Who shall decide: telling the truth and avoiding the law—patient consent in the millennium

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Over the centuries, the history of medical ethics has been peppered with issues of justifiable non-disclosure and confidentiality. A major feature of contemporary discussion is whether respect for autonomy requires more disclosure, consultation, decision-making and, in addition, the protection of confidential information.

The issue of mutual decision-making, and, therefore, individual responsibility has been highlighted by some Medical Council decisions in which the inappropriate or inadequate follow-up of reports perceived not to have been received by the doctor concerned, and, thus, not discussed, was deemed to be a reprehensible action on the part of the doctor. Doctors are to be responsible for ensuring all relevant reports are received by the patient and appropriate action taken.

Many writers consider that there is no absolute obligation to tell the truth, as information may carry risks for the patient. In some cases physicians must make a balance judgement as to the manner in which a story is conveyed and the amount of information disclosed; particularly if the news is unpleasant.

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In patients who clearly do not wish to be informed about cancer (and some may well indicate such preference), philosophers will view truthfulness as ensuring no harm is done. Whether this supposed reluctance to hear the indescribable is simply a self-defence mechanism, we may never know.

Deception is often believed to be easier to justify than blatant lying because deception does not necessarily threaten the trusting relationship between doctor and patient. A different view, which I hold, is that all intentional suppression of information violates patient autonomy, thus our fundamental duty. Belief about the nature of life and death (and the hereafter) as well as family ties and networks, will aid in coping with the prospect of serious disease, and of near-death. Unwelcome information can be provided under conditions allowing further family contact in appropriate circumstances so specific issues can be addressed in a way which enhances the doctor–patient relationship.

Informed consent

As a term, this is relatively new in the world of medicine, appearing in the literature in 1957 and discussion on the subject accelerating since 1972. There has been a move away from the physician's obligation to disclose towards a patient's understanding of information provided and an obligation, therefore, to provide information in a manner enhancing such understanding. And there lies a possible dilemma.

The concept of 'informed consent' recognises the patient's right of self-determination. The arguable feature of this involves the precise meaning of 'informed' or, in fact, rational; the words mean exactly what we want them to mean (in the words of Alice).This follows a decision made in 1914 by Judge Cardozo in which he stated:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without consent, commits an assault.[1]

Subsequent Courts (both in the UK and USA) oblige a doctor 'to make reasonable disclosure of the nature, and probable consequences, of a procedure'.

Why informed consent

According to Lord Justice Scarman, speaking to the BMA in 1986, the patient has rights, such that 'the duty of the doctor has been to conduct himself in his relationship with his patient in a way which is in his (doctor's) judgement furthers the best interests of his patient'. Others have stated that a physician violates his duty to his patient and subjects himself to liability if he withholds any facts necessary to form the basis of an intelligent consent. The immediate concern is in determining how much information is enough.

Professor Skegg (Dunedin) has outlined the factors affecting the answer as:

- the capacity to understand (the nature and purpose);
- the wish to be informed;
- the importance of the procedure;
- the risks involved; and
- the effect of the information (on the patient).[2]

Consent can be seen as both an individual action (on the part of a single patient) or a set of rules by which groups of patients can be treated. The authority conveyed in the individual consent scenario means there is understanding, without any undue influence (coercion) and an intention to act lawfully.

Reasonable disclosure

A decision in Kansas determined that a doctor had a duty to make a reasonable disclosure of the inherent risks of a procedure; failure to do so could be deemed to constitute negligence. What was considered 'reasonable' was then to be determined by medical experts, in the context of 'normal practice' of the time.

An English judgement (in 1972) attempted to quantify a doctor's obligation to disclose. The plaintiff suffered paralysis following laminectomy. His action was based on allegations that he was not warned about the risk (of paralysis). The Court concluded that the standard demanded was set by law, not by physicians (i.e. in contrast to previous decisions). The obligation for that doctor was to disclose all material risks.

The High Court of Australia (subsequent to that decision) has determined that a risk is natural, or material, if, in the circumstances of a particular case, a reasonable person (in that patient's position), if warned of the risk, would have attached significance to it. There has, then, been a change in focus in that what constituted a natural risk was now what a reasonable person might consider such risk; not a reasonable doctor. The Court at that time also considered that a standard of disclosure based on current practice may well be a façade for non-disclosure! The patient's right of self-determination now shaped the boundaries of the duty to reveal.

Some authors ask whether doctors have special dispensation from the usual principles which guide society's conduct. One contention is that it is impossible to look after patients and always to be truthful and open. Further, difficulties arise where the duty to disclose information may be neither compelling nor obvious, but simply create anxiety.

