Cheryl Chin assesses a landmark case

NEW TEMPLATE FOR THE UK LAW OF CONSENT

Last year a landmark case changed how the UK law of consent is to be interpreted and applied.[1] The emphasis in decision making must be on partnership and shared decisions, not paternalism. Doctors who ignore or withhold information from their patients, even about a very small risk, may now be breaking the law.

The case has introduced a patient-focused test to the UK law on informed consent. It concerned a patient named Mrs Montgomery, who was expecting her first child. As the mother, being both small and having diabetes mellitus, the risk of shoulder dystocia during labour was 9–10%. She expressed concern to her doctor about the size of the baby and whether she would be able to deliver vaginally. She did not, however, ask 'specifically about the exact risks'. Nor did her doctor discuss the potential risks of shoulder dystocia. In her estimation, the risk of a grave problem resulting from a shoulder dystocia was very small. The risk of a brachial plexus injury in such a case is 0.2% and the risk of cerebral palsy or death from complications is 0.1%. The doctor contended that if shoulder dystocia were mentioned to every diabetic patient, most women would ask for a caesarean section. In her opinion it was not in the interests of women to have caesarean sections.

However the birth *was* complicated by shoulder dystocia. Mrs Montgomery's son was deprived of oxygen and subsequently diagnosed with cerebral palsy as well as Erb's palsy. The court reasoned that the doctor ought to have advised the patient of the substantial risk of shoulder dystocia and that if she had, the patient would have opted for a caesarean section. The judgement makes it clear that patients in the UK now have a legal right to be informed of material risks before making a decision. These material risks are determined by the circumstances of the particular case, and whether a reasonable person in the patient's position would be likely to attach significance to it.

GMC guidelines on consent produced in 2008 influenced the judgment. They emphasised the need for a dialogue to ascertain the beliefs and values of the patient, enabling doctors to learn what risks and complications of each option would be considered to be material to the patient. In that sense, it is a move away from medical paternalism.[2] So what are the implications for doctors now? Most doctors will already understand informed consent within the parameters of the GMC guidelines.[3] A risk to one patient may not be seen as such to another. Thus, it is vital to ascertain the views, hopes and wishes of every patient considering a procedure.

Most doctors will be reasonably familiar with the Bolam Test regarding medical negligence.[4] This test asks whether a doctor's conduct or action is supported by a responsible body of medical opinion. Up until this case, the Bolam Test put the responsibility on the clinician to decide how and what information to impart.

Now the law makes it clear that the key questions to be asked are: '*Would a reasonable patient want to know this information? Would this particular patient consider it to be important and relevant information?*' This change is in keeping with developments in Australian and Canadian law.

This new model of dialogue fits in well with what John Wyatt calls the 'expert-expert relationship'[5] or what Per Fugelli called 'shared power.'[6] This new case law, together with the joint GMC and NMC guidelines on the duty of candour,[7] seem to have brought back the notion of professional judgement. As Soko commented in the *BMJ*, 'A pro forma approach to consent is common but is ethically and legally dubious.'[8] Pro forma approaches tend to signify a technician-client relationships that is based on a contract. Shared power between the patient and the doctor, however, should be a collaborative relationship based on mutual respect and trust. Both parties bring their expertise, doctors their knowledge of treatment options and ethical frameworks, patients their knowledge of their history and way of life. Together, they reach a consensus, always keeping respect central.[9] This is how doctors can show that they care deeply for their patients as individuals.

In light of this new ruling, the process of consent for abortion procedures may justify more scrutiny. There is no legal requirement for the doctor to have seen a patient requesting an abortion, to have a one-to-one conversation about personal values and beliefs or the risks and complications of the various options available. The new ruling has now made it clear that in the consent process we should explore options with that specific patient in mind. Those who ignore or withhold information due to bias are breaking the law.

It is also possible that doctors who withhold information, such as the link between abortions and subsequent prematurity, may also be at risk.[10] The case for independent abortion counselling and accurate information giving has just got stronger.

Informed consent is about established trust and a deep respect for a patient's autonomy. In the process of informed consent, patients need to know that they can rely on their doctor to be truthful and unbiased, caring and acting in their best interest. Just as God bestowed on us free will and bore the burden of the possibility that we might turn away from him, just as the rich young ruler did,[11] we are asked to bear the burden of informing our patients as best as we possibly can, bearing the burden of sorrow that they may choose wrongly or unwisely.

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