What is consent?

John de Bono

The Paterson Inquiry has brought renewed scrutiny of the relationship between surgeon and patient. The fifth anniversary of the Supreme Court's landmark decision in *Montgomery* is a good time to review the current state of play on the law of consent and the implications for surgeons.

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To understand *Montgomery* we need to take a step back and recognise how things used to be. In what some will still regard as the good old days, it was for the surgeon rather than the patient to decide on what treatment was required. Advice was acceptable, and a surgeon was not negligent, if he acted in accordance with the practice of a reasonable body of surgeons in the same field. In practice this meant that doctors could choose how much information to give a patient and whether to give options for alternative treatments.

This approach was endorsed by Lord Diplock in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* decided in 1985. His view was that patients might be put off by a detailed discussion of risks and it was up to a doctor to decide how much information to provide:

"The only effect that mention of risks can have on the patient's mind, if it has any at all, can be in the direction of deterring the patient from undergoing the treatment which in the expert opinion of the doctor it is in the patient's interest to undergo."

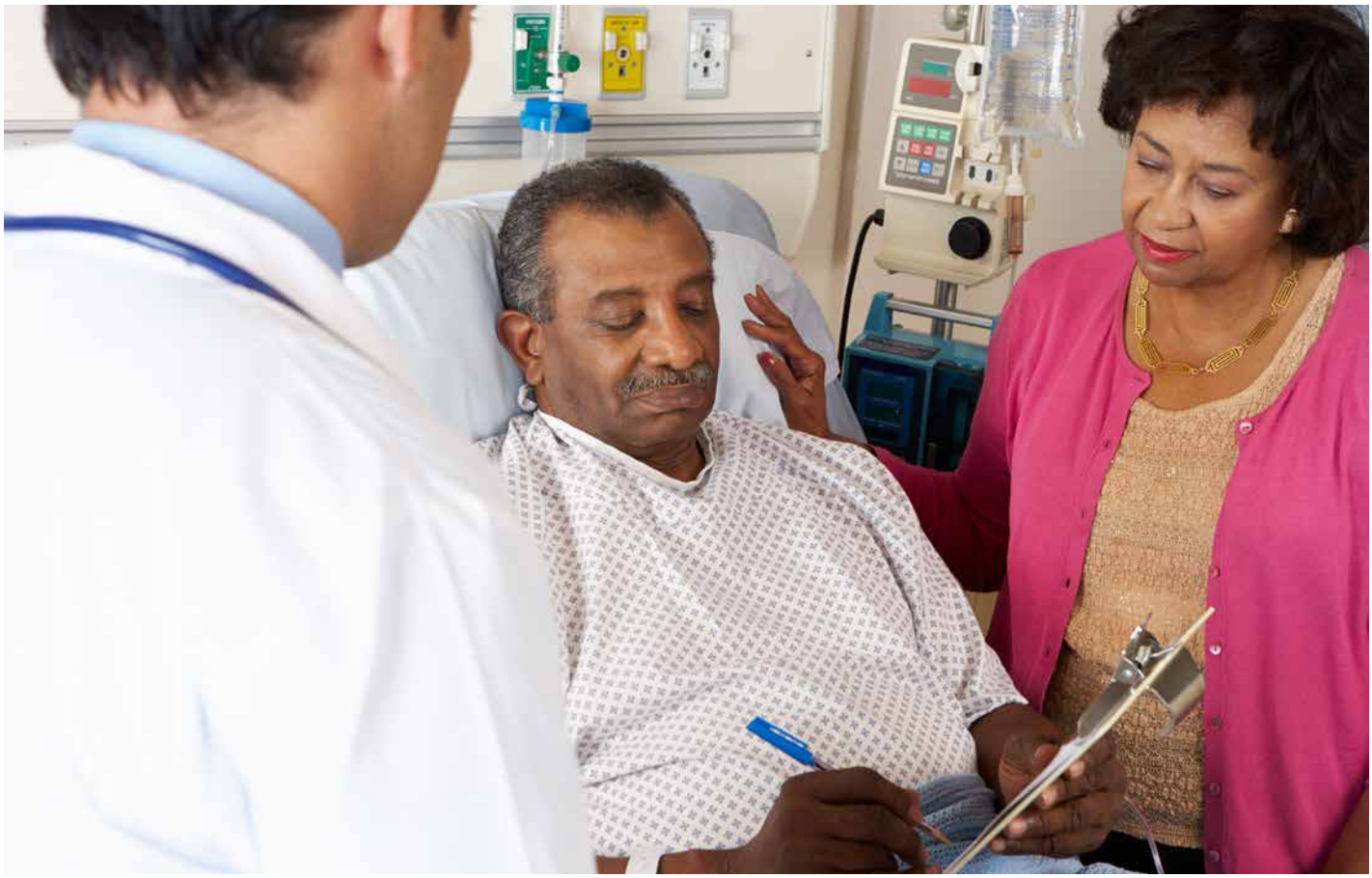
As an overall approach this was the highpoint of paternalism in medicine. There was also an element of snobbery in the judgment. Lord Diplock observed that if an educated patient such as a barrister or judge had any concerns about the proposed treatment he would have the ability to ask appropriate questions of his surgeon. Everyone else need not worry. Sidaway remained good law until *Montgomery* in 2015.

