Consent to treatment in the UK: Time for practice to reflect the law

In March 2015 a Supreme Court ruling led to a change to the law governing consent to treatment in the UK. [(1)] This shifted the emphasis from consent as an issue of medico-legal practice, with the focus on the doctor's legal duty to disclose the risks involved in the proposed treatment, to enabling the patient to make informed decisions. The ruling emphasises the importance of patient autonomy, consent to treatment now being considered to be an indicator of the quality of patient care particularly with regard to safety, communication and respect for patients. [(1,2&3)] Guidance from the General Medical Council (GMC) and Department of Health (DH),[(2&3)] reflects this ruling and brings the UK closer to the US, Canada and Australia. [(4&5)]

The ruling centred on a woman with diabetes who, as a result of complications during delivery, gave birth in 1999 to a boy who had disabilities. Shoulder dystocia is a well-recognised concern during labour in women with diabetes and the woman raised concerns about the size of her baby and the risk of vaginal delivery. However, her obstetrician's policy was not to advise diabetic women routinely about shoulder dystocia. The obstetrician said, "If you were to mention shoulder dystocia to every patient [with diabetes], if you were to mention to any mother who faces labour that there is a very small risk of the baby dying in labour, then everyone would ask for a Caesarean section, and it's not in the maternal interests for women to have Caesarean sections". [(1p5)] She also said that the woman had not asked her "specifically about exact risks" but had she done so, the obstetrician would have advised her about the risk of shoulder dystocia and if she had requested an elective Caesarean section, she would have been given one.

Previously, judgements in the UK have inclined towards what are deemed to be the appropriate standards of disclosure of the risks involved. Standards of disclosure concern the doctor's legal duty, to exercise reasonable care and skill in the provision of professional advice and treatment[(5)] rather than the patient's desire for, or comprehension of information. The responsible practitioner standard had therefore tended to take precedence over the reasonable person standard. Known as the *Bolam* test,[(6)] this required the doctor

involved to demonstrate that she/he provided information to the patient that a doctor of good standing in the medical community would provide to her or his patient.[6] This standard supported an assumption that 'doctor knows best': "The provision of too much information may prejudice the attainment of the objective of restoring the patient's health".[7] By contrast, the new Supreme Court ruling[1] states that: "There is no reason to perpetuate the application of the Bolam test".

Patients' experiences of consenting to treatment are important for the quality of the care they receive. Consent to treatment is underpinned by values about the individual's right to self-determination over her/his own body.[8] Yet, in practice, issues relating to the type and amount information to be disclosed and how this process is best achieved remain a subject of international debate within the medical profession.[8,9] Consent is (or should be) more than a signature on a form. However, importance is often given simply to the written documentation of consent.[8] Moreover, evidence suggests that in the UK some patients perceive signing the consent form as a paternalistic and legalistic mandatory routine of little relevance to them. In the eyes of such patients, it is a legal document designed to legitimise doctors' decision-making, providing them and the hospitals with "a get out of jail free card" should something go wrong.[10] Such perceptions can reduce the amount of information patients actively seek. Many signing consent forms without reading their contents, this probably signifying trust in their clinicians.[10]

Issues of consent to medical treatment have been at the heart of two major public enquiries in the UK[11,12] which led to the Department of Health adopting a national approach to promoting good practice. An important feature was the production of four standard consent forms, reflecting the needs of different groups such as children and incompetent adults, which all NHS organisations are expected to use. In contrast to this standardised approach, the Supreme Court ruling[1] is that: "The doctor's duty of care takes its precise content from the needs, concerns and circumstances of the *individual* patient, to the extent that they are or ought to be known to the doctor". For this, the crucial legal issue is "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 that the *particular* patient would be likely to attach significance to it".[p28]

Given this change to UK law and the evidence about patients' perceptions of consenting to treatment, a "one size fits all" approach appears obsolete and out of step with the specific patient focus of the legal ruling. While it may be necessary to have written evidence of the patient's agreement to a particular treatment, consideration now needs to be given to how this process can be more individualised by incorporating procedures other than the routine signing of the consent form into day-to day practice. Such alternatives might include following up the initial two-way discussion between clinician and patient in a letter sent to the patient, or in a patient held pre-surgery record detailing the conversation. The patient can then consider the information at leisure, using it as a basis for subsequent decision making and further discussion with clinicians as she or he deems necessary.

References

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