How to inform patients about side effects of regional anaesthesia and analgesia

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OVER THE YEARS THE METHODS of informing patients about the side effects of any procedure have changed.

Many years ago there was a paternalistic attitude – we (medical staff) did what we felt was in a patient's best interests – usually, but not always telling them what we were going to do but discussion of potential side effects etc was minimal or non existent.

Gradually, as a result of changes in the law it became necessary to discuss side effects with patients – but we (medical staff) decided what we would tell the patients. The information given usually related to the most common side effects but rare potentially fatal side effects were not mentioned. In the UK a legal case seemed to set a rate of about 1:100 as the cut off point – side effects less common than 1:100 did not need to be discussed. For RA this was very useful as it meant we had no "legal" need to discuss things like spinal headache or accidental dural puncture as the incidences of these were at or below 1:100. More rare problems such as paralysis or death did not need to be mentioned. Other legal cases set the standard as that practice "accepted as proper by a responsible body of medical men." Thus surveys demonstrating what anaesthetists did or did not tell their patients were very useful. The number of doctors required to make a "responsible body" of opinion was never defined - it may only need two or three to support a particular line of action and there would be no legal case to answer even if the majority of doctors would follow some alternative treatment.

More recently in the UK the law is changing yet again in two important ways:

- Judges have questioned the validity of a "responsible body" of medical opinion and have stated that the use of adjectives such as – responsible, reasonable and respectable – all suggest that the body of opinion to be relied upon is logical and is valid in the light of well-known advances in medical knowledge. If the opinion is out of date then a judge may reject the opinion irrespective of how many doctors still follow that out of date practice.
- the emphasis is moving from what the reasonable doctor might tell a patient to what does the reasonable patient want to know

Thus judges may rely on "evidence based medicine" to reach a decision if the feel medical staff are still using some old fashioned out of date practice.

Our other problem now is knowing what a reasonable patient would like to know or needs to know. Rare side effects we might think not very important eg a slight change in the voice after intubation may have significant consequences for a world class opera singer.

As regards the side effects of Regional anaesthesia, surveys indicate that women want to know all the side effects – even the very rare ones. These surveys also show inconsistencies:

- While women want to know whether a side effect can occur the majority do not want any numbers attached to it. (How anyone can make a valid judgement if they do not know the relative risk is beyond me).
- How women say they will react to the information they have been given depends on the circumstance – eg in labour or not in labour!

Today the law indicates that a patient's right

to make decisions about her care is meaningless unless she has sufficient information. This is called her "Right to know" and is ethically and legally more important than the physician's concern that the patient may be frightened by the information and then refuse treatment. Even if a risk is a mere possibility, yet if it carries with it serious consequences, such as paralysis or death, it should be regarded as a material risk and therefore requires disclosure.[1] ❐

References

1. Brooks H, Sullivan WJ. The importance of patient autonomy at birth. IJOA 2002; 11: 196-203

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