

Lecture Notes, 2010 – 2011. Code: Med.01.03-v4-10.10

## Medical law

### Topic 1 (of 10), Lecture 3 (of 4): Consent

## Information that has to be imparted to a patient in order to receive a valid (or 'real' or 'informed'(?)) consent. Consequences of breaching the standard.

### Aim:

To review case law to determine what amount of information a patient must have before he can provide a valid consent to treatment.

### Objectives:

After careful study of this topic you should be able to:

1. Explain the legal issues which arise from divergent views on the amount of information a patient should be given before he can be said to have consented to treatment;
2. Discuss what is meant by 'real', 'informed' and 'voluntary' consent;
- 3 Explain the significance of the decision in the *Sidaway* case and developments *post-Sidaway* and discuss whether or not English law has incorporated a doctrine of informed consent.

### How Information Must be Imparted to an Autonomous Patient

Prior to the administration of medical treatment or the commencement of an investigative procedure, the principle of respect for the patient's autonomy dictates that, where applicable, the patient should be supplied with appropriate information, preferably in non-technical language, of the nature and effect of the proposed treatment or procedure (i.e. the information should be '*understandably communicated*': *Kelly v Hazlett* (1976) 75 DLR (3d) 536); and this should be communicated by a medical practitioner.

Moreover, it is essential that the patient's consent is fully and freely given (not coerced), unqualified, and given voluntarily if it is to be effective in avoiding legal liability for an alleged non-consensual medical touching.

### The Amount of Information to be Imparted

With reference to the extent, or the amount, of information a patient is to be given before his valid consent can be obtained and before any treatment or procedure is undertaken, *Bristow J* said in: *Chatterton v Gerson* (1981):

“ ... once the patient is informed in *broad terms of the nature of the procedure which is intended*, and gives her consent, that consent is **real** ... Of course, if information is withheld in bad faith, the consent will be vitiated by fraud.”

However, if it is correct that a patient need be informed only in ‘broad terms of the nature of the procedure which is intended’ (or, as was said more recently, ‘in broad terms and simple language’, *per Hale J*, in *Cambridgeshire County Council v R (An Adult)* (1995)), this generates questions such as:

- (i) what amount of information can be withheld by a registered medical practitioner (a ‘doctor’) without vitiating a patient’s consent?;
- (ii) could a doctor lie to his patient without vitiating his consent?;
- (iii) if a doctor was, in fact, found liable for not disclosing information would an action arise in (say) battery or negligence?

**(i) Would a doctor incur liability if it was a matter of practice not to disclose certain information?**

**The long-held paternalistic position in English Law** (see pp10-12 for details on how this position became qualified, then eroded).

**Bolam v Friern HMC [1957] 2 All ER 118**

This concerned the administration of ECT (electro convulsive therapy) without an anaesthetic – a practice that was common at the time - to a mentally ill patient to whom the risk of a fracture in such a procedure had not been explained. It was known that in the absence of the administration of an anaesthetic an effect of ECT is to precipitate violent convulsive movements in the form of a fit in the patient, with muscular contractions and spasms attended by a very slight risk of bone fracture. B, in fact, suffered such a fracture and he alleged, *inter alia*, that the defendants were negligent in failing to warn him of the risks he was running when he consented to the treatment. B’s expert witness thought that a patient should be warned of the risk of fracture, but the defendant’s doctors took the view that it was not desirable to warn a patient of the risk unless he asked about it.

**HELD: McNair J:** “A doctor is not ... negligen[t] if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ... [and] if a warning had been given, would it have made any difference? The only man who can really tell you the answer to that question is [B], and he was never asked the question.” The defendants were not liable.

**N.B.:** (1) Whilst there may be arguments amongst the medical profession as to what constitutes best practice, as long as there’s a *responsible body* of practitioners (>=10%) advocating a particular practice, the **House of Lords** decided that the law would not

intervene to decide which is best: Maynard v West Midlands RHA (1985). {However, this decision must now be seen in the light of the judgments in Bolitho (1997) and in Re S (2000)}.

**N.B.:** (2) The professional practice (or Bolam) standard of disclosure was followed in Chatterton v Gerson and Hills v Potter (infra). More importantly, it was followed in Sidaway (1985), a House of Lords case.

