	19	8 (42.1)	11 (57.9)	p = 0.973 [†]
No	211	88 (41.7)	123 (58.3)	
COPD				
Yes	11	4 (36.4)	7 (63.6)	p = 0.484 [†]
No	219	92 (42.0)	127 (58.0)	
Obstructive sleep apnoea				
Yes	10	4 (40.0)	6 (60.0)	p = 0.590 [†]
No	220	92 (41.8)	128 (58.2)	
Chronic kidney failure				
Yes	20	6 (30.0)	14 (70.0)	p = 0.265 [†]
No	210	90 (42.9)	120 (57.1)	
Diabetes				
Yes	57	19 (33.3)	38 (66.7)	p = 0.138 [†]
No	173	77 (44.5)	96 (55.5)	
Thyroid pathology				
Yes	25	10 (40.0)	15 (60.0)	p = 0.852 [†]
No	205	86 (42.0)	119 (58.0)	
Anaesthesia				
General	137	55 (40.1)	82 (59.9)	p = 0.898 [*]
Combined	50	23 (46.0)	27 (54.0)	
Regional	32	13 (40.6)	19 (59.4)	
Sedation	11	5 (45.5)	6 (54.5)	

IR: interquartile range; IC: informed consent; ASA: American Society of Anaesthesiologists scale; MoCA: Montreal Cognitive Assessment scale; COPD: chronic obstructive pulmonary disease

* Statistically significant. p < 0.05; † Pearson's chi-square test; * Mann-Whitney test; † Linear-by-linear association test; † Fisher's exact test * Chi-square test

As regards civil liability, the actions due to medical liability are mainly due to (i) malpractice or medical error or (ii) to violation of patient rights, namely the right of self-determination and individual freedom, closely related to the principle of IC.⁴ A voluntary conduct is required within civil liability (contractual or non-contractual) from which any harm would illegally result to the patient, in addition to an adequate causal link between actions carried out by physicians and the harm, leading to a proved physician fault.¹¹

The Portuguese Civil Code (*Código Civil*)⁹ is aimed at protecting the legal right to self-determination, physical and moral integrity of the human being. Surgeries are not exempt of risks that can aggravate patient's health status and therefore the patient's awareness on any of these possible complications is crucial. Informed consent has a crucial relevance to establish the legality of any medial or surgical intervention (article 340 of the *Código Civil*).⁹ Its absence can be deemed litigious for personal injury (due to violation of the right to self-determination and individual freedom) or for property damage (due to aggravated health status in context of arbitrary medical or surgical interventions). In such a case, physicians are obliged to compensate patients for the damage produced with their action.⁴³

According to the article 150 of the Portuguese Penal Code (*Código Penal*),¹⁰ medical or surgical interventions performed by physicians or other qualified professionals with a therapeutic aim and according to the *leges artis* are not considered as aggravated maltreatment. On the other hand, whenever an intervention is carried out according to the *leges artis*, under a technically adequate procedure, without the adequate patient's consent (and validated according to the suppositions in the article 157), this would correspond to an arbitrary medical or surgical intervention and a crime against individual freedom, punishable by a prison sentence of up to three years or criminal fines. When physicians act allowing for a non-consented risk by patients

and this occurs, they can get involved into a legal action due to physical abuse by medical negligence (art. 148) or negligent homicide (art. 137).⁴⁴ Patient's consent only enable to rule out a violation of patient's self-determination and not any other legal assets.⁴⁵

Despite the relevance of an IC form, decisions taken by foreign tribunals, namely in Australia and in the United Kingdom^{46,47} have refused the value of these documents with the argument that these have been reduced to formalities and no appropriate information having been established (in some studies, less than half of the patients were informed on the therapeutic alternatives)⁴⁸ or patient awareness on the situation to be consented for (written consent is signed by a significant percentage of patients without having understood the associated legal rights).⁴⁸ There is still little experience with legal processes of medical liability related to IC (Court Judgements in 09/10/2014 and 7/03/2017 of the Portuguese Supreme Court of Justice)^{49,50} and no process has been carried out related to the absence of a written IC for anaesthesia.

Therefore, a simple signed form is not enough to ensure the validity of patient's consent while appropriately informed and free, which had clearly been laid down by the Norm 015/2013 of the Portuguese *Direção-Geral da Saúde*, updated in 04/11/2015³: "the process of obtaining an IC does not just involve the administrative procedure of obtaining the patient's written or oral agreement for the proposed action, rather being part of a systematic and continuous attitude of the healthcare professionals".

