

Watching the disclosure for consent evolve

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Prudence; is she a doctor or a patient?

- Choosing what information to disclose to a patient; for them then to decide for or against treatment; Traditionally a medical choice.
- Accordingly, the standard was set by the (prudent) reasonable doctor.

- *Should this standard be set by the reasonable doctor or the reasonable patient ?*

Surgeons know best

- Patient seeks Dupuytren's surgery; '*hand will be fine*'. But it wasn't....appeal court held that disclosure did not extend to warnings '*...calculated to frighten or distress the patient*'
- A patient chose thyroidectomy amongst other alternatives, after surgeon promised *there would be no risk to voice*. Jury found against the claimant, whose left vocal cord was paralysed intraoperatively
- Kinney v Lockwood Clinic [1932] 1 DLR 507
- Hatcher v Black (1954) The Times, July 2nd

The first hint of the reasonable patient

- *Reibl v Hughes (1980) 114 DLR (3d)*
- Brain surgery proposed to avoid a threatened stroke
- 4% risk of death; 10% of iatrogenic stroke
- Dr Hughes did not disclose these risks, for fear of frightening or distressing Mr Reibl.
- Peri-operative stroke occurred, paralysis ensued.
- Court found that Mr Reibl should have been warned

English Appeal Court wavers.

- Mrs Sidaway was paralysed following cervical spinal surgery. Surgeon warned of 2% risk root damage, but did not disclose risk of cord damage.
- Three of five judges found the Bolam test applicable for disclosure
- Two disagree, asserting that the reasonable patient must set the standard.

- *Doctors remained the standard-setters for what to disclose.*

- Sidaway v Board of Governors of the Bethlem Royal Hospitals & Maudsley Hospital [1985] AC 871

Australia adopts the reasonable patient

- *Rogers v Whitaker* [1993] 4 Med LR
- Patient seeking an improvement in the appearance of and sight in a near-blind right eye (penetrating injury)
- Surgeon fails to disclose risk 1/14000 of sympathetic ophthalmia
- Reasonable corneal & ant.chamber surgery on right, but Maree Whitaker's left eye blinded.
- Court finds that (i) disclosure substandard and (ii) standard of care should be set primarily by the court, reflecting the reasonable patient

Pearce v UBHNHST (1999)48 BMLR 118 CA

- Tina Pearce G6P5, 42/40, “begging to come in for induction or CS”
- Obstetrician favours normal birth, no intervention. Advises mother of risks of induction; natural birth safer; recovery from CS slower.
- No disclosure of the risks of foetal death *in utero*
- “Not to behave like a child”
- Baby died 5/7 later, *in utero*

Pearce (1999)

- “If there is a significant risk which would affect the judgement of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that risk, if the information is needed so that the patient can determine for herself... as to what course to adopt”

Results of Pearce

- If there is a significant risk which would affect the judgement of a reasonable patient.....
- No longer dependent on the reasonable doctor
- So no longer any need for a medical expert witness to advise a court on the standard of care for disclosure...Bolam withdraws from disclosure cases.
- ***The objective standard is that of the prudent patient***

Pearce confirmed in HL

- *Chester V Afshar* [2004] UKHL 41
- Mr Afshar had a duty to warn of small but unavoidable risk occurring after reasonable surgery
- Miss Chester suffered cauda equina syndrome after disc surgery
- House of Lords adopt *Pearce*.

GMC 2008. Consent: patients and doctors making decisions together s8

- You should not make assumptions about
 - The information a patient might want or need
 - The clinical or other factors *a patient might consider significant*, or
 - A patient's level of knowledge or understanding of what is proposed
- (Pearce)....If there is a significant risk which would affect the judgement of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that risk....

Disclosure of alternatives

- *Birch v UCHL NHSFT [2008] EWHC 2237 (QB)*

Patient informed of the 1% risk of stroke after catheter angiogram; but not of the (negligible) risks of stroke after MRA

‘...Duty to inform a patient....not discharged unless she is made aware of comparative risks of different procedures’

Montgomery v Lanark. [2015]

- Mrs M 5', 1st baby, IDDM. Large baby anticipated, October 1999, with weight on shoulders, so risk of dystocia during NVD. This risk not disclosed; obstetrician reluctant to put Mrs M (and diabetics generally) off NVD.
- Dystocia at 12 minutes, cerebral palsy, quadriplegia
- Court finds that mother would have elected for CS if it had been offered to her....and that it should have been.