Accordingly, from the time of *Bolam* and for about the next 40 years, English law recognised that if a ‘responsible body of medical men’ believed that it was in the patient’s best interests *not* to disclose certain information then a doctor would not be negligent if he acted in accordance with such a practice, merely because there was a body of opinion that took a contrary view. Clearly, then, the law could countenance the non-disclosure of, perhaps, a considerable amount of information if a doctor thought it would not be in the patient’s interest to be told. As noted by **Mason & McCall Smith (2/e, 1987)**:

This view of what is generally known as ‘*therapeutic privilege*’ accepts that, since the treatment is likely to be to the patient’s benefit, then it is legitimate to withhold information which would merely serve to distress or confuse him<sup>1</sup>.

{**1.** A guide, albeit one now to be treated with caution, as to what should be taken into account when deciding how much information to give to (rather than withhold from) a patient was given in what may have been a persuasive precedent by **Woodhouse J** in the New Zealand case of:

**Smith v Auckland Hospital Board [1965] NZLR 191**

To be taken into account should be the gravity of the condition to be treated, the importance of the benefits to be expected to flow from the treatment or procedure, the need to encourage him to accept it, the relevant significance of its inherent risks, the intellectual and emotional capacity of the patient to accept the information without such distortion as to prevent any rational decision at all, and the extent to which the patient may seem to have placed himself in his doctor’s hands with the invitation that the latter accept on his behalf the responsibility for intricate or delicate decisions.

{**2.** Contrast the discretion given to the doctor in Smith with the approach of the **American** case of Canterbury v Spence *infra*. Note, also, that in ‘modern law medical paternalism no longer reigns’, per **Lord Steyn** in Chester v Afshar (2004)}

**(ii) Could a doctor deliberately lie to his patient without incurring liability?**

**Hatcher v Black (1954) *The Times*, 2 July**

Mrs H., who occasionally broadcast for the BBC, was advised to have an operation when it was discovered that she had a toxic thyroid gland. In reply to her question of whether

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<sup>1</sup> In addition to case law such as Bolitho (1999) and Re S (2000), see also *BMJ* 1999; 319: September, 18<sup>th</sup> – re a discussion on ‘*therapeutic alliance*’ – i.e., the concept of trying to get doctor and patient to work together for the best outcome, as opposed to seeing potentially polarized views.

there would be any risk to her voice, she was reassured that there was none. However, in the course of the operation a nerve was so badly damaged that she could not speak properly and she never broadcast again. As **Denning LJ** noted: “[The surgeon] admitted that on the evening before the operation he told [P] that there was no risk to her voice, when he knew there was some slight risk, but that he did it for her own good because it was of vital importance that she should not worry. In short, he told a lie, but he did it because he thought in the circumstance it was justifiable.”

**Held:** It was a matter for clinical judgment [i.e. therapeutic privilege]; the surgeon was not liable.

(See now: **Lord Bridge** in *Sidaway*, (1985) where he said (*obiter*) that when questioned by an autonomous patient, “ ... the doctor’s duty must ... be to answer both truthfully and as fully as the questioner requires”. Q: *If Sidaway* and *Hatcher v Black* represent conflicting views, does any *post-Sidaway* case law clarify the position? {see p11, *infra*})

### **(iii) If a doctor did incur liability what is the likely cause of action for non-disclosure of information?**

#### **Chatterton v Gerson [1981] QB 432**

“When the claim is based on negligence the plaintiff must prove not only the breach of duty to inform but that had the duty not been broken she would not have chosen to have the operation. Where the claim is based on trespass to the person, once it is shown that the consent is unreal, then what the plaintiff would have decided if she had been given the information which would have prevented vitiation of the reality of her consent is irrelevant.

“In my judgment once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of action on which to base a claim for failure to go into risks and implications is **negligence**, not trespass.” per **Bristow J**.

#### **Hills v Potter [1984] 3 All ER 716**

P alleged non-disclosure of a risk of injury inherent in a medical procedure and claimed that non-disclosure gave rise to an action both in battery and negligence.

**Held:** The claim for battery was rejected by **Hirst J** who said that:

“ ... P’s undoubted consent to the operation which was in fact performed negatives any possibility of liability under this head. ... I respectfully agree with **Bristow J** in deploring reliance on [battery] in medical cases of this kind. The proper cause of action, if any, is **negligence**.”

