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Ethical conundrums in anaesthetic practice

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Anaesthetic practice in South Africa in 2016 is fraught with various ethical issues, which do not always have straightforward solutions.

These ethical issues may include:

- Informed consent in its broadest sense
- Occupational exposure from an anaesthetised patient
- The suspicion or discovery that a colleague is substance abusing in theatre
- End of life decision-making

Informed consent

The Health Professions Act 56 of 1974 of South Africa[1] is the law under which we as anaesthesiologists and anaesthetists in South Africa practise. This law states that we are required to inform our patients of the costs of their treatment. Likewise, the Consumer Protection Act[2] informs us of the following:

- We are required to give our patients a written quotation;
- We may not charge more than this quotation;
- This "financial consent" needs to be obtained preoperatively;
- This transaction should preferable be in writing;
- This consent can be obtained by another person acting on the patient's behalf.

Insofar as ethical and legal consent for anaesthesia in adult patients is concerned, we are bound by the National Health Act 61 of 2003.[3] This replaced our previous legislation in South Africa which had a very paternalistic attitude to informed consent from patients. The National Health Act embodies the ethical principle of patient autonomy, which is the right to decide for oneself.

Obtaining informed consent from a patient is a process, and not merely a signature on a piece of paper or a form. It entails the following:

- Assessment of the patient's age (must be >18 years) and decisional capacity. The latter is usually fairly straightforward in adults, but can be somewhat of a challenge in children, when one applies the Children's Act 38 of 2005.[4]
- Description of the proposed anaesthetic intervention, incorporating risks, benefits and consequences, as well as costs, if applicable. One needs to check that the patient understands the information.
- The patient makes a decision and communicates this, and signs in writing to this effect.
- The patient must be reminded that consent may be withdrawn at any time. The consequences of withdrawal need to be understood.

When adult patients lack decisional capacity (which may be for a variety of reasons), The National Health Act (NHA) mandates that the following process be followed:

- An advance directive must be sought. If not available or not applicable, then the following surrogates may consent on the patients behalf, provided the patient has not previously knowingly refused the exact same treatment (anaesthetic):
  - A proxy, mandated in writing (power of attorney);
  - A person authorised by law or a court order;
  - The patient's spouse or partner;
  - Parent;
  - Grandparent;
  - Adult child;
  - Brother or sister.
- If none of the above options are available and the treatment is urgent to prevent either death or irreversible damage to the patient (and the patient has not previously refused the exact same treatment), then the emergency treatment may be performed without consent. It is recommended that consent is sought afterwards, in these circumstances.

In patients who are < 18 years of age, the Children's Act 38 of 2005[4] applies, when deciding on informed consent for anaesthesia. Legally, the consent of the parent or guardian is required if the child is < 12 years of age, or over that age but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the treatment.

If a child is older the 12 years, then the Children's Act states as follows:

- A child may consent to his or her own medical treatment or to the medical treatment of his or her child IF the child is over the age of 12 years AND the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment. This would apply to epidural analgesia, for example.
- A child may consent to the performance of a surgical operation on him or her or his or her child if the child is over the age of 12 years AND the child is of sufficient maturity AND has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation and the child is duly assisted by his or her parent or guardian. This applies to consent for surgery and anaesthesia.

In the case of an emergency then the following applies:

- The superintendent of a hospital or the person in charge of the hospital in the absence of the superintendent may consent to the medical treatment of or a surgical operation on a child if the treatment or operation is necessary to preserve the child's life and is so urgent that it cannot be deferred.
- A High Court or children's court may consent to the medical treatment of or a surgical operation on a child in all instances where another person that may give consent in terms of this section refuses or is unable to give such consent.

In all matters pertaining to children the overriding ethical principle is that the decisions that are made must be IN THE BEST INTERESTS OF THE CHILD.

Other ages for consent in children as per the Children's Act 38 of 2005[4] include the following:

- Female circumcision is banned.
- Male circumcision may only be carried out in a male >16 years with his consent, unless it conforms to religious practices or is medically necessary.
- Virginity testing may only be performed in children > 16 years under strict conditions.

