



Does the Doctor Know Best? A Deconstruction of Informed Consent

by Christopher Monaghan

Abstract

The law in relation to informed consent has shifted to a patient-centred approach and no longer is the doctor deemed to know best. It is only when the patient has been given sufficient knowledge of the treatment, do they have the power to make an informed choice.

This article analyses the law of informed consent and outlines how the law has finally recognised the right of patient autonomy. It is now the patient, not the doctor, who has the right to decide. Particular focus will be placed on information disclosure, what this entails, and how it enables greater protection and empowerment for the patient. Finally, as the law in regards to informed consent is still fluid, comparative law from other jurisdictions and guidance from the medical profession will be analysed to gauge the best course for development.

This article offers a unique objective view of the law in relation to informed consent by not only outlining its accolades but also highlighting where ambiguity remains. It will conclude that the right of patient autonomy in informed consent is unassailable and the law will only further develop along this line of patient-centred thinking.

Introduction

'Consent is typically seen as the cornerstone of medical practice.'¹ A patient must consent to treatment for it to take place.² For valid consent to occur, 'the patient must (1) voluntarily agree, (2) have the mental capacity, and (3) obtain adequate information about the procedure'.³ This article focuses on the third requirement of information disclosure. Consent, by its definition, is the power to make a choice; to accede or to refuse. Information is vital in making a *real* choice, and failure to disclose information removes the patient's right to decide if they are willing to accept the risks of treatment.⁴ Throughout information disclosure, there is a distinct clash between paternalism and patient autonomy. Paternalism is defined as 'refusing to acquiesce in the wishes or desires of another person for that person's own benefit'.⁵ When a doctor elicits a paternalistic approach, 'they place the moral principle of benefiting the patient (the doctor's definition) on a higher plane than the moral principle of autonomy'.⁶ In the disclosure of pre-operative information, patient autonomy is key. Traditionally, the law supported the paternalistic attitudes of the medical profession, especially when there were questions raised as to the (mis)conduct of doctors. In recent times, however, patient autonomy has been at the front of judicial decision-making and the law has finally recognised the

¹ Patrick Davey (ed) and others, *Medical Ethics, Law and Communication at a Glance* (John Wiley & Sons 2017).

² If no consent an action can be both a tort (battery) and a crime (assault).

³ Michael Jones, *Medical Negligence* (4th edn, Sweet & Maxwell 2008).

⁴ Carolyn Johnston and Penelope Bradbury, *100 Cases in Clinical Ethics and Law* (2nd edn, CRC Press 2016).

⁵ James Childress, *Who Should Decide? Paternalism in Health Care* (OUP 1982).

⁶ Tom Beauchamp and Laurence McCullough, *Medical Ethics: The Moral Responsibilities of Physicians* (Longman Higher Education 1984).

patient is not ‘an ill-informed bystander to the opinion of the doctor’ but rather a person with the right to make an informed choice.⁷

To illustrate how the law no longer offers greater protection to medical professionals, the current legal obligations must be stated. The law which has impacted on the medical profession will be discussed and guidance will be drawn from longer standing Australian law. Following this, detailed analysis will be provided of the two main categories of information disclosure; (1) material risks and (2) alternative treatments. While discussing this, critical analysis will be included of both requirements, demonstrating the law is not fully developed and more judicial scrutiny is required. The article will summarise the current legal position and state that while it is in an inchoate state, it clearly places the patient, not the doctor, at its centre.