The Supreme Court of Canada was also of the opinion that any liability for non-disclosure of a risk can only lie in **negligence** and not in battery:

**Reibl v Hughes (1980) 114 DLR (3d)**

“[A]ctions of battery in respect of surgical or other treatment should be confined to cases where surgery or treatment has been performed or given to which there has been no consent at all or where, emergency situations aside, surgery or treatment has been performed or given beyond that to which there was consent ... [U]nless there has been misrepresentation or fraud to secure consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than battery. ... such a failure arises as the breach of an anterior duty of due care in carrying out the particular treatment to which the patient has consented. It is not a test of the validity of the consent.” per **Laskin CJ**

| <b>Comparing actions in Battery and Negligence for failing to impart an alleged significant risk to a patient – hence failing to obtain a valid consent - prior to the administration of medical treatment</b>          |   |
|---|---|
| <b>Battery</b>  | <b>Negligence</b>   |
| Requires physical contact to be made.   | Contact not required: may be based on the absence, or the inadequacy, of information that led to an invalid consent.  |
| The patient need not establish any tangible injury: the essence of the action is in the unwanted touching – i.e., action may be based on the absence, or the inadequacy, of consent that has led to an invalid consent. | An action based on the breach of a duty to inform must also be accompanied by proof that had the patient been informed of the risk(s), (s)he would not have chosen to have the operation <i>at that time</i> .  |
| An action in battery is actionable even if the patient’s health improves. A criminal action in assault may arise from the same action.  | Negligent withholding of information is unlikely to result in criminal action.  |
| It is for the patient to prove that (s)he did not consent to the touching.  | The test for medical negligence <i>has been</i> based on what a responsible body of medical practitioners would disclose.   |
| A doctor found liable in battery may be liable for all the damage that can factually be shown to flow from his wrongdoing.  | An action for liability in negligence is in respect of reasonably foreseeable damage.   |
|   | <p>“[T]he [correct] cause of action on which to base a claim for failure to go into risks and implications is <b>negligence</b>, not trespass.” per <b>Bristow J</b>, in <u><i>Chatterton v Gerson</i></u> (1981).</p> <p>The proper cause of action, if any, is <b>negligence</b>.” Per <b>Hirst J</b> in <u><i>Hills v Potter</i></u> (1984).</p> |

## **The Focus on Negligence Brought About by the Change in Emphasis From ‘merely’ Obtaining Consent to the Disclosure of ‘Appropriate’ Information Prior to Obtaining Consent ...**

In essence, in the first-half of the twentieth century, legal liabilities for non-consensual medical touchings were decided mainly in battery with some in negligence: case law wasn't consistent. However, as the ethicists, **Faden and Beauchamp**, stated: “ ... the second half of the century evoked a dramatic new development: the evolution of the traditional duty to *obtain consent* into a new, explicit duty to *disclose certain forms of information* and then to obtain consent.”

The process adopted in *some* American States of obtaining consent via disclosure of all **material risks**, i.e. more information than is the norm under the professional practice standard, became known as ‘informed consent’, an expression which originated in the 1957 case of *Salgo v Leland Stanford Jr University Board of Trustees*. Of equal, if not more, significance than the quantum of information disclosed, is the fact that *the standard for disclosure is set by the law* and **NOT** by the medical profession as in the professional practice standard. (See *infra*). It followed, then, that even if medical treatment was flawless but that injury had resulted from a known risk inherent in the procedure that is *undisclosed* to the patient, the medical practitioner still may be liable. This liability would be in negligence. Nevertheless, it still remained to be decided how much information had to be disclosed for consent to be regarded as ‘informed’. Here, a dichotomy of opinion - between the professional practice standard and the prudent patient standard - has been voiced since at least 1960.

### **The Professional Practice Standard**

In the American case of *Natanson v Kline* (1960), a doctor was held liable in negligence because the patient was not informed of collateral hazards that *‘any reasonable medical practitioner’* would disclose. [This standard implicitly permits discretion in the amount of information disclosed: and liability in negligence may be avoided if it is the standard practice of a responsible body of medical opinion not to disclose certain information, e.g. where the risk of damage is thought to be small - less than 2% (say) - i.e. in this country the *‘Bolam standard’*]. In jurisdictions where such discretion is permitted in the amount of information disclosed, the discretion being exercised in accordance with a judicially approved standard of responsible medical opinion, the standard is referred to as the **professional practice standard of disclosure**. It may be argued that such a paternalistic or ‘doctor knows best’ approach infringes a patient’s autonomy.

### **The Prudent Patient Standard**

By contrast with the principles of the professional practice standard, the 1972 cases of *Canterbury v Spence* and *Cobbs v Grant* continued the trend established after *Salgo* of requiring disclosure of diagnosis, prognosis with and without treatment, proposed treatments, risks inherent in the treatment, and alternative treatments and their risks.

