Informed Consent to Medical Treatment

– What needs to be disclosed?

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INTRODUCTION

Things can go wrong in the surgical procedure and bad outcome and adverse results may result due to human error, negligent or not. More often the patient's complaint will be:

"You did not inform me of the risk which became a reality. I would not have consented to the operation if I had known of the risks, so you have caused my injury and failed in your medical duty of care to inform". Is there sufficient information for the patient's consent?

Consent is an ethical principle. Medical treatment can only be performed with the consent of a competent patient. Administering medical treatment without consent, would be considered a failure to respect a patient's autonomy violating an individual's right of self-determination. Consent must be freely given with the patient understanding the nature, risks, benefits, alternatives and limitations of the proposed treatment. Any medical treatment given without consent may ground an action in trespass to the person for which damages are payable. The consent form is for the patient to acknowledge that the nature and purpose of the treatment has been fully explained, understood and consented to. The patient never consented to the doctor's negligence but only to the risks and complications involved. However in an emergency situation where a patient is unable to consent, e.g. due to unconsciousness, a doctor may be justified in carrying out emergency treatment based of the basis of the doctrine of necessity or implied consent. Under 'implied consent' it is presumed that a patient would have consented to the treatment as it was necessary to save his life or from serious harm.

DOCTOR'S LEGAL DUTY TO DISCLOSE INFORMATION

What is the level or standard of disclosure to be expected in medical law? A patient can only give real consent to medical treatment if he has sufficient information to make a decision for an informed consent. It is important for doctors to disclose information to their patients about:

- the name of the operation
- nature of the proposed treatment
- what the operation involves
- other treatment options or alternatives
- potential complications
- risks of the operation
- risks of no treatment
- special precautions required post-operatively
- benefits of treatment
- limitations of treatment
- success rate of operation
- what happens on admission
- how patient will feel after treatment

Information includes warning. The doctor's duty is to disclose any real risks in the treatment and also to warn of any real risk that the treatment may prove ineffective. Alternative treatments should also be told especially if there is a choice between surgical and medical procedures. All 'material' risks of procedure must be disclosed subject to therapeutic privilege. The fact that a patient asked questions showing concern about the risk would make a doctor aware that his patient does attach significance to the risk and thus affect its materiality. A lot depends on the patients way of questioning.

This was why in the Australian case of Rogers v Whittaker (1992), a 1:14,000 chance of blindness turned into a risk which it was found to be negligent not to disclose. A risk, even if it is a mere possibility, should be regarded as 'material' if its occurrence causes consequences. Once a patient ask 'how serious' the operation is, the doctor should at least discuss the relative conveniences and expertise as well as possible risks. To say less would be misleading and inadequate. Good communication is stressed and is highly desirable between the doctor-patient relationship.

Clearly a failure by the doctor to disclose the risks of treatment may result in an action brought in negligence. The test which medical negligence is assessed is the Bolam test, which has recently been redefined in the recent case of Bolitho v Hackney Health Authority (1997). The ability and willingness of the courts in Bolitho case to consider the correctness of a professional view has been extended beyond information disclosure and into treatment. This case arose out of a failure of a hospital doctor to examine and intubate a child experiencing respiratory distress, leading to brain damage through asphyxia. The plaintiff patient had expert evidence that a reasonably competent doctor would have intubated in those circumstances. The defendant doctor had her own expert witnesses saying that non-intubation was a clinically justifiable response.

Under Bolam test, a doctor is not negligent if what he has done is accepted by a responsible body of medical opinion. But according to Lord Browne-Wilkinson in Bolitho case (a House of lords case), the court must be satisfied that the

body of opinion rests on a logical basis. Clearly this seems to be a rejection of the Bolam test. It was a matter for the court and not medical opinion to decide the standard of professional care. As stated by Mason & McCall Smith: Law and Medical Ethics (5th ed) at 225,"... Bolitho case has been regarded by some commentors as representing a significant nail on Bolam's coffin.