The Law

In the beginning, the ‘confusing’⁸ decision in *Sidaway v Board of Governors of the Bethlem Royal Hospital*,⁹ established the *Bolam* Test¹⁰ should apply to disclosure of medical information. Over time, lower courts moved to a more patient-centred approach and added the stipulation that a doctor must disclose a significant risk if a reasonable patient would want to know about it.¹¹ The development of the law by lower courts was ‘slightly confusing’.¹² In *Montgomery v Lanarkshire Health Board*,¹³ the Supreme Court got their ‘teeth into the issue of materiality of risk’ again, and this time enshrined the patient as the key in decision-making.¹⁴

While the judges recognised lower courts had been applying a more patient-centred approach,¹⁵ the history of the case itself showed some doctors were still paternalistic in their attitude towards information disclosure, and certain judges were willing to support this perspective. In *Montgomery*, however, the court affirmatively established its ‘commitment to protecting patients’ right to self determination’.¹⁶ This is exemplified in deciding the *Bolam* Test was no longer applicable to information disclosure.¹⁷ Doctors are under an obligation to disclose ‘material risks’ and ‘alternative treatments’ to the patient.¹⁸ The courts decision finally recognises ‘patients want to assert their own rights, especially in the context of decision-making’.¹⁹

It is prudent to point out that the decision in *Montgomery* should have minimal effect on healthcare practice, as patients have been at the centre of the majority of doctor’s decisions. The court has ‘given legal effect to guidance in force’²⁰ by the British Medical Association,²¹ the Department of Health²² and the General Medical Council (GMC)²³ which advocated this patient-centred approach. With the law now aligning to professional practice, two important points arise. The

⁷ Chris Neale, ‘*Montgomery*, Upheaval or Evolution?’ (2015) 159(20) SJ 25.

⁸ Lesley Johnston, ‘Informed consent and lingering shadow of *Chester v Afshar*’ (2015) 19 SLT 81, 84.

⁹ [1985] AC 871 (HL).

¹⁰ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 – doctor would not be liable if reasonable body of medics agreed.

¹¹ *Pearce v United Bristol Healthcare NHS Trust* (1998) 48 BMLR 118 (CA), see also *Wyatt v Curtis* [2003] EWCA Civ 1779.

¹² John-Paul Swobada, ‘*Montgomery* is the nail in the coffin for *Bolam*’ (2015) 159(16) SJ 17.

¹³ [2015] UKSC 11.

¹⁴ Rob Heywood and José Miola, ‘The Changing Face of Pre-Operative Medical Disclosure: Placing the patient at the Heart of the Matter’ (2017) 133(Apr) LQR 296, 300.

¹⁵ *Montgomery* (n 13) [63].

¹⁶ Leroy Edozien, ‘UK Law on Consent Finally Embraces Prudent Patient Standard’ (2015) 350 BMJ H2877.

¹⁷ *Montgomery* (n 13) [86].

¹⁸ *ibid* [87].

¹⁹ Margaret Brazier and Emma Cave, *Medicine, Patients and the Law* (6th edn, MUP 2016).

²⁰ Lauren Sutherland, ‘The Law Finally Reflects Good Professional Practice’ (2015) 123 *Reparation Bulletin* 4, 6.

²¹ British Medical Association, ‘Consent Tool Kit’ (5th edn, 2009).

²² Department of Health, ‘Reference Guide to Consent for Examination or Treatment’ (2009).

²³ General Medical Council, *Consent: Patients and Doctors Making Decisions Together* (GMC 2008) and General Medical Council, *Good Medical Practice* (GMC 2013).

first is the question of 'are the floodgates about to open?'²⁴ It would appear not. The NHS Litigation Authority, the body responsible for claims relating to healthcare in the National Health Service, is serene about the judgment.²⁵ As the practice of doctors has mostly mirrored the new standard of the law, there is little to be feared. Secondly, as the law has now closed the gap between it and the medical profession, patients' rights are enhanced. Doctors who failed to follow GMC guidance would not be immediately disciplined, however, persistent failure may put their registration at risk.²⁶ As the law has now enhanced its own standard, patients can be assured the courts will require a doctor to meet this legal threshold, thus protecting their right to receive relevant information.