This is known as the **patient-centred reasonable person standard** (or the *prudent patient standard*). This standard operated in only a *minority* of American States. It would appear that *discretion* in the amount of information disclosed on this standard was severely *curtailed*. However, this does **NOT** mean that *every* risk has to be disclosed:

“It seems obviously *prohibitive* and *unrealistic* to expect physicians to discuss with their patients *every* risk of proposed treatment - no matter how small or remote - and *generally unnecessary* from the patient’s viewpoint as well.” [And as to what should be discussed]: “... the test for determining whether a particular peril must be divulged is its materiality to the patient’s decision: all risks potentially affecting the decision must be unmasked. ... Furthermore, the standard is not subjective as to either the physician or the patient; it remains *objective* with due regard for the patient’s informational needs and with suitable leeway for the physician’s situation. In broad outline, we agree that a risk is thus *material* when a *reasonable person*, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.” [By contrast with the *Bolam* standard, however ]: “Respect for the patient’s right of self-determination on particular therapy demands a *standard set by law* for physicians rather than one which physicians may or may not impose on themselves. Any definition of scope in terms purely of a professional standard is at odds with the patients prerogative to decide on projected therapy himself.” (per **Robinson J**, *Canterbury v Spence* 464 F 2d 772 (1972)).

There is no difference, then, in English and North American cases in deciding that information must be disclosed to a patient so as to obtain a valid consent. As **Hirst J** said in *Hills v Potter* (1984): ‘English law *does* require the surgeon to supply to the patient information to enable the plaintiff to decide whether or not to undergo the operation.’ He then added: ‘The distinctive features of the Canadian and United States cases relate to the **amount of information** required and perhaps more importantly, the **standard** by which the surgeon’s conduct is to judged.’

| Comparing ‘Real Consent’ in English law with ‘Informed Consent’ as adopted in <u>some</u> American States |  |  |
|---|--|--|
|   | Real Consent   | Informed Consent   |
| 1   | The patient is to be informed in <i>broad terms</i> of the nature of the treatment intended.   | <u>All material risks</u> are to be disclosed.   |
| 2   | The <i>medical profession</i> sets the standard of information disclosure  | The standard for disclosure is set by <u>the law</u>   |
| 3   | Focuses on the <i>actual patient</i> , i.e., ‘ <i>the patient</i> [who] is informed in broad terms of the nature of the treatment intended’. | The standard is <u>objective</u> with its focus on the likelihood of a ‘ <u>reasonable person</u> ’ in what a physician knows, or should know, to be the patient’s position, attaching significance to the risk or cluster of risks before deciding whether or not to forego the proposed therapy. |

## Judicial Reaction to the Opportunity to Adopt 'Informed Consent' in English Law

Whether the English courts favoured the adoption of the prudent patient standard, i.e. the requirement of a medical practitioner to obtain his patient's *informed* consent prior to treatment, fell to be decided by the House of Lords in: Sidaway v Bethlem Royal Hospital (1985).

The significance of the Sidaway case was stated by **Lord Scarman** as " ... plainly of great importance. It raises a question which has never before been considered by your Lordships' House: has the patient a legal right to know, and is the doctor under a legal duty to disclose, the risk inherent in the treatment which the doctor recommends."

### **Sidaway v Board of Governors of the Bethlem Royal and the Maudsley Hospital [1985] AC 871.**

For several years, following an accident at work, S endured persistent pain in her right arm and shoulder. Later the pain spread to her left arm too. An operation relieved the pain for a while. Some years later S was once again in constant pain. She was admitted to the Maudsley Hospital and F diagnosed pressure on a nerve root as the cause of her pain. F decided to operate to relieve the pressure and S gave her consent to surgery. As a result of that operation S became severely disabled by partial paralysis. She then sued both F and the Maudsley Hospital. S did not suggest that the operation had been performed otherwise than skilfully and carefully. Her complaint was this: the operation to which she agreed involved two specific risks over and above the risk inherent in any surgery under general anaesthesia. These were: (i) damage to a nerve root, assessed as about a 2% risk; and (ii) damage to the spinal cord, assessed as less than a 1% risk. It was this second risk which materialised and she consequently suffered partial paralysis.

**HELD:** The doctor's obligation to advise and warn his patient was part and parcel of his general duty of care owed to each individual patient. *Prima facie*, providing he conformed to a responsible body of medical opinion in deciding what to tell and what not to tell his patient he discharged his duty properly. Accordingly, [and from 1985 (up to the present?)] **there is (or was) NO doctrine of informed consent in this country** (cf., say, some States in America) where it was essential that a doctor informed the patient of all *material* risks inherent in the treatment so as not to vitiate the patient's consent.

