The decision in *Birch* marks another step away from the much criticised *Sidaway* approach to consent.

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Introduction

Obtaining, in broad terms, a patient's consent to treatment establishes a defence to the tort of battery[1,2] but a duty to warn of risks remains. The doctrine of informed consent has been adopted in North American jurisprudence but sits uncomfortably with English law. In this, a patient has a right to be told of the risks attending a proposed treatment. The patient is the arbiter of what risks he considers material, rather than the medical profession. This patient-centred interpretation of consent is in stark contrast to the position that prevailed in domestic law at the time of *Sidaway* v *Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital*[3], which required only that the doctor informs a patient of risks that *he* considers material.

Setting aside considerations of capacity and Convention rights, the central issue remains the extent to which doctors should disclose the risks of treatment to their patients. The Sidaway case is the starting point to this discussion which, in subsequent cases and by comparison of English law with North American and Australian jurisprudence, will illustrate a change in the common law on consent and the judicial approach to the rights of patients and the duties of doctors.

Sidaway: an uneasy precedent

The duty of a doctor to warn of the risks associated with a particular treatment was first considered in *Bolam* v *Friern Hospital Management Committee*[4]. Here, a doctor's non-disclosure of the risks of electro-convulsive therapy was largely overshadowed by the alleged breach in duty of care in failing to administer a muscle relaxant drug or, at least, to have adequately restrained the patient during treatment. The successful defence to an action in negligence was based in the extent to which there is a duty to warn,[5] and what a

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[1] *Chatterton* v *Gerson* [1980] 3 W.L.R. 1003.
[2] *Appleton* v *Garrett* [1997] 8 Med. L.R. 75.
[3] *Sidaway* v *Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] A.C. 871.
[4] *Bolam* v *Friern Hospital Management Committee* [1957] 1 W.L.R. 582.
[5] McNair J: '…you have to make up your minds whether or not it has been proven to your satisfaction that when the defendants adopted the practice they did (namely, the practice of saying very little and waiting for questions from the patient), they were falling below a proper standard of competent professional opinion on this question of whether or not it is right to warn.'

responsible body of professional opinion would have done (or said) under similar circumstances.[6]

Some years later, the case of *Reibl* v *Hughes*[7] established, in Canadian jurisprudence, that the patient's right to be informed of the risks of treatment *is* protected by the doctor's duty to warn.[8]

In Sidaway, however, the focus was upon what the medical profession, rather than the patient, deemed to represent a material risk. The claimant was left paralysed following cervical laminectomy and complained that had she been made aware of the risk of damage to the spinal cord (a risk accepted as around 1-2%), she would have declined to undergo that operation. The House of Lords applied the Bolam standard and concluded that, since a responsible body of medical opinion would have acted similarly (i.e. disclosed the same risks), the claim in negligence failed in having failed to establish a breach in duty of care.

This paternalistic 'doctor knows best' approach did little to determine what the patient *ought* to be told. The Bolam test represented a 'best-fit' solution to the problem of disclosure but there was unease in Lord Bridge's judgement.[9] He also found the Canterbury doctrine[10] to be 'quite impractical' on the grounds that it bypassed the role and value of the doctor-patient relationship in enabling doctors to make 'best interests' judgements about the disclosure of risks.

Lord Templeman envisaged that the court might set its own standard for determining what, by way of risks, should be disclosed to a patient facing treatment. He recognised the patient's right to make an informed decision and that a doctor, in failing to disclose potentially grave risks, might be held to be negligent unless there was a valid and cogent clinical reason for withholding that information.[11]

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[6] '(a doctor)…is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.'

[7] *Reibl* v *Hughes* [1978] 89 D.L.R. (3d) 112.

[8] Laskin CJC: 'What is under consideration here is the patient's right to know what risks are involved in undergoing or forgoing certain surgery or other treatment.'

[9] Lord Bridge: '…even in a case where, as here, no expert witness in the relevant medical field condemns the non-disclosure as being in conflict with accepted and responsible medical practice, I am of opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it.'

[10] 'Every human being of adult years and sound mind has a right to determine what shall be done with his own body.' *Canterbury* v *Spence & Washington* [1972] U.S. Court of Appeals District of Columbia Circuit 464 F 2d 772.

[11] Lord Templeman: 'If the practice of the medical profession is to make express mention of a particular kind of danger, the court will have no difficulty in coming to the conclusion that the doctor ought to have referred expressly to this danger as a special danger unless the doctor can give reasons to justify the form or absence of warning adopted by him. Where the practice of the medical profession is divided or does not include express mention, it will be for the court to determine whether the harm suffered is an example of a general danger inherent in the nature of the operation and if so whether the explanation afforded to the patient was sufficient to alert the patient to the general dangers of which the harm suffered is an example.'