The court noted the departure from the *Bolam* Test will 'reduce the predictability of the outcome of litigation'.²⁷ In Australia, patient autonomy was recognised many years before UK law in the case of *Rogers v Whitaker*.²⁸ Concerns with the law today can be compared with those previously raised when *Rogers* was decided. Initially, the patient-centred approach caused 'concern amongst doctors', who anguished at the proposition of being judged by lawyers and not their medical peers, however, it was 'allayed over time'.²⁹ Captivatingly, research from the Australian standard post *Rogers*, indicated doctors remained ill-informed about their duty to disclose risks to patients.³⁰ Doctors 'routinely underestimated the importance of a small set of risks that vex patients'.³¹ The most appropriate way to ensure rights of patients were not infringed by doctors was by informing doctors precisely of their legal obligations.^{32,33} These lessons from Australia have clearly been taken into consideration by UK law. The law, in conjunction with GMC guidance, now offers a clear roadmap for doctors to understand their legal and ethical requirements. This assists doctors adapting a patient-centred approach, and further enhances the rights of the patient.

Material Risks

The law's first main requirement is the disclosure of material risks. While risks associated with treatment are part of medical expertise, disclosure is not purely a matter of professional judgement. Therefore, the patient, not the doctor, is entitled to decide 'what risks they are willing to run'.³⁴ The doctor must disclose all material risks and the concept of materiality was 'changed by the law in *Montgomery*'.³⁵ 'The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware the particular patient would be likely to attach significance to it.'³⁶ This test has the patient-centred approach entrenched within its objective and subjective limbs. The objective element covers the catch-all requirement of a reasonable patient, while its subjective counterpart caters for the idiosyncrasies of the particular patient. Questions still arise as to the adequacy of this test in protecting the rights of the patient and whether it strikes an appropriate balance.

In the objective approach, what does 'in the patients position actually encompass?'³⁷ This question has been neglected in both literature and case law.³⁸ Although there is a dearth of information in case law, an example can be drawn from *Rogers*, where the fact the woman only had

²⁴ Peter Worlock, 'Consent: Where Are We in 2016?' (2016) 5(3) BJ360 38.

²⁵ NHS Litigation Authority, *Report & Accounts 2014/2015* (NHS Litigation Authority 2015).

²⁶ GMC 2008 (n 23).

²⁷ *Montgomery* (n 13) [93].

²⁸ [1992] HCA 58.

²⁹ Anne-Maree Farrell and Margaret Brazier, 'Not so new directions in the law of consent?' (2016) 42 BMJ 85.

³⁰ Loane Skene and Richard Smallwood, 'Informed Consent: Lessons from Australia' (2002) 324 BMJ 39.

³¹ Marie Bismark and others, 'Legal Disputes over Duties to Disclose Treatment Risks to Patients' (2012) 9(8) PLoS Medicine.

³² *ibid.*

³³ Skene (n 30).

³⁴ *Montgomery* (n 13) [83].

³⁵ Richard Griffith and Cassam Tengnah, *Law and Professional Issues in Nursing* (4th edn, Learning Matters 2017).

³⁶ *Montgomery* (n 13) [87].

³⁷ Heywood (n 14).

³⁸ José Miola, 'On the Materiality of Risk: Paper Tigers and Panaceas' (2009) 17(1) MLR 76.

one functioning eye was a factor the court took into account when considering the objective test.³⁹ Although it appears physical factors are the leading criterion,⁴⁰ it is suggested the court should clarify the matter by defining what 'in the patients position' actually encompasses. The second, subjective test caters for the patient's personal attributes (i.e. religious beliefs) by requiring the doctor to disclose information they ought to reasonably know the patient would want to receive. While this subjective test 'adequately protects the patients' interest in information',⁴¹ does it skew the balance of rights too heavily in their favour?

It would appear not. This subjective test 'does not require a doctor to know in advance all what matters to an individual patient',⁴² however, it does encourage the doctor to have an increased scrutiny when conversing with patients. Instead of thinking, does this procedure satisfy the everyday patient, they will be required to contemplate, is this the appropriate course of action for this particular patient, based on what I know of them? For example, as the woman in *Rogers* had one working eye, indubitably she would attach greater significance to the risk of loss of sight in the other eye which would render her blind.⁴³ An unjust position would be to require doctors to know every detail about a patient, however, where it is blatantly obvious the patient would attach significance to a key piece of information, the subjective limb should not be disregarded 'merely because they did not ask a certain kind of question'.⁴⁴ The law strikes an appropriate balance between the rights of the patient and does not place an unfairly onerous duty on the doctor.