#### **(N.B.:**

(i) That there was no doctrine of informed consent in English law was confirmed in Re T (adult)(refusal of medical treatment) [1992] 4 AllER 649 @663. Moyes v Lothian Health Board [1990] 1 Med LR 463 @469 provided the authority for informed consent not being part of Scots law.

(ii) 'Informed consent', in this context, refers to the *objective* assessment of the informational needs of *a reasonable person*, in what the physician (doctor) knows or should know to be the patient's position; that is, a person who, as a patient, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.

(iii) There is no basis in believing that the legal standard on the disclosure of information

was amended by the requirement inserted in the NHS Patient's Charter (1991) that patients were 'to be given a clear explanation of any treatment proposed, including any risks and alternatives before [they] decide whether [they] will agree to the treatment').

That there was no doctrine of informed consent in this country meant, in essence, that it was still a matter of *clinical judgment* as to the facts to be disclosed to the patient: serious adverse consequences had normally to be disclosed to help the patient decide, although that was subject to the doctor's duty to consider the best interests of his patient. In the *Sidaway* Case there was only a 1% risk of damage (paralysis) occurring, and it was an accepted medical practice not to disclose this risk. Therefore, no negligence was established. However, the court added (obiter) that if a doctor is questioned by the patient, he should answer truthfully and as fully as the person asking the questions requires.

**Lord Bridge's** reasons for rejecting the doctrine of informed consent included:

"*First*, it gives insufficient weight to the realities of the doctor/patient relationship. A very wide variety of factors must enter into a doctor's clinical judgment not only as to what treatment is appropriate for a particular patient, but also how best to communicate to the patient the significant factors necessary to enable the patient to make an informed decision whether to undergo the treatment. The doctor cannot set out to educate the patient to his own standard of medical knowledge of all the relevant factors involved. ... *Secondly*, it would seem to me ... unrealistic to confine expert medical evidence to an explanation of the ... fact(s) and deny the court evidence of medical opinion and practice on the particular issue of disclosure which is under consideration. *Thirdly*, the objective test [i.e. the patient centred reasonable person standard] seems to me to be so imprecise as to be almost meaningless."  
(**Lord Keith** concurred with **Lord Bridge**).

Moreover, **Lord Bridge** said that: "... non-disclosure in a particular case ... is an issue to be decided *primarily* on the basis of ... the *Bolam* test."

**Kennedy and Grubb** wondered if 'primarily' is to be equated with the word 'rightly' as used by the Master of the Rolls in the Court of Appeal judgment in *Sidaway* when he said: 'The duty is fulfilled if the doctor acts in accordance with a practice *rightly* accepted as proper by a body of skilled and experienced medical men.'

**Lord Templeman** was of the opinion that:

"... if a patient knows that a major operation may entail serious consequences [he] cannot complain of lack of information unless [he] asks in vain for more information or unless there is some danger which by its nature or magnitude or for some other reason requires to be separately taken into account by [him] in order to reach a balanced judgment in deciding whether or not to submit to the operation, ..." [and]

“At the end of the day, the doctor, bearing in mind the best interests of the patient and bearing in mind the patient’s right of information which will enable the patient to make a balanced judgment must decide what information should be given to the patient and in what terms that information should be couched.”

However, **Lord Templeman’s** judgment did not contain an unequivocal acceptance of *Bolam*. This was evidenced by his statement that: ‘The court will award damages against the doctor if the court is satisfied that the doctor *blundered* and that the patient was deprived of information which was necessary ...’

**Lord Diplock**, however, appeared to promote a divisive application of informed consent in that it would be confined to ‘highly educated men of experience’. He said:

“ ... when it comes to warning about risks, the kind of training and experience that a judge will have undergone at the bar makes it natural for him to say (correctly): it is my right to decide whether any particular thing is done to my body, and I want to be fully informed of any risks there may be involved of which I am not already aware from my own general knowledge as *a highly educated man of experience*, so that I may form my own judgment whether to refuse the advised treatment or not.”

*Lord Diplock’s* focus on ‘educated men’ was far too restrictive for *Lords Bridge and Keith* who made no such qualification as to education or experience in stating that: ‘when questioned specifically by a patient of apparently sound mind about risks involved in a particular treatment proposed, the doctor’s duty must .. be to answer both truthfully and as fully as the questioner requires.’