A recent English Court of Appeal case of Penney & Anor v East Kent Health Authority (2000), held that the Bolam test applied subject to the qualification that expert evidence that the defendant's conduct accorded with sound medical practice had to be capable of withstanding logical analysis... and that in areas of conflict between two competent experts holding genuinely different opinions, the judge can decide which evidence to prefer. In other words, the Bolam test is not applicable here.

In recent years, there is a movement away from Bolam and there are many evidence that the English courts will not apply rigidly the Bolam standard in disputes over information disclosure. In an English case of Newell and Newell v Goldenberg (1995), the patient successfully sued the doctor for negligently failing to warn her that the vasectomy could not be guaranteed to prevent pregnancy.

In another English case of Williamson v East London and City Health Authority and others (1997), the judge held that non-disclosure of the full nature of the surgery to remove a breast prosthesis which was a mastectomy amounted to negligence.

In another English case of Lybert v Warrington Health Authority (1996), the court held that the doctor was negligent in failing to disclose the risk that a hysterectomy might not provide protection against conception.

In the Malaysian case of Kamalam v Eastern Plantation Agency (1996), the Bolam principle was not followed. A Malaysian judge can now decide on his own disregarding expert medical evidence on the sufficiency of consent. The Malaysian court has followed the Australian case of Rogers v Whittaker (1992). The patient in Rogers case sued the doctor for failure to warn the risk of developing a condition known as 'sympathetic opthalmia' which is a rare complication with a chance of 1:14,000. The High Court held that a doctor had a duty to warn of material risks. The Bolam test and Sidaway's case were rejected by Australia in regard to the doctor's duty to inform and disclose information.

In the Malaysian case of Hong Chuan Lay v Dr Eddie Soo Fook Mun (1998), the judge held that a doctor had a duty to give information and advice. His medical duty involves the disclosure of diagnosis of the patient's illness, the nature of the proposed treatment and the risks involved. The Court held that it is for the court [and not a body of medical opinion] to judge the adequacy of information disclosure for an informed consent. Medical opinions are still required to assist the court in its deliberation.

ATTACK ON BOLAM TEST

The Bolam test has also been challenged in some other jurisdictions such as in America, Canada, Australia and South Africa. There is no decided Singapore case. But Singapore doctors should be aware of the recent developments in America, Canada, Malaysia, South Africa and Australia attacking and rejecting Bolam test. It is highly desirable for a doctor to record in his medical notes that risks and alternatives were disclosed and understood by patients, apart from the patient signing the consent form. It is no harm to disclose all 'material' risks and information to patients as they have a right to do what they want with their own bodies. Patients could choose to do nothing after being informed of the alternatives or options available and the consequences of no treatment. This is respecting patient's autonomy or self-determination in biomedical ethics. ■

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◄ *Page 5 – Speech by Dr Chen Ai Ju*

with all our doctors, dentists and hospitals standing collectively as the medical centre and drawing patients from the region is also still not fully realised. Historically, the medical profession has taken the lead to initiate many changes in healthcare in Singapore, I am hopeful that the younger generation of doctors will continue this spirit of being the change agent and to further push for progress under the leadership of the SMA, the Alumni, the AM, and the COFP and to work with the government towards our goals to promote health and to alleviate disease and suffering.

I joined the medical profession at the most important time of Singapore's history, when it became an independent nation. I am pleased to have participated and contributed to the improvements in health and the changes in health-care in Singapore. As healthcare professionals, our challenge is to improve the quality of life of our patients, treating them with the same respect and dignity that we expect for ourselves. We must also be mindful, we are not immune to public criticism. Our decisions and actions will be challenged more and more, as health is a subject close to everyone's heart. But I am confident our profession will be able to meet the challenges and uncertainties of the new information, biomedical and molecular technologies in the years ahead and bring medical practice to an even higher and more dynamic plane. But we must never become too enamoured with technologies and forget that Medicine, including Genomic medicine requires not only a good mind but also a good heart. Patients are not mere statistics. They have feelings. Let us show more compassion and be more communicative in our dealings with them. Let us also be more collegial to our professional colleagues as we have to work as a team to achieve the common mission." ■