It has been accepted that if a patient asks a question, the doctor must give 'true and full answers',⁴⁵ regardless of whether they believe it to be wise.⁴⁶ Problems arise when a patient is not given information simply because they did not ask about it. This is not because the patient is being deliberately ignorant, but rather they do not know there is a question to be asked. As with Mrs Montgomery, because she 'had not raised questions of specific risks involved in vaginal delivery',⁴⁷ the doctor decided she was not entitled to the information. This line of reasoning is clearly unjust. Doctors cannot be seen as guardians of information, who are only required to divulge based on what the patient directly asks. By necessitating doctors have a higher regard for their patients and requiring them to have a greater insight into what they think will be relative, the law has put an end to the *don't ask don't get* era of information disclosure.

Although the doctor is now obliged to divulge more information to the patient, they must not tactically abuse this requirement by 'bombarding the patient with technical information' which would inhibit the understanding of its contents.⁴⁸ A doctor cannot meet this prerequisite by simply handing the patient a document containing a plethora of information and then necessitating a signature to absolve liability. While this is an undeveloped area of the law,⁴⁹ doctors must now ensure information is comprehensible and presented in an understandable manner. To require the doctor to ensure understanding, however, would be a step too far. It would place the doctor in an unfair position and place them with an unrealistic burden. Instead, the doctor has a greater requirement to try and ensure understanding, rather than 'simply communicating it in a manner which is understandable'.⁵⁰ In a culturally diverse society, issues now arise as to how the doctor can satisfy this duty to provide

³⁹ *Rogers* (n 28).

⁴⁰ *ibid*.

⁴¹ Alexander Capron, 'Informed Consent in Catastrophic Research and Treatment' (1974) 123 University of Pennsylvania Law Review 340, 416-417.

⁴² Emily Jackson, *Medical Law: Text, Cases and Materials* (4th edn, OUP 2016).

⁴³ *Rogers* (n 28).

⁴⁴ *Rosenberg v Percival* (2001) 205 CLR 434.

⁴⁵ *Sidaway* (n 9) 898.

⁴⁶ Save for the therapeutic exception, where a doctor can withhold information if it would be detrimental to the patient's health – see *Montgomery* (n 13) [85].

⁴⁷ *Montgomery* (n 13) [17].

⁴⁸ *ibid* [90].

⁴⁹ Kevin Williams, 'Comprehending Disclosure: Must Patients Understand the Risks They Run?' (2000) 4 MLI 97.

⁵⁰ Tracey Elliott, 'A break with the past? Or more of the same?' (2015) 31(3) PN 190, 194.

comprehensive information. They have not, however, been adequately addressed by the law and this lack of specificity acts neither in the patient's or doctor's interest.⁵¹

Alternative Treatments

The second main requirement is patients must be aware of any 'reasonable alternative or variant treatment'.⁵² If the right to information is to enhance patient autonomy, then that information 'must include alternatives'.⁵³ This requirement is limited to *reasonable* alternatives or variants, and the key lies in determining what amounts to reasonableness. The court, however, provided absolutely no detail on this, and while its inclusion only further advances the rights of the patient, the paucity of detail on what is required is not helpful.

It is necessary to analyse the decision in *Birch v University College London Hospital NHS Foundation Trust*⁵⁴ where this requirement was discussed in detail. Here the claimant was successful in claiming a breach of duty by her doctor for not disclosing the option of an alternative treatment; namely a MRI which had a less risk of stroke than a catheter angiography.⁵⁵ While Cranston J refused to state 'in general terms when such a duty would arise',⁵⁶ it is possible to derive certain principles which can act as guidance for future implementation.