Many patients are unaware of medical terms and have wrong notions on the anaesthesia procedure^{13,51} and these should be made clear. Understanding the anaesthesia procedures, their benefits and adverse effects will be improved by systematically obtaining IC for anaesthesia.^{13,14} Despite no consensus on which information should be systematically discussed with patients, it is always wise to discuss

Table 2 – Patient distribution per department (n = 230)

Department n (%)	Total n = 230	With written IC for anaesthesia n = 96 (41.7)	Without written IC for anaesthesia n = 134 (58.3)	p-value
General Surgery	92	37 (40.2)	55 (59.8)	p = 0.584 ¹
Vascular Surgery	21	8 (38.1)	13 (61.9)	
Gynaecology	11	6 (54.5)	5 (45.5)	
Orthopaedics	32	18 (56.3)	14 (43.8)	
Plastic Surgery	14	5 (35.7)	9 (64.3)	
Urology	53	19 (35.8)	34 (64.2)	
Oral and Maxillofacial Surgery	7	3 (42.9)	4 (57.1)	
Total, n (%)	230	96 (41.7)	134 (58.3)	

¹ Fisher's exact test; IC: informed consent

(i) the proposed procedure and for what reason; (ii) the expected benefits and outcomes; (iii) the risks, complications and consequences involved, in addition to (iv) information on alternatives. The pattern of each specific patient is what should determine any criteria regarding adequacy and sufficiency of shared information aimed at patient's self-determination.⁴² The legal obligation should be transformed into an encouragement to dialogue and shared information adequate to each particular situation and to patient's concerns, individual characteristics and probability of each outcome.³⁸ These factors may influence the proposed anaesthesia, namely the decision of general or regional anaesthesia, according to patient's characteristics and risks.⁵² Far too complex or overloaded forms, as well as highly technical language that would prevent patient understanding should be avoided.

Lack of adequate information and awareness of anaesthesia can induce patient's or patient representative dissatisfaction regarding healthcare and therefore corresponding to risk factors for dispute.⁵³ In fact, dissatisfaction regarding the information given on the different anaesthesia alternatives, in addition to risks and benefits of the procedure has been confirmed in current literature.¹² Poor consistency in shared information by different anaesthetists from the same institution has also been found.¹³ In certain contexts, as an inadequate communication between patients and physicians may be the main cause for dispute,⁵⁴ pre-anaesthesia assessment in a specific consultation has even been recommended by some authors, according to what has been recommended by the norm no. 029/2013 of the *Direção Geral de Saúde*, "Avaliação Pré-Anestésica Para Procedimentos Eletivos".¹⁷

Apart from having to provide patients with adequate information, IC process should be adequately recorded. Maintaining clear records, namely kept within the patient's medical record, is a crucial practice in medical approach, with a contribution to clarify the validity of a patient's consent and adequate medical care. However, other authors have found that only a suboptimal percentage of physicians actually follows these recommendations by routine.^{26,55} This failure may prevent from reaching a clear conclusion on the IC validity.

Different constraints in obtaining an IC for anaesthesia have been described by anaesthetists –current work overload in the national health system results in a frequent situation in which the anaesthetist only meets the patient a few minutes before surgery, with no appropriate time or conditions to have an informed discussion and free from external constraints. Constraints regarding the selection of the information to be shared with patients have been described by different anaesthetists in previous studies²⁶ or regarding communication barriers and the lack of time.⁵⁵ Even though these are the realities, constraints should not explain for the absence of IC as an ethical and legal imperative.

No differences were found in obtaining a written IC for anaesthesia between the different surgery procedures in this study, allowing for the conclusion that suboptimal im-

plementation of IC for anaesthesia cuts across the whole institution. An IC form previously designed by the Ethics Committee of the institution has been used, using a simple and available language, providing summarized data aimed at encouraging the oral discussion, designed for a systematic use in clinical practice.

The fact that only the elderly population, a small number of patients and hospital departments, in addition to the fact that only one hospital has been considered were the major limitations of the study.

CONCLUSION

Even though considering the limitations of the study, a suboptimal implementation of written IC for anaesthesia was found, showing the need for widespread use and standardisation of the procedure to obtain an IC for anaesthesia. Preoperative patient assessment, the systematic use of a specific IC for anaesthesia and its recording are crucial to improve patient's awareness of the status of Anaesthesiology as a distinctive specialty in any medical or surgical intervention.

Obtaining the IC is an ethical, disciplinary and legal duty in any surgery, aimed at protecting patient's self-determination, recognised by different legal and ethical regulations. The anaesthetist's autonomy has been laid down and has therefore the obligation to obtain patient's IC for each procedure. In order to be valid, consent should be adequately informed and recorded, contributing to prevent and clarify any possible litigious process. The absence of a valid IC is a violation of good medical practice and of patient's individual freedom and disciplinary, civil or penal liability of the responsible physician could be invoked.

Despite constraints regarding its systematic implementation, obtaining a written IC is very relevant and should not be neglected. The study of obtaining a written IC in a younger population would be very relevant, in order to establish comparisons and to study possible underestimates of the discussion with older patients and their ability of self-determination. Knowing whether this reality cuts across other Portuguese hospitals, including non-university hospitals, would certainly be relevant, in addition to the reasons for non-systematic implementation of consent for anaesthesia.

HUMAN AND ANIMAL PROTECTION

The authors declare that the followed procedures were according to regulations established by the Ethics and Clinical Research Committee and according to the Helsinki Declaration of the World Medical Association.

DATA CONFIDENTIALITY

The authors declare that they have followed the protocols of their work centre on the publication of patient data.

CONFLICTS OF INTEREST

The authors declare that there were no conflicts of interest in writing this manuscript.

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