Occupational exposure from an anaesthetised patient

A common ethical issue facing anaesthetists in theatre is inadvertent exposure to the patient's bodily fluids via splash or needle stick injuries. If the patient's HIV status is known, then the procedure to be followed is straightforward, with HIV testing of the anaesthetist and post exposure prophylaxis if necessary. If the patient's HIV status is not known and the patient is anaesthetised, then it is not possible to obtain proper informed consent with counselling for HIV testing as is required by law. A patient's right not to be tested for HIV or any other condition is sacrosanct in our laws, such as the Constitution and the NHA.[5] There have been many instances in case law, where HIV testing has been performed on prisoners and others without consent, and the findings have been in favour of those tested without consent. In an anaesthetised patient, taking blood for HIV testing without the patient's consent can be viewed as assault, with a violation of the person's dignity and integrity, both of which are protected by the Constitution. One may argue that consideration of the health care worker's rights must also be considered. However, one would still violate the patient's rights, by testing for HIV without consent, and ethically this is not justified. The NHA suggests that consent should be obtained once the patient is awake after the anaesthetic, as post exposure prophylaxis for the health care worker should start within 24 hours of the exposure. In cases where the patient remains unconscious, such as being treated in the intensive care unit, a case can possibly be made for proxy consent for HIV testing. In conclusion, if one cannot test the patient for HIV after accidental occupational exposure, it is advised to proceed with post exposure prophylaxis for the anaesthetist or health care worker.

A colleague who is found substance abusing in theatre

This scenario is a very uncomfortable one for anaesthetists and anaesthesiologists. Commonly our nursing colleagues draw our attention to the possibility that a colleague is abusing theatre drugs because of certain tell-tale signs, symptoms and behaviours, such as:[6,7]

- Signing out increased quantities of opioids and sedatives;
- Inconsistencies in recording missing drugs;
- Requests from individuals to work longer hours;
- Wearing long sleeves to conceal arms;
- Spots of blood on clothing;
- Changes in behaviour such as wide mood swings;
- Altered/illegible anaesthetic records;
- A desire to work alone, but requiring frequent bathroom breaks;
- A disproportionate number of patients in pain in the recovery room;
- Physical signs such as tremors, pin-point pupils and unexplained weight loss.

If one strongly suspects that a colleague is abusing theatre drugs, then the best way to confirm this is to observe him/her actually abusing the drugs. Confronting a colleague who is suspected of substance abusing is usually met with angry denial. What is our ethical duty if we find a colleague substance abusing in theatre, whilst being at work, anaesthetising patients? Our immediate duty is firstly to protect the patient/s, by persuading our colleague to hand over the anaesthetic to someone competent, and secondly to protect the substance abusing colleague from possibly performing an anaesthetic mishap whilst under the influence of drugs.

The Health Professions Act 29 of 2007[8] defines a substance abusing colleague as being impaired. The Act also states that "It is every doctor's duty to inform an appropriate person or body when doubt arises about a colleague's fitness to practice appropriately". In anaesthesia in South Africa, the following persons or bodies would be applicable:

- The hospital manager in the private sector, or HOD, in the case of the public sector;
- The SA Society of Anaesthesiologists;
- The Health Committee of the HPCSA.

In respect of the latter, it is best if the doctor concerned self-reports, as opposed to having a colleague report him/her. The Health Committee then follows up and advises and manages the doctor concerned appropriately.

End of life decision making

there are many ethical (and legal) end of life issues, such as living wills/advance directives, DNR orders, withdrawing/withholding treatment, and assisted dying/active euthanasia.

Assisted suicide is one issue that is currently illegal in South Africa, and engenders heated and emotional debate. One of its proponents is Archbishop Emeritus Desmond Tutu, who stated "I revere the sanctity of life – but not at any cost. I confirm I don't want my life prolonged. I can see I would probably incline towards the quality of life argument, whereas others will be upset if I said I wanted assisted dying. I would say I wouldn't mind actually."

In 2015 Mr Stransham-Ford brought an application to court in Pretoria, requesting that a medical practitioner assist in ending his life, which was medically untenable. The court ordered that he was entitled to be assisted by a doctor in ending his life, and that the doctor would not be considered to have acted unlawfully. The court stated that this case dealt with the right to life and the right to dignity, as well as the sacredness of the quality of life. The court recommended that similar cases should be heard on a case by case basis. This judgment has changed the law, and is currently being appealed. The results of this appeal may have far-reaching ramifications for future anaesthetic practice and decision-making.

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