The first indicator an alternative treatment will be construed as reasonable is if it is less risky than the one proposed. This is because the patient will want to follow the procedure carrying the least amount of risk. While the doctor may be of the opinion the proposed treatment is best, they must disclose this *reasonable* alternative. It is the patient who is at risk of the procedure, not the doctor. To ensure the patient has made the best choice in conjunction with their own interests, they must be aware of alternative treatments, especially when they reduce the likelihood of a risk materialising.

Another indicator will be when an alternative is being proposed by another doctor. Medical opinion is opinion. It is not certainty and it is not definite. This basic fact was pivotal in the formulation of the *Bolam* Test, as the court recognised medical opinion can differ on the most appropriate action to take. What one doctor may propound, another may dissuade, and it is this discord the patient should be made aware of. The suggestion is not being made that every doctor should be consulted to ascertain what treatment they would propose. In contrast, where another doctor has advocated an alternative, the patient must be made aware to ensure they are not 'denied the opportunity to make an informed choice'.⁵⁷

An additional advantage of alternatives being discussed is it helps 'contextualise the treatment' for the patient by undertaking a comparative analysis of the options available.⁵⁸ More questions will be asked by the patient, and naturally more answers will be given. This will place the patient in a stronger position to make an informed choice. It will, however, be for lower courts to determine how this requirement is developed. If the two guidelines mentioned above are interpreted with a patient-centred approach, it will further illustrate the law providing the patient with sufficient rights to ensure they can reach an informed decision.

⁵¹ Heywood (n 14).

⁵² *Montgomery* (n 13) [87].

⁵³ Nils Hoppe and José Miola, *Medical Law and Medical Ethics* (CUP 2014).

⁵⁴ [2008] EWHC 2237 (QB).

⁵⁵ *ibid* [77].

⁵⁶ Shaun Pattinson, *Medical Law and Ethics* (4th edn, Sweet & Maxwell 2014).

⁵⁷ *Birch* (n 54) [79].

⁵⁸ Colm McGrath, 'Trust Me, I'm a Patient...': Disclosure Standards and the Patient's Right to Decide' (2015) 74(2) CLR 211, 214.

Conclusion

In conclusion, the fact patients are offered greater protection than medical professionals in the law of informed consent is unassailable. The law has shifted from protecting the interests of doctors to protecting the rights of patients. The disclosure of material risks is now a two armed test, containing both an objective and subjective limb. Respectively, they cater for the average patient and then the particulars of the specific patient in the patient's position. While the doctor is now required to become more engaged on what the patient will want to know, they are not expected to know every detail. This strikes the correct balance and sets a patient-centred standard that is not only fair but also achievable. The recognition of the requirement to disclose alternative treatments is welcomed. Patients now have the ability to compare the options given to them and decide which one they believe is best. In addition, not only must information be disclosed, but the doctor is under a duty to try and ensure the patient has understood what is being said. While there does remain some ambiguity in the law that the lower courts must develop, if a doctor fails to place the patient at the centre of their decision-making, a judge will readily do so in court.

In her thesis, McCormick wrote that 'due to the history of paternalism within health-care, the incidence of patients having the recognised right to make an informed choice may be less than adequate'.⁵⁹ It is safe to say the law has come a long way since it refused to acknowledge the rights of the patient. Hegel once stated the 'owl of Minerva only takes flight at the onset of dusk'.⁶⁰ The Supreme Court has only now recognised the correct approach for the law to take due to the hindsight provided by the medical profession which attempted to admonish paternalism years prior. The days of the *doctor knows best* are now over. Patients now have the right to make a choice, the right to be consulted, but above all, the right to be informed.

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⁵⁹ Dolores McCormick, 'Problems in Communication: Truth-Telling and Informed Consent' (MPhil thesis, Queen's University Belfast 1994).

⁶⁰ David James (ed), *Hegel's Elements of the Philosophy of Right* (CUP 2017).