Somewhat different national approaches to the law of consent to medical intervention are reflected in the House of Lords judgement in the case of Sidaway (1), referred to by Mr Norrie in this issue, and in the American legal doctrine of informed consent so thoroughly investigated in action and inaction in an American psychiatric hospital by Lidz and associates (2) (see Dr Chiswick’s review in this issue). Nonetheless some movement towards the American position can be detected in the Sidaway judgement and it is perhaps worthwhile comparing the two.

Until recently the question of what information should be given to patients in the context of consent to treatment has by English law been left to doctors to decide. According to a leading case, Bolam v Friern Hospital Management Committee (3), they would not be held negligent in law, (even when there existed a different practice advocated by another responsible body of medical men), provided they ‘acted in accordance with the practice accepted by a responsible body of medical men’. As Lord Scarman summarised the Bolam doctrine (1), ‘the law imposed the duty of care but the standard of care was a matter of medical judgement’. So far as advice about risks was concerned, the judge made it quite clear in Smith v Auckland Hospital Board that the ‘paramount consideration is the welfare of the patient, and given good faith on the part of the doctor I think the exercise of his discretion in the area of advice must depend upon the patient’s overall needs’ (4).

In America and Canada the tendency (by no means universal) is to reject the ‘medical judgement’ position typified in the Bolam and Smith cases and to replace it with ‘the prudent patient’ position as outlined in the US Court of Appeals judgement in Canterbury v Spence (5). This, as Lord Scarman summarised it when giving his judgement in the Sidaway case (1), had four components: first that adults of sound mind had the right to determine what should be done with their bodies; second that consent was informed choice and therefore entailed an opportunity to evaluate knowledgeably the options available and the risks attendant upon each; third that material risks therefore had to be disclosed by the doctor, (and it was in this context that the court defined ‘material’ by the prudent or reasonable patient test: a risk was material ‘when a reasonable patient 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 determining whether or not to forgo the proposed therapy’). Fourth, the doctor in any case retained a ‘therapeutic privilege’ which enabled him to withhold information about risks if reasonable medical assessment indicated that disclosure would pose a serious threat to the health of the patient.

In the Sidaway judgement (1) only one of the five law lords (Lord Diplock) accepted the unmodified Bolam doctrine in the context of deciding what information a doctor should be legally obliged to give to his patient if he is not to be negligent. Lord Scarman, having first summarised as above the American legal doctrine enunciated in Canterbury v Spence, then went on more or less to accept it. English law, he concluded, ‘should recognise a duty of the doctor to warn his patient of material risk inherent in the treatment he was proposing (especially if the treatment was surgery); the test of materiality being whether in the circumstances of the particular case the court was satisfied that a reasonable person in the patient’s position would be likely to attach significance to the risk’. Even if the risk was material, the doctor would not be liable ‘if upon a reasonable assessment of his patient’s condition he took the view that a warning would be detrimental to his patient’s health’.

Two other law lords (Lord Keith said he agreed with Lord Bridge) rejected the American doctrine as ‘impractical’ and stated that disclosure ‘had primarily to be a matter of clinical judgement’; nonetheless they added that a judge in some circumstances – for example where an operation was associated with a ten per cent risk of a stroke as in the Canadian case of Reibl v Hughes (6) – might decide that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent doctor would – in the absence of some cogent clinical reason – fail to make it. Lords Bridge and Keith also added that ‘when questioned by a patient of apparently sound mind about risks involved in a particular

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treatment proposed, the doctor’s duty was to answer both truthfully and as fully as the questioner required.

The remaining law lord (Lord Templeman) said that he subscribed neither to the theory that the patient was entitled to know everything nor to the theory that the doctor was entitled to decide everything. However, there was no doubt that ‘a doctor ought to draw the attention of a patient to a danger which might be special in kind or magnitude or special to the patient, as in Reibl v Hughes’. While the doctor had to decide what should be said and how it should be said . . . ‘[W]here the patient’s health and future were at stake the patient had to make the final decision’.

Thus with the exception of Lord Diplock (for whom the Bolam doctrine and the doctor’s assessment of his ‘comprehensive duty of care to the individual patient’ remained the determining criterion) the remaining four law lords judged that the ‘professional standard’ of the Bolam doctrine required modification towards allowing patients to make their own decisions about treatments which involved ‘material’ (Scarman) or ‘substantial’ (Bridge and Keith) risks or ‘which might have disadvantages or dangers’ (Templeman).

Although it is thus clear that English law has been moved by the Sidaway judgement somewhat nearer to the American ‘informed consent’ position of Canterbury v Spence, what is remarkable about even the American position is how much its professed concern for the patient’s individual autonomy is modified by a paternalistic readiness to let doctors override that autonomy. Thus the ‘reasonable patient’ test means that even according to the American doctrine doctors need not consider the risk perceptions of ‘unreasonable’ patients (how many of us are ‘reasonable’ in our risk perceptions?): and that even if ‘reasonable patients’ would consider a particular risk ‘material’, still a doctor does not have to disclose it to his patient if he considers that to do so would threaten his patient’s mental or physical health. In this respect the judgement of Lords Bridge and Keith that doctors should truthfully and fully answer individual patients’ questions about risks is more radical in its respect for patients’ autonomy than is Canterbury v Spence.

Given this acceptance of so much medical discretion by the standard American legal doctrine of informed consent, why is it so widely disliked by the medical profession both in America and in Britain? It may well be that it is not the substance of the legal requirement that is disliked so much as the way in which it has been implemented. If so the chief culprit is probably the American reification of ‘informed consent’ so that instead of being informed agreement between two rational and mutually well-regarding parties it has become a mere piece of paper covered in extensive, often barely comprehensible, medical information – and signatures. As Lidz and his colleagues suggest, ‘[C]onsent forms are viewed by many doctors as a substitute for talking to patients, and by many patients as nothing but paperwork’ (7).

It seems hardly contentious to claim that in general it is a good thing for adequately informed consent to be obtained from patients before doctors do things to them. The claim is justifiable not only as Justice Kirby justified it in these pages (8) in terms of respect for the integrity and autonomy of patients and their ‘right of self determination’ but also, in the large majority of cases, on the consequentialist grounds that patient care and overall welfare is improved if adequately informed consent is obtained. It seems clear however that current American methods of obtaining it are not adequate or satisfactory and in particular that the current use and design of consent forms is a failure.

One improvement might be to separate the ‘act of consent’ from the discussion of the nature, risks and benefits of proposed medical interventions, and of alternative management options. At least in fairly standard cases, there seems no reason why the normal (or once normal) discussion between doctor and patient should not be supplemented by a clear, well written and informal account of the procedure proposed and alternatives, outlining potential harms and benefits and their likelihood in ways which patients can relate to the risks and benefits of ordinary living. Such accounts could be written by professional writers in the light of medical and other appropriate requirements and be pretested, as Lidz and colleagues urge, on normal and clinical populations to ensure that they are reasonably comprehensible. Patients would need to keep a copy and discuss it with friends, advisers and their medical carers. These informal written accounts need not be part of the legal consent document, and there would doubtless be many justifiable (and legally sanctioned) exceptions to their use (emergencies, incompetence, voluntary relinquishment, and even, perhaps, rare cases of ‘therapeutic privilege’). Such a system, instituted with the real intention of helping patients participate more fully in decisions about their medical care, might succeed in avoiding the legalistic horrors of the ‘informed consent form’, while helping patients to give more adequately informed consent to treatment and other interventions.

References and notes


(7) See reference (2): 331 and ix–xii.