**Lord Scarman** delivered the only dissenting opinion as far as disclosure of information was concerned: he clearly favoured adoption of the doctrine of informed consent. He said:

“ ... in a medical negligence case where the issue is as to the advice and information given to the patient as to the treatment proposed, the available options and the risks, the court is concerned primarily with a patient’s right. The doctor’s duty arises from his patient’s rights. If one considers the scope of the doctor’s duty by beginning with the right of the patient to make his own decision as to whether he will or will not undergo the treatment proposed, the right to be informed of significant risk and the doctor’s corresponding duty are easy to understand, for the proper implementation of the right requires that the doctor be under a duty to inform his patient of the material risks inherent in the treatment.”

**Lee** (*Law and Morals: Warnock, Gillick and Beyond*) reviewing *Sidaway* concluded:

“So if the *Sidaway* case poses a simple conflict between autonomy and paternalism, the resolution of that conflict is not so simple. The majority of the Law Lords seem to think that autonomy is not an absolute value, that individuals are not necessarily always the best judges of their own interests and that

therefore paternalism by the doctor is sometimes justifiable. ...

“So *Sidaway* raises the question whether the law and doctors should accept one moral position or another. The law could sanction doctors’ natural tendency to be paternalistic or it could say that the autonomy of the individual is paramount. ... The Law Lords end up saying both.”

**1993-2004: The beginning of a judicial trend towards the acceptance of the prudent patient [doctrine of informed consent?] standard in English medical law – or just a simple rejection of relying on the *Bolam* test as the standard by which information disclosure is judged?**

A significant first step in rejecting the *Bolam* standard appeared to have been taken by the **High Court of Australia** delivering a persuasive precedent in *Rogers v Whitaker* (1993). Here, it was decided that it is a matter for the courts to determine the standard of care owed by a doctor to his patient: medical practice will be no more than a guide to help judges in their decision-making. This does not prevent a doctor from claiming ‘therapeutic privilege’, however, particularly where a patient is ‘unusually nervous, disturbed or volatile’.

In common with the prudent patient standard in America (*Canterbury v Spence*) and Canada (*Reibl v Hughes*), *Rogers v Whitaker* decided that a patient must be informed of all *material risks*. These are risks to which *either* a reasonable person in the patient’s situation would attach significance, **or** to which *the patient in question* would attach significance if he was informed of them by a doctor who was aware or should have been aware of his (the patient’s) concerns. If the patient can show that he would not have consented if he had been informed of all material risks, then, in essence, the doctor has no defence to a charge of negligence.

Back in England, the decision of the High Court, in *De Freitas v O’Brien*, in February 1994, appeared to confirm the ongoing applicability of the *Bolam* standard, so retaining the conservative approach of deferring to medical opinion. However, a more significant decision was reported the same year in: *Smith v Tunbridge Wells Health Authority* where a 28-year-old man succeeded in claiming that he had not adequately been informed of the inherent risk of impotence before having rectal surgery. He succeeded in his claim despite evidence that a responsible body of surgeons did not warn their patients of such a risk. The claimant succeeded because the judge said the failure to warn was neither reasonable nor responsible.

A further restraint on the *Bolam* standard, was disclosed in the decision made in

November 1997, by the **House of Lords**, in *Bolitho v City and Hackney Health Authority*, and reported in: (1997) *The Times* 27<sup>th</sup> November. Here, the applicability of the *Bolam* test was affirmed **but** it was subject to the proviso that in cases involving the weighing of risks against benefits it could be demonstrated that the experts who had formulated their view had directed their minds to the question of comparative risks and benefits and had reached a defensible conclusion on the matter. That is, before a practice could be described as being in accordance with the practice accepted as proper by a 'responsible' or 'reasonable' or 'respectable' body of professional opinion the exponents of that opinion could demonstrate that such opinion had a logical basis. **If the courts were not convinced that a logical conclusion was reached by the medical profession, then the law would set the standard for them.** However, the principal qualification to this apparent revision of the *Bolam* standard was expressed by **Lord Browne-Wilkinson** when he said that it would 'very seldom' be right for a judge to conclude that the genuine views of a competent medical expert were illogical ... though he reserved the right to do so.

Clearly, it remained to be seen whether the intentional failure to disclose risks to a patient prior to an operation had a logical basis if the risks which materialised caused the patient a degree of disability, i.e., could 'therapeutic privilege' be said to be a defence rooted in logic? Could paternalism: (i) be logical; and (ii) be logical to the extent that it overrides autonomy?