Montgomery v Lanark. [2015]

-Ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.
-Materiality... *a reasonable person* in the patients 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.”
- *Supreme Court endorses the prudent patient as objective standard for disclosure*
- No different to GMC’s advice in 2008

Uncertainties of practice post certainty of principle

- Mrs A...2015
- Tasmin....2015
- Webster...2017
- Thefaut....2017

Mrs A v East Kent Hosp Univ. NHST [2015] EWHC 1038

- Should have been offered amnio at 32/40 in face of poor foetal growth; birth of baby with chromosome 4 & 11 anomalies avoidable by a 32-35/40 termination
- 0.1% risk ‘theoretical, negligible, background’; not material.
- *C.f Material risk; in circumstances of particular case, a reasonable person in (Mrs A’s) position would likely attach significance to the risk*
- But Mrs A found not to be such a person; cross referencing her attitude to risk of Downs or premature delivery secondary to amnio.
- *31/3/2015 (20 days post Montgomery)*

Tasmin v Barts Health NHST [2015] EWHC 3135

- Delayed CS led to hypoxic brain injury; CS delayed by waiting for a foetal blood sample
- 30/10/2015...7 months post *Mrs A v East Kent*
- ‘A risk of 0.1% (the risk of HIE in all births) is an immaterial risk for purposes of *Montgomery*’
- *Beware; If elective or non-therapeutic, where option of non-treatment feasible, even a negligible/theoretical/background risk should be regarded as engaging a duty to warn...consider Whitaker*

Webster v Burton Hosps [2017] EWCA Civ 62

- Antenatal diagnosis reduced foetal growth, asymmetry, polyhydramnios
- Obstetrician asserts he recognised the theoretical heightened risk of perinatal death conferred by this combination, but chose not to disclose this to mother
- If she'd known, mother would have requested delivery at term
- Spontaneous delivery 11 days post term, 'profound' cerebral palsy, due to cord compression
- Court finds that evidence founding risk had an 'extremely small statistical base, ...which was not accompanied by guidance, official or academic, about management of timing of delivery'
- Court held that obstetrician should have disclosed the inherent risk.

Thefaut v Johnston [2017] EWHC 497

- Spinal cord damaged; surgery only for acceleration of recovery; patient would have refused surgery, given adequate disclosure
- A need for adequate dialogue, with ‘time and space’
- Adequacy extends to the impression related to the patient (Letter)

Further to my telephone conversation with you today I am writing to confirm that I understand you have had facet joint injections which did not help your pain. I therefore think that as your symptoms are deteriorating it would be entirely reasonable to recommend surgery to your back. By taking away part of the disc and trimming up the bone that is compressing the nerve passing down to your left leg *I think that there should be at least a 90% chance of ridding you of your leg pain. As I explained to you back pain is not quite as likely to settle, but as your symptoms have come on at the same time I think that there is every chance that your back pain will settle as well.* The risks of surgery are fortunately very small. There is a 0.1% chance that I could damage the nerve (giving you weakness cocking up your left foot) and there is a 2% chance that you could have a leak of the spinal fluid which would delay your discharge from hospital by a few days but would not have any long term connotations

No mention of conservative option...

Thefaut v Johnston [2017] EWHC 497

- Spinal cord damaged
- A need for adequate dialogue, with 'time and space'
- Adequacy extends to the impression related to the patient (Letter)
- Letter gave false impression of likely recovery
- Inappropriate to obtain consent for first time immediately prior to elective surgery
- But *Thefaut* time and space for dialogue not so easy in urgent or emergency situations....

In conclusion, the story of disclosure for consent....

- Legal ripples travel slowly (*Reibl* 1980...)
- *Montgomery* ‘fleshes out’ the common law established in *Pearce*, but does not represent a sea change in that judgment.
- Despite a settled standard, plenty of work to do on the details of practice
- Is (inevitably) largely written in the context of neurological harm.