A fundamental problem of consent

Nothing is inherently remiss in present methods of obtaining consent

EDITOR,—John Mitchell describes the case of a consultant anaesthetist who was found guilty of serious professional misconduct by the General Medical Council.¹ After giving a general anaesthetic for dental surgery the anaesthetist inserted a diclofenac suppository for pain relief (which was inadvertently inserted into the patient's vagina) without the patient's consent. The case and the commentaries by Michael A Jones and John N Lunn raise several points.

The verdict of the General Medical Council's professional conduct committee has, it appears, in one particular respect created a formal distinction between the hospital setting and the dental surgery. In the dental surgery it is now mandatory that, when a treatment is to be given to a patient in a site remote from the operative site, the patient must be made aware of this during the preoperative discussion of his or her overall management. While the importance of informing patients about their treatment is accepted, it is our understanding that, except in the specific circumstances of the case reported, the general recommendations and practice concerning consent have not changed. There is no suggestion that "sectionalised consent" should be introduced. We must emphasise, however, that it is both polite and prudent to give information concerning treatments that may be unfamiliar to the patient—for example, suppositories used for analgesia. This is particularly important during preoperative discussion with parents and their children and with female patients.

The accompanying charge, as reported by Mitchell, of paternalism levelled against anaesthetists, coupled with the statement that patients have the right to be scared, needs to be refuted as foolish and irrational for both humane and scientific reasons. We endorse the comments made by John N Lunn in this regard.¹ Anaesthetists have a record of sensible and sensitive communication with patients; their teaching and training emphasise that they must use discretion in explaining techniques and possible complications to patients. While there is no argument with the concept that patients have the right to be informed and the right to refuse treatment, the anaesthetist also has a responsibility to ensure patients' safety and well-being. The risks of anaesthesia are increased by excessive preoperative agitation, and every effort must be made to decrease this by psychological and, if appropriate, pharmacological preparation.

Advice to authors

We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.

To call this paternalism is a travesty of accepted good practice, and if this was said at the hearing it would portray a profound lack of understanding of the challenge facing anaesthetists.

By any measure the record of anaesthetic management in Britain and Ireland is of the highest order. It would be unfortunate if any interpretation of this report should introduce confusion by suggesting that there was something inherently remiss in the present methods of obtaining consent for anaesthesia and that there was a need to obtain sectionalised consent.

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1 Mitchell, J, Jones MA, Lunn JN. A fundamental problem of consent. *BMJ* 1995;310:43-8. (7 January.)

Dentist is aggrieved at outcome

EDITOR,—I was the dentist involved in the case discussed by John Mitchell and others.¹ I wish to point out that I was found guilty of assault on two patients—the woman mentioned and a young boy. The anaesthetist, however, was found guilty of assault on only the woman. Having played no part in the decision to administer the diclofenac suppository or in its administration and, as Mitchell wrote, having not even touched the suppository, I feel very aggrieved by the outcome.

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1 Mitchell J, Jones MA, Lunn JN. A fundamental problem of consent. *BMJ* 1995;310:43-8. (7 January.)

Patients' trust must be respected

EDITOR,—When I empathised with the patient in the medicolegal case discussed by John Mitchell and others (that is, I considered what I might feel if I were her) I felt that I too would have been perturbed.¹ Putting aside complex issues of consent, I hope that a simple emphatic account of her experience and a comment may elucidate the core problem of her complaint.

"As a married woman of 22, I went in for a straightforward tooth extraction, needing, I presumed, straightforward general anaesthesia. Particularly as I was going to be fully clothed while I was under general anaesthesia, it would not have crossed my mind that a man of over 40 was planning to push a foreign body into my rectum. To have this rectal insertion explained to me afterwards as a fait accompli would have been bad enough. I then, however, found an unusual and unexpected discharge oozing from my vagina. When my husband and I were reassured that I had not been raped or sexually assaulted while under general anaesthesia, I was still perturbed. After all, a foreign body meant for insertion into my rectum by a man's finger, which was not explained to me before routine surgery, was inadvertently inserted into my vagina. This is a far cry from any problems I might have envisaged from a straightforward tooth extraction."

Many doctors seem quickly to forget that vaginal and rectal examinations and treatments are particularly intimate. This is because they may have potentially many such examinations and treat-

ments to carry out and they find the feeling of intimacy associated uncomfortable. This makes them anxious. A way of dealing with this is to "forget." Inevitably with this kind of forgetting, however, there is a disadvantage. These doctors will in some way lose touch with the feelings of the people for whom they care, both at work and at home. This is the brutalising effect of medicine.

Private parts are appropriately named. They are used for excretion of faeces, urine, and menstrual blood; for sexual excitement and sexual intercourse. Exposure of these parts potentially makes a woman vulnerable, so to expose herself to someone else is an act of trust and therefore generates intimacy. When women trust doctors and expose themselves or put themselves in a position where they may be exposed this trust must be respected and the intimacy acknowledged.

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1 Mitchell J, Jones MA, Lunn JN. A fundamental problem of consent. *BMJ* 1995;310:43-8. (7 January.)

Patients' should be able to say no

EDITOR,—John N Lunn comments, "Consent for anaesthesia is different from consent for surgical or medical treatment because cooperative effort is not required. In order to be anaesthetised patients have to do very little."¹ It is precisely because anaesthetised patients are helpless and unable to defend their personal boundaries that it is important to obtain their consent for all procedures while they are conscious.

In my research on post-traumatic stress disorder in women who have undergone obstetric or gynaecological procedures one of the features that differentiated traumatised from non-traumatised women was their having undergone medical procedures without feeling that they had given informed consent.² One woman was horrified to find out that, while under anaesthesia, she had been examined vaginally by several medical students without her consent. Years later she still felt violated by the experience. More than one woman had consented to a hysterectomy, only to wake to find that she had also been castrated without having been asked.

I have a collection of many such stories. The issue is one of choice and control in relation to the patient's personal boundaries. When a patient enters the doctor's working environment there is an immediate power differential in favour of the doctor. It is therefore difficult for the patient to defend herself. Thus systems need to be in place that redress the power balance and facilitate informed choice for patients, including the right to say no.

In relation to the case reported by John Mitchell, clinical jargon euphemistically camouflages the truth, which is that a man put his finger in a women's vagina without her consent.¹ Most women would understand that as assault, and for it to happen "patients have to do very little."

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1 Mitchell J, Jones MA, Lunn JN. A fundamental problem of consent. *BMJ* 1995;310:43-8. (7 January.)

2 Menage J. Post-traumatic stress disorder in women who have undergone obstetric and/or gynaecological procedures. *Journal of Reproductive and Infant Psychology* 1993;11:221-8.