Lord Scarman's dissenting judgement considered what, by reference to the North American standard, a reasonable patient might regard as a material risk and introduced the concept of therapeutic privilege:

> 'The test of materiality is whether in the circumstances of the particular case the court is satisfied that a reasonable person in the patient's position would be likely to attach significance to the risk. Even if the risk be material, the doctor will not be liable if upon a reasonable assessment of his patient's condition he takes the view that a warning would be detrimental to his patient's health.'

Sidaway to Pearce: gradual change

Despite the difficulties encountered in Sidaway, the Court of Appeal quickly moved to apply the same Bolam test in *Gold* v *Haringey Health Authority*[12] in accepting that a responsible body of doctors would not have warned about the chance of failure of female sterilisation. Whether or not this test could properly be applied to contraceptive, rather than therapeutic, interventions was questioned by Lloyd LJ.[13]

Notwithstanding the obvious concerns in Sidaway, further cases followed in which the Bolam test, applied as the standard of disclosure,[14,15] remained unconstrained by Bolitho.[16]

In the Australian case of *Rogers* v *Whittaker*[17] it was held, having adopted Lord Scarman's test of materiality of risk, that a patient contemplating surgery upon her near-blind right eye should have been warned of the risk of sympathetic ophthalmia affecting the left eye. This risk, estimated to be no greater than 1:14,000, was clearly material to the patient as it could, and did, result in loss of vision in her only functioning eye. That the risk of sympathetic ophthalmia was material to this particular patient was not only self-evident considering her medical condition, but it was also demonstrated by her persistent questioning about risks.

The Australian High court went one step further than Lord Scarman in determining that a risk would be material if a doctor *should* be aware of its relevance to that patient, even if he wasn't,[18] a ruling which was followed in the subsequent Australian case of *Chappel* v *Hart*.[19]

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[12] *Gold* v *Haringey Health Authority* [1987] 3 W.L.R. 649.
[13] Lloyd LJ: '..a doctor's duty of care in relation to diagnosis, treatment and advice, whether the doctor be a specialist or general practitioner, is not to be dissected into its component parts.'
[14] *Moyes* v *Lothian Health Board* 1990 S.L.T. 444.
[15] *Abbas* v *Kenney* [1996] 7 Med. L.R. 47.
[16] *Bolitho (Deceased)* v *City and Hackney Health Authority* [1998] A.C. 232.
[17] *Rogers* v *Whittaker* [1993] 4 Med. L.R. 79.
[18] 'A risk is material if in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should be reasonably aware that the particular patient, if warned of the risk, would be likely to attach significance to it.'
[19] *Chappel* v *Hart* [1999] 195 C.L.R. 232.

Hence although the materiality of a risk is, in the main, likely to be a product of the probability of it eventuating and its gravity, its relevance to the patient in question is critical. Where the risk is so remote that *no* reasonable patient would regard it as significant the duty to warn of that risk diminishes. In *Rosenberg* v *Percival*[20], Gleeson CJ held that in so far as causation is concerned:

> 'The more remote a contingency which a doctor is required to bring to the notice of a patient, the more difficult it may be for the patient to convince a court that the existence of the contingency would have caused the patient to decide against surgery.'

Unfortunately there is no legal definition, in percentage terms, as to what would constitute such a remote risk.

A move towards the 'reasonable patient' test

In *Pearce* v *United Bristol Healthcare NHS Trust*[21], Mrs Pearce had requested her obstetrician to expedite the delivery of her overdue baby but was persuaded to await the natural onset of labour. Unfortunately the baby was stillborn. The court held that risk of stillbirth attending the recommended course of action (around 0.1-0.2%) was so small as to make non-disclosure of that risk defensible. In his judgement Lord Woolf MR returned to the objective 'reasonable patient' test, effectively distancing Bolam from the legal standard.[22] Importantly, a new duty to consider the understanding and emotional condition of the patient was also introduced.[23]

In the case of *Wyatt* v *Curtis*[24], the Court of Appeal, in applying a subjective ('this patient') test, accepted that had Mrs Wyatt been warned of the risks of foetal abnormalities arising as a result of contracting chickenpox during pregnancy she would have sought an abortion. In the strikingly similar *Arndt* v *Smith*[25] case, the Supreme Court of Canada applied a modified objective test of the 'reasonable' patient[26] and reached the opposite conclusion since the patient was clearly sceptical of medical intervention and badly wanted a child.[27]

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[20] *Rosenberg* v *Percival* [2001] HCA 18.
[21] *Pearce* v *United Bristol Healthcare NHS Trust* [1999] E.C.C. 167.
[22] Woolf MR: '… if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt.'
[23] Woolf MR: '…the doctor, in determining what to tell a patient, has to take into account all the relevant considerations, which include the ability of the patient to comprehend what he has to say to him or her and the state of the patient at the particular time, both from the physical point of view and an emotional point of view.'
[24] *Sarah Wyatt* v *Dr Anne Curtis, Central Nottinghamshire Health Authority* [2003] EWCA Civ 1779.
[25] *Arndt* v *Smith* [1997] 2 S.C.R. 539.
[26] 'the "reasonable person" who sets the standard for the objective test must be taken to possess the patient's reasonable beliefs, fears, desires and expectations'
[27] Causation and disclosure of medical risks. Tony Honore. L.Q.R. 1998, 114(Jan), 52-55.