{First, to answer the question at the top of p4, *supra.*: case law decided after *Sidaway*, (but before the House of Lords decision in *Bolitho*), that addressed the opinions of **Lords Bridge** and **Keith** in *Sidaway*, where their Lordships had opined that " ... when questioned specifically by a patient of apparently sound mind about risks involved in a particular treatment proposed, the doctor's duty must ... be to answer both truthfully and as fully as the questioner requires", reaffirmed the *Bolam* test – in other words, paternalism/therapeutic privilege continued to displace autonomy: *Gold v Haringey Health Authority* [1988] 2 All ER 888; and *Blyth v Bloomsbury Health Authority* [1993] 4 Med LR 151}.

Second, a Court of Appeal decision in 1998 and a journal article in 1999 are noteworthy. In *Pearce v United Bristol Healthcare NHS Trust* (1998) 48 BMLR 118, Mrs Pearce's child was stillborn two weeks after the due date of her delivery. Mrs Pearce had been warned of the risks of induction and Caesarean section but not of the low risk of a stillbirth associated with non-intervention. Given the low risk, the Court of Appeal held that she had not established negligence in the failure to disclose the risk. However, the case is noteworthy for the surprising ratio expressed by **Lord Woolf MR**, viz;

"In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course of action he or she should take in relation to treatment, it seems to me to be the law ... that *if there is a significant risk* which would *affect the judgment of a reasonable patient*, then in the normal course it is the responsibility of the doctor to inform *the patient* of that risk, if the information is needed so that *the patient* can determine for him or herself as to what course he or she would adopt".

How a 'significant risk' is determined is not explained, however. Moreover, the ratio may not be sufficiently precise enough to displace Bolam.

### **BMJ, September 1999**

The polarized positions of the paternalistic doctor and the patient pursuing self-determination have long been subjected to the criticism that always to elevate one perspective above that of the other in a difficult decision-making process is most unlikely to be as productive as trying to base treatment on an agreed basis; i.e., one based on a 'partnership' of the doctor and patient working together for a common purpose – the restoration, as far as is practicable, of the patient to 'full-health'. It is hoped that the promotion of this '*therapeutic alliance*', via the patient receiving a greater degree of disclosure of 'treatment options, outcomes, and the limitations of medical care' will encourage more patient 'self help' and will result in keeping 'costs down and ensure that demands for health care are channeled appropriately.' (eBMJ 1999; 319: 719-20, (18 September).

If this policy progresses beyond being a mere target of the government's, then it may lead to a form of informed consent where it falls to be decided if *the patient in question* - and not the mythical reasonable patient – has had sufficient disclosure of the material facts so as to have enabled him to have made an informed choice in relation to a treatment option.

### **House of Lords, 2004**

Finally, in 2004, a *House of Lords* case served as a reminder that a failure to disclose information, of itself, does not lead to an action in negligence: causation still remains to be established. So, in Chester v Afshar, the claimant succeeded in her claim that had she been warned of the attendant risks in the operation she underwent, she would not have had the operation at that time. She did not aim to prove that had she been warned of the risks she would never have undergone the operation, merely that had she been warned she would have taken further advice. Her agreement to the operation and the resulting paralysis resulted from the surgeon's inadequate advice.

### **Conclusions on the standard relating to the amount of information to be imparted to an autonomous patient in order for a valid consent to be obtained**

Given the status of the judge who gave the dictum in Pearce – *Lord Woolf MR* –, the qualifications put on the *Bolam* test by the House of Lords in Bolitho, and *Lord Steyn's* comment in Chester v Afshar that in 'modern law medical paternalism no longer reigns', it would appear that there *is* undoubtedly a distinct trend away from the professional practice or Bolam test that held sway for almost 40 years.

At last, it would appear that English law is paying more attention to the concept of patient

autonomy – perhaps even a prudent patient standard – but any use of the term ‘informed consent’ should be used with caution, particularly bearing in mind the damning comment of **Lord Bridge** in *Sidaway* where he said that: “the objective test [i.e. the patient centred reasonable person standard] seems to me to be so imprecise as to be almost meaningless.” If **Lord Woolf’s** dictum in *Pearce* was modified to accommodate part of the dictum in *Rogers v Whitaker* (1993) so that it became: “ .. if there is a significant risk which would affect the judgment of a reasonable patient, [or ***the patient in question***] ... ”, then, surely, not only would the common law be moving to a uniform standard but the standard would be closer to confirming that ‘over his own body and mind the [patient] *is* sovereign’.

