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CHANGES TO THE LAW OF MEDICAL CONSENT – THE PATIENT PERSPECTIVE ON CONSENT TO SURGERY

A recent Supreme Court Ruling (Montgomery) has overturned the Bolam test with regard to patient consent to medical treatment. It creates a legal obligation for dialogue between patient and clinician, and a significant shift towards greater patient autonomy. The focus is now away from the opinion of the reasonable doctor to that of reasonable and autonomous individual patient except under specific circumstances where the patient does not have the capacity to make a decision.

The ruling means that surgeons (and other clinicians) must make patients aware of any material risks involved in any recommended treatment, and of any reasonable alternative treatments. However, this extends beyond the physical and health consequences of treatment and takes into account non-clinical issues in the patient's particular circumstances, and whether or not a reasonable person in the same position would be likely to attach significance to the risk or, alternatively, that the doctor is or should reasonably be aware that a particular patient would be likely to attach significance to it.

Thus, risk is no longer a series of percentages that can be applied to all patients but must be interpreted for the individual patient, and how that patient subjectively perceives the risks and benefits of treatment. Surgeons will need to probe much further into the character of their patient and their wishes than has been customary in the past, and to be sure that the information that has been given has been understood.

Patients have reported feeling that they were ill prepared for the consequences of treatment, and it is hoped that the new consent process will help them be more realistically informed. It is also hoped that despite this added burden, surgeons will remain flexible and see ways of modifying treatment so that patients can fulfil what is important to them, be it time with family, work or leisure so that they can live as they wish during or after treatment.

However, whilst the Montgomery case appears relatively simple to determine what the reasonable patient would have deemed a risk, just as most mothers expect to give birth to a healthy baby, there may well be unintended consequences of the new ruling. If all mothers were made aware of every risk, however small, the majority might opt for a caesarean section. Other more complex problems will emerge where procedures are relatively untested or evidence limited, whilst different surgeons may favour different surgical techniques with different risk probabilities.

Whilst many have felt that previous recent guidance on the process of consent was aspirational, it has now become enshrined in the Law with the imperative that it be deliverable in the NHS. Preparing the patient in advance to reflect on what is important to them by way of quality information to take home, compiled with the assistance of patients with the relevant condition, and educating patients with a list of what they may like to ask their surgeon in advance of a consultation may help make the process more efficient. It will of course be much easier to realise with a long term patient population, who are well known to a department and regular attenders at clinic.

The Law Lords, whilst stating that patients are now more independent, may have underestimated the diversity of patient characteristics in the UK. Thus, from a patient perspective, it is pleasing to see that the Lords have continued to enable choice to extend to those patients who wish to have a more paternalistic relationship with their doctor, and who may not wish to be advised of the risks of a procedure. This is a patient view which should always be respected.

Whilst many surgeons may welcome what they perceive to be a move towards greater patient centred care, and which treats the patient more holistically, others may feel that this is yet further erosion of their professionalism in an already difficult climate. With Consultant Outcome Publications and other additional administration, busy surgeons may feel that they are being asked to relinquish their expert knowledge, for which they have laboured hard, and that this additional burden will put further pressure on them to be scrupulous in recording a complex dialogue. Further, they may feel frustrated in not being able to persuade a patient to undertake a course of action which they feel is in that patient's best interests.

It must be appreciated, however, that careful recording of discussions with the patient will be critical, as this will be the only way of providing evidence that discussion did, indeed, take place. In addition, it is of paramount importance that the discussion takes place with the most senior surgeon involved with performing the procedure, and it follows that the consent process will be more complex for major operations than for more minor cases.

Despite the added burden, however, surgeons are now being presented with an enlarged scope of consent and it is to be hoped that they will gain satisfaction from the knowledge that the additional effort involved in the new process will mean that patients may adjust better to life after surgery and treatment, and accept and understand the consequences of their decisions. In addition, if implemented properly, it will also certainly reduce the risk of litigation.

For practical advice, see the Clinical Governance Board's statement on consent, posted on the ACPGBI Website in December 2015. (http://www.acpgbi.org.uk/content/uploads/2016/01/Consent-Clinical-Governance-Board-Statement-December-2015.pdf)

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