Sedley LJ, in the Wyatt case, viewed the standard of disclosure set in Pearce as a refinement of that in Sidaway, with an interpretation that converges with the North American standard:

> 'Lord Woolf's formulation refines Lord Bridge's test by recognising that what is substantial and what is grave are questions on which the doctor's and the patient's perception may differ, and in relation to which the doctor must therefore have regard to what may be the patient's perception.'

Chester to Birch: an end to medical paternalism

The ambit of risks attending any given treatment makes it difficult to prove which of those risks, in isolation, would have been determinative of a patient declining treatment. In some cases the claimant has failed on this issue of causation[28] others have succeeded[29,30].

Chester v *Afshar*[31] was an important landmark because it removed the requirement for the claimant to demonstrate that, had they been warned of the risks, they would not, at *any* subsequent time, have undergone the proposed treatment. Mrs Chester argued that had she been aware of the risk of spinal cord ischaemia and paralysis that accompanied the surgery she underwent, she would not have consented to it. That she would, in all likelihood, still have undergone that procedure at some later date was considered irrelevant as she could, for example, have sought the opinion of a surgeon more skilled in that procedure to lessen the risk. Lord Steyn observed that:

> 'In modern law medical paternalism no longer rules and a patient has the right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery.'

It is not, however, enough for a doctor simply to discharge his duty to warn of risks. While recognising that there is no duty for doctors to *test* the understanding of patients, in *Al Hamwi* v *Johnston*[32] it was suggested by Simon J that:

> 'Clinicians should take reasonable and appropriate steps to satisfy themselves that the patient has understood the information which has been provided.'

A duty to *ensure* a level of understanding has since been established in common law[33,34,]

Five years after Pearce, the High Court extended the autonomous rights of patients to be informed of the risks associated not only with the planned procedure, but also with the

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[28] *Smith* v *Barking, Havering and Brentwood Health Authority* [1994] 5 Med. L.R. 285.
[29] *Smith* v *Tunbridge Wells Health Authority* [1994] 5 Med L.R. 334.
[30] *McAllister* v *Lewisham and North Southwark Health Authority*[1994] 5 Med L.R. 343.
[31] *Chester* v *Afshar* [2004] 3 W.L.R. 927.
[32] *Al Hamwi* v *Johnston, The North West London Hospitals NHS Trust* [2005] EWHC 206.
[33] *Deriche* v *Ealing Hospital NHS Trust* [2003] EWHC 3104.
[34] *Cooper* v *Royal United Hospital Bath NHS Trust* [2005] EWHC 3381.

range of alternative treatment options. In *Birch* v *UCL Hospital NHS Foundation Trust*[35] the patient faced, and suffered, a 1% risk of stroke during cerebral catheter arteriography, a risk that could have been eliminated by MRI angiography. Mrs Birch was unaware of the alternative treatment options and their relative risks. Cranston J held that the failure to discuss comparative risks amounted to a breach of the doctor's duty of care[36].

The Birch case represented a further quantum leap in the common law on consent, positioning as it did the patient at the heart of the decision making and treatment planning process.

Conclusion

It is easy for litigation-conscious doctors to regard the process of consent strictly in terms of their legal, rather than their ethical, duty and there have even been calls from some in the medical profession to re-brand 'consent' as a 'request for treatment'[37]. This may do more to protect the doctor in law than it does to promote a duty of care in the best interests of the patient.

Guidance issued by regulatory bodies such the Department of Health, the defence associations and the GMC now reflects a convergence with the North American and Australasian doctrine of informed consent, based upon an objective test of what the reasonable patient would want and need to know.

Since the somewhat clumsy precedent set by Sidaway, the law has thus moved away from medical paternalism, and a 'doctor knows best' approach to consent, towards a patient-centred process that gives greater effect to the primacy of the patient's right to self-determination. No longer does therapeutic privilege, viewed by some as the cornerstone of medical paternalism, afford doctors a convenient defence to the non-disclosure of risks.

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[35] *Birch* v *UCL Hospital NHS Foundation Trust* [2008] EWHC 2237 (QB).

[36] Cranston J: '…in my judgment there will be circumstances where consistently with Lord Woolf MR's statement of the law in Pearce v United Bristol Healthcare NHS Trust the duty to inform a patient of the significant risks will not be discharged unless she is made aware that fewer, or no risks, are associated with another procedure. In other words, unless the patient is informed of the comparative risks of different procedures she will not be in a position to give her fully informed consent to one procedure rather than another.'

[37] Shokrollahi K. Request for treatment: the evolution of consent. Ann R Coll Surg Eng 2010; 92: 93-100.

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