### **Voluntariness**

A final point from **Lee** is that: ‘Informed consent involves more than the disclosure of risks. The consent has, in addition, to be voluntary.’ The crucial point is whether a ‘voluntary’ decision can be made in the absence of full knowledge of the facts needed to make an informed consent since: “ .. freedom of choice predicates not only full knowledge of the circumstances on which the exercise of choice is conditional ... but the absence of any feeling of constraint ..”. (per **Winfield & Jolowicz**).

‘Full knowledge’ of the facts would include information relating to alternative courses of action/prognosis with and without the proposed treatment. Furthermore, it has been questioned whether, for example, a patient ill in hospital is capable of making a voluntary decision since “... the condition of illness itself is sometimes spoken of as ‘coercive’ or involuntary. [Perhaps] Voluntariness is best regarded as a matter of degree, rather than as a quality that is wholly present or absent in particular cases.” (**President’s Commission, Making Health Care Decisions**).

**Skegg** makes another point in that: “If there is neither express assent nor express dissent, a court may draw a distinction between consent and submission. ... Mere submission is often indicative of consent, but where it is shown that the person acquiesced because he did not realise what was involved or ... for fear of consequences of refusal, the courts may find that the person did not consent.”

## References

- Brazier, M & Cave, E.** Medicine, Patients and the Law, 4<sup>th</sup> edn., 2007. London: Penguin, Ch.5, pp107-118;
- Jackson, E.** Medical Law: Text, cases and Materials, 2<sup>nd</sup> edn., 2010. Oxford: OUP, Ch.4
- McHale, J, Fox, M, and Murphy, J.** Health Care Law: Text and Materials, 2<sup>nd</sup> edn., 2007. London: Sweet & Maxwell, Ch.6, pp360-403;
- Pattinson, S.D.** Medical Law and Ethics, 2<sup>nd</sup> edn., 2009. London: Sweet & Maxwell, Ch.4, particularly pp119-136.
- Stauch, Wheat & Tingle.** Text, Cases & Materials on Medical Law, 3<sup>rd</sup> edn., 2006 London: Routledge-Cavendish, pp132-155.

## Cases

- \*\*\* Sidaway v. Board of Governors of the Bethlem Royal Hospital and Maudsley Hospital [1985] AC 871 \*\*\*
- Bolitho v. City and Hackney Health Authority [1997] 4 All ER 771.
- Pearce v. United Bristol Healthcare NHS Trust (1998) 48 BMLR 118.
- Chester v Afshar [2004] UKHL 41

## Workshop Questions

1. To what extent, if at all, do you believe that the House of Lords decision in Sidaway (1985) is in accord with the principle of respect for a person's autonomy? As part of your answer, provide a full analysis of **Lord Scarman's** opinion in Sidaway.
2. How, if at all, does 'informed' consent differ from 'real' consent? To what extent, if at all, do you agree with **Lord Bridge's** opinions in rejecting the doctrine of informed consent in Sidaway?
- 3 (a) Given that " ... when questioned specifically by a patient of apparently sound mind about risks involved in a particular treatment proposed, the doctor's duty must ... be to answer both truthfully and as fully as the questioner requires", to what extent, if at all, can Hatcher v. Black be considered 'good law'?
- (b) Explain why you support / do not support **Lord Diplock's** confinement of the application of the doctrine of informed consent to "highly educated men of experience".

- 4 (a) Discuss the significance of the Sidaway case as identified and expressed by Lord Scarman.  
(b) Explain the connection, if any, between real consent and the voluntariness of a patient's consent.  
(c) To what extent, if at all, is the English law on the quantum of information to be imparted to a patient before a valid consent can be said to be obtained at variance with that in other English-speaking jurisdictions?
- 5 (a) Explain what Bolam v Friern HMC (1957) decided.  
(b) Explain what the decisions in Chatterton v Gerson (1981) and Hills v Potter (1984) have in common.  
(c) To what extent, if at all, do you agree with Lord Templeman's opinions in Sidaway?
- 6 Critically evaluate the proposition that: "The Sidaway case sets the scene for a discussion of paternalism as it relates to informed consent." (Lee).
- 7 Therapeutic privilege may be a defence grounded in logic but it should not be a defence to an action that actually displaced patient autonomy in respect of the quantum of information imparted to that patient when (s)he required true and full answers to those questions (s)he asked prior to giving her/his real consent to medical treatment.

Discuss

- 8 Explain the contributions, if any, to the development of English law on information disclosure to patients prior to obtaining a valid consent made by: (a) Pearce v United Bristol Healthcare NHS Trust (1998); and (b) Chester v Afshar (2004).