The danger of providing an inadequate level of information, in law outside NZ, is the threat of a case in negligence (or battery).[3] The first requires that a breach of duty to inform has been proven, and that, had such a duty not been broken, the patient would not have given a lawful consent at all.[4]

The end result of this view is that a failure to provide sufficient depth of information has negated a lawful consent unless such consent has been obtained by fraud or misrepresentation (of the possible consequences of a procedure). It is not enough to rely purely on avoiding the prospect of battery (allowing for the perceived safety for doctors under ACC).

How often have we heard ourselves claim that, had all the risks of a procedure, or even prescription drug-taking, been discussed, no intelligent patient would consider proceeding! Where in fact, are the limits to the extent of informing? It hinges, generally, on the likelihood and significance of risk.

Informed consent, then, constitutes a greater level of understanding by the patient of the inherent risks of any proposed treatment; as well as the nature and purpose of it. The issue which concerns Courts is whether the risk about which a patient has not enquired, should be discussed (both ethically and legally). The 'likely' risk is now set in mind, if not in law, by that risk considered significant enough to constitute misadventure (i.e. outside the 1% threshold).

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Difficulties arise when considering trust, as the law cannot set boundaries for that in the somewhat fragile doctor–patient relationship. Courts take the view that the *law*, not doctors, decide what should be considered to be material risk when giving medical consent.

Why do we need consent?

Consenting is not to be regarded as a passive process, although frequently there is presumption that consent has occurred as a result of some interaction between the parties involved.

Some of the advantages (of informed consent) are:

- patient satisfaction (I like what he's doing);
- aiding adjustment (I know what I'm doing);
- a defence against unwarranted intrusion (he's only doing this);
- a respect (for rights)—I agree with what he's doing and he has asked me what I want.

In a legal–philosophical sense, consent can be taken as an authorisation (of a proposal to treat), as well as purely an expression of assent (to act). The authorisation implies that there has been an understanding of the nature and consequences of a procedure, and that there has been no coercion. There is, then, not only an agreement between two parties, but also an acknowledgement that a proper legal process has been followed and that no repercussions may follow.

There is a (mis)conception that shared decision-making and informed consent are synonymous; shared decision-making implies an equality in input between patient and doctor; clearly, in most cases, this does not exist. Every medical procedure does not need equality in decision-making at all; some requires little patient input, other than listening to and accepting the advice. A patient may wish that her physician makes all the necessary decisions about management.

There is authority implicit in some patient consent; broad or narrow. Autonomous consent-giving, no matter how enthusiastic or cooperative the patient may be, does not mean lawful consent. This is particularly so when the patient consent-giver is under the legal 'age of consent'. This transfer of authority (to proceed) may not satisfy legal requirements in that geographic region.

Consumerism in the millennium and consent

The ethical responsibilities of the physician in the realm of integrated services is beyond the scope of this article. However, within the legal concept of consent discussed, must come willingness to alleviate pain and suffering beyond the patient's ability to pay.

Physicians with a commercial interest in the business of providing care are subject to the same legal provisions as those in solo practices. Consent to treat does not imply an agreement to over-service.

References

1. Cardozo J. Schloendorff v Society of NY Hospital. In: 125 N, editor; 1914.
2. Skegg PD. Law, ethics and medicine: studies in medical law. USA: Oxford University Press; 1985.
3. Somerville M. Structuring the issue in informed consent. 1981;26:740.
4. Robertson G. Informed consent to medical treatment. 1981;97:102.

Cardiovascular disease risk profile tools and New Zealand—the best way forward?

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The favourable trends in cardiovascular disease (CVD) mortality rates in New Zealand over the past 35 years may not be sustained due to less favourable trends with smoking and obesity.[1] This is of particular concern for at-risk groups, such as Maori and Pacific people.[2,3,4] This essay sets out to provide two distinct viewpoints on the best way forward and disseminate what these two pieces of research bring to the debate about how to progress this issue.

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The case for the use of CVD risk profile tools

In 2006 Bannick et al. offered a possible avenue to combat this issue.[5] They described the CVD risk factor status of over 18 000 patients profiled in routine general practice in New Zealand.[5] Patients' CVD risk was assessed and managed using a web-based clinical decision support programme called PREDICT-CVD.[1] The authors conclude that PREDICT-CVD is a practical and effective tool for systematically generating standardised patient CVD risk factor profiles during routine primary care practice. They propose that, when implemented widely, PREDICT-CVD will enable primary care organisations to monitor the CVD risk burden and management in their practice populations using a nationally standardised evidence-based approach.[5]