The facts of *Montgomery* are now well known. A choice had to be made between an elective caesarean section or vaginal delivery. Nadine Montgomery was short (under 5ft) and had diabetes. She therefore had a 10% risk of the birth being complicated by shoulder dystocia and if that happened there was a 10% risk of serious harm to her baby, giving a one per cent overall risk of serious injury to the baby from a vaginal delivery. Her obstetrician's preference was for a vaginal delivery. She told to the court that she believed that if offered the choice Mrs Montgomery would have opted for the caesarean section. Mrs Montgomery duly had her vaginal delivery, the baby became stuck and suffered a serious hypoxic ischaemic brain injury.

The Supreme Court accepted that the obstetrician had acted in accordance with the practice of a reasonable body of obstetricians. Moving the goalposts significantly they found that this was no longer the correct test. The question is not whether a reasonable doctor would have offered different treatment but what a reasonable patient would want to know. If there are reasonable alternative treatments then a patient is entitled to know and to make her own choice. The court held:

"The doctor is therefore under a duty 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."

This ruling has significant implications for trauma and orthopaedic surgeons. If elective surgery goes wrong a patient can argue that they would not have had the operation had they been properly advised of alternative options. Post-operative infection following hip replacement might be a recognised non-negligent complication of surgery but a patient who was not advised of that risk or of the alternative treatment options, including not having surgery, has a prima facie case in negligence.



Lawyers will tell you that consent cases used to be rare in practice. This was because even if a breach of duty was established a patient would struggle to prove what we call 'causation'. If you give me sub-standard advice I have to prove that I would not have had the same operation with proper advice.

Here too the goalposts have moved significantly in favour of the litigant. In *Thefaut v Johnston*, 2017, Mr Justice Green, found that a patient had not been given adequate advice about spinal surgery. Had she been properly advised she would either have not had surgery at all or would have had surgery on a different date. She was therefore entitled to damages for the disability that resulted from the otherwise non-negligent complication of a dural breach.

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A claimant who suffers a non-negligent complication of elective surgery need now only prove that had they been given appropriate advice about risks or treatment options they would have delayed surgery to 'think over' their options. The court will find that had they decided to go ahead with surgery but on a different date the rare, non-negligent complication, would probably not have happened. Many surgeons struggle with the logic of this position, arguing that if you suffer a complication of surgery on Monday you would probably have suffered the same problem with the same operation on Tuesday.

So how do surgeons protect themselves? Patients will often be convinced that there was no discussion of risks or alternatives. Surgeons need to be careful to record in a letter or the clinical notes that the patient was given a choice and what the alternatives were.

Advice needs to be specific to the patient. The risks of hand surgery might be different for the pianist and the barrister. The courts have left unanswered the obvious question of the surgeon: how great a risk need be to require a mention. It is not just a question of risk but the seriousness of the consequences and the implications for a particular patient.

Perhaps inevitably the Supreme Court kept its options open as to how great a risk need be to require a mention. It is not just a question of risk but the seriousness of the consequences and the implications for a particular patient.

In *Thefaut* the judge gave the following guidance for surgeons consenting patients:

- The dialogue between doctor and patient must be 'adequate'.
- There must be 'adequate time and space' for there to have been a reasonable dialogue.
- Communication must be 'de-jargonised'.
- The doctor's duty is not fulfilled by bombarding the patient with technical information.
- The routine demand of a signature on a consent form does not by itself mean anything in terms of consent.
- Consent should not be taken for the first time on the day of surgery.

Of course where your patient is unconscious or exsanguinating all bets are off and the court will be quite happy for you to revert to exercising your best paternalistic judgement as to what to do. That may be some reassurance, at least to the trauma surgeon. ■

Note from the Editor: *A follow-up article is planned addressing how the law stands with regards to consent for the non-elective but conscious patient typically encountered in trauma practice.*