Update on the UK law on consent

Last week’s case of Montgomery v Lanarkshire Health Board has important implications for doctors

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All doctors should be aware of the landmark decision in Montgomery v Lanarkshire Health Board, given by the UK Supreme Court on 11 March 2015.

Nadine Montgomery was a woman with diabetes who gave birth by vaginal delivery. Her baby, Sam, was born with serious disabilities after shoulder dystocia during delivery. The doctor, Dina McLellan, did not tell Montgomery of the 9-10% risk of shoulder dystocia. McLellan said that she did not routinely discuss the risk of shoulder dystocia with women with diabetes for fear that, if told, such women would opt for a caesarean section. The court held that McLellan should have informed Montgomery of the risk and discussed with her the option of a caesarean section.

Bolam test is out

After the Montgomery case, the so called Bolam test, which asks whether a doctor’s conduct would be supported by a responsible body of medical opinion, no longer applies to the issue of consent. The law now requires a doctor to take “reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.”

So doctors must now ask themselves three questions:

• Does the patient know about the material risks of the treatment I am proposing?

• Does the patient know about reasonable alternatives to this treatment?

• Have I taken reasonable care to ensure that the patient actually knows this?

To answer the first question doctors must form a view of what counts as a “material risk.” The law defines it as either a risk to which a reasonable person in the patient’s position would be likely to attach significance or a risk that a doctor knows—or should reasonably know—would probably be deemed of significance by this particular patient.

The focus on “this particular patient” is key. A material risk to one patient may not be to another. A surgeon last week told me that he discloses risks of 1% and more. This is a perilous habit. In the Australian case of Rogers v Whitaker there was a one in 14 000 chance of blindness in one eye. Although the risk was remote, the claimant was already blind in the other eye, making the risk of great significance to the claimant. The Australian court found the doctor’s failure to disclose this risk to be negligent.

A pro forma approach to consent—repeating a memorised script—is a common but ethically and legally dubious practice. The UK Supreme Court talks of a “dialogue” between doctor and patient, reminiscent of the conversation model of consent of the bioethicist Howard Brody.

The Supreme Court emphasised the need to give information in clear terms and to avoid “bombarding the patient with technical information which she cannot reasonably be expected to grasp.”

If information is material, doctors should generally disclose it. They should not wait for the patient to ask for it. In the Montgomery case the Supreme Court noted that “there is something unreal about placing the onus of asking upon a patient who may not know that there is anything to ask about.”

So, when obtaining consent, law abiding doctors will ask themselves these questions:

• Does the patient know about the material risks of the treatment I am proposing?
  – What sort of risks would a reasonable person in the patient’s circumstances want to know?
  – What sorts of risks would this particular patient want to know?
• Does the patient know about reasonable alternatives to this treatment?
• Have I taken reasonable care to ensure that the patient actually knows all this?
• Do any of the exceptions to my duty to disclose apply here?

To these six questions I would add a seventh: Have I properly documented my consent process?

Exceptional cases

There are three exceptions to the duty to disclose. Firstly, the patient might tell the doctor that he or she would prefer not to know the risks. Just as patients are not forced to read the instructions that accompany drugs, nor should they be forced to discuss risks that they would rather not know.

Secondly, the doctor might reasonably consider that telling the patient something would cause serious harm to the patient’s health. Many years ago I used this scenario as part of my research on truth telling in medicine: “Mr Smith is taken to hospital after a heart attack. He is recovering in intensive care, and his chances of a full recovery are good. On examination, doctors discover that Mr Smith has a form of cancer that is quite successfully treatable with modern drugs and radiotherapy. Mr Smith’s father died from this type of cancer years before, and it is known that Mr Smith has a great fear of the disease. His blood pressure is in poor control, and minimising stress is medically desirable to lower the risks of another heart attack. Should the doctor, at this time, tell Mr Smith that he has a form of cancer?” Three quarters of my 85 doctor respondents answered “No.” As long as the doctor’s belief that disclosure would cause severe harm is reasonable, withholding the information will not be unlawful. The Supreme Court warns, however, that this “therapeutic exception” should not be abused.

Thirdly, no consent is needed in circumstances of necessity, such as when a patient in need of urgent treatment is unconscious or lacks capacity.

Ethically astute readers will note that the law now demands a standard of consent broadly similar to that required by the professional guidance of the General Medical Council. Doctors who follow that guidance will not fall foul of the law.

Other readers will hold the view that consent is a myth invented by lawyers and ethicists and may ask, “How do we find the time to get such consent?” The court’s answer is that the law must impose some obligations “so that even those doctors who have less skill or inclination for communication, or who are more hurried, are obliged to pause and engage in the discussion which the law requires.”

The law is set. Some doctors will need to adapt. As Porgy sings, “No use complainin’.”

Competing interest: I know personally and was a member of the same chambers as James Badenoch QC, the lead barrister for the appellant, but I was not involved in this case.

Provenance and peer review: Commissioned; not externally peer reviewed.

News: Doctors should not cherry pick what information to give patients, court rules (BMJ 2015;350:h1414, doi:10.1136/bmj.h1414)

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