Browne Jacobson

Informed consent - where are we now?

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Browne Jacobson has recently represented defendants in two important consent decisions (Bayley v George Elliot Hospital NHS Foundation Trust and Shaw v Kovac and University Hospitals of Leicester).

This article explores the implications of those decisions and identifies the key issues for consideration in informed consent claims.

Post-Montgomery developments

How then, has the law developed since Montgomery?

While Chester and Montgomery both lay emphasis on the growing acceptance of the fundamental importance of a patient's right to autonomy over their own body, neither go further in suggesting a free-standing right to damages simply for loss of autonomy as opposed to personal injuries resulting from a negligent failure to properly warn the patient (as claimed in the case of Shaw).

Furthermore, little guidance has previously been provided as to what constitutes an alternative treatment option of which a patient must be informed. The below case of Bayley has provided clarification on this issue.

Bayley v George Eliot Hospital NHS Trust

The decision in Montgomery was further clarified in the recent case of Bayley. The claimant claimed that the treating clinicians ought to have advised her of all available treatment options (including treatment options available to her outside of the UK) and that such advice should have included notification of the availability of thrombo-iliac venous stenting.

The claimant put forward an argument that attempted to extend the provisions of Montgomery, so as to define what constitutes a treatment option of which a patient must be informed. The claimant's proposed 'two limb test' was advanced as follows:

1. Is the treatment option published in a respectable, specialist, peer reviewed medical journal?
2. Will that treatment be of benefit to the patient?

The claimant invited HHJ Worster to approach the issue of 'options' in the same way as 'risk' and concluded that he should find that if a patient is likely to attach significance to the options, or the doctor should be reasonably aware that the particular patient would attach significance to those options, then the patient must be notified.

This argument was rejected by HHJ Worster. The following can be surmised as the test to be applied in order to establish whether a treatment option is an alternative treatment option of which a patient must be advised:

1. There must be knowledge of the alternative treatment option.
2. The alternative treatment option must be within the knowledge of the competent clinician (i.e. Bolam standard).
3. The alternative option should not be a variant of an existing treatment option and there should be evidence of the alternative procedure being performed for the same purpose (i.e. just because stenting is used in heart surgery does not indicate that it is an alternative treatment option for stenting in other parts of the body).
4. The alternative treatment option must be accepted practice.
5. The alternative treatment option must be an 'appropriate option', not just a 'possible option' (it might be inferred that traditional Montgomery principles will be relevant to the assessment of this limb of the test, we may seek to rely on Bolam in order to substantiate the 'appropriateness' of an option).

The decision in Bayley is incredibly helpful to defendants and to clinicians as a whole. HHJ Worster opted not to impose an unduly high threshold when determining what constitutes an alternative variant treatment option of which a patient must be advised. To adopt the claimant's proposed test would represent a considerable expansion of the Montgomery test and of what we understand to be the obligations of clinicians working in the NHS both now and in the past. It would place a significant new burden on NHS clinicians.

Shaw v Kovac and University Hospitals of Leicester NHS Trust (2017)

In Shaw, the claimant appealed the damages awarded at first instance on the basis that a failure to obtain the informed consent of a patient could give rise to a separate award for compensation in a developing area of law and medical ethics which in that case was purported to be worth £50,000.

Court of Appeal unanimously upheld the decision that a failure to obtain informed consent should not give rise to a separate head of damages. The claimant had already received compensatory damages, so a conventional award in addition was not necessary or appropriate. If an individual's suffering was increased by knowing that his or her 'personal autonomy' had been invaded through want of informed consent then that could be reflected in the award of general damages. In his leading judgment, Lord Justice Davis agreed the risk of a proliferation of such claims would have "very real, even if unquantifiable, financial, practical and other implications."

Post-Montgomery

Sensible approaches are being adopted by the judiciary when determining the extent of clinicians' duties and damages as they relate to informed consent cases. In Bayley, a higher threshold for informed consent as it relates to 'alternative treatment options' was not adopted and in Shaw, the argument that informed consent should give rise to a separate award for compensation was rejected.

Below are four important points that ought to be considered when assessing the consent process Post-Montgomery:

1. Even if an adverse outcome is a recognised risk of a procedure, clinicians should continue to pay close attention to the consent process. Failure to consent a patient to the Montgomery standard can lead to damages being awarded on the basis that the patient was not advised of all risks and benefits associated with the particular procedure.
2. Beware of standard / pre-printed consent forms and reliance on brochures. Detailed conversations need to take place between a clinician, with the appropriate expertise and knowledge of the procedure, and their patient.
3. Irrespective of the constraints on clinicians' time, discussions must be clearly documented including the explanation provided as to the nature of the risks, benefits and alternative treatments available to patients (including the possibility of undergoing no treatment at all).
4. Alternative treatment options must be explained to the patient. However, this does not go so far as to require the patient to be advised of a variant of an existing treatment option used for another purpose (as outlined in the stenting example described above). There should be evidence of the alternative procedure being performed for the same purpose for which the current patient now requires treatment.

Finally, a failure to obtain informed consent does not give rise to a separate distinct head of damage. However, if a patient's pain and suffering is increased by the knowledge that their 'personal autonomy' has been invaded through want of informed consent (i.e. it has contributed to a psychiatric injury) that could be reflected in the award of general damages for pain suffering and loss of amenity.

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