THE CURRENT PROBLEM OF CONSENT-TAKING

Text by Dr Chew Shing Chai

On Thursday 26 July 2018, I attended a peer review lecture at Mount Elizabeth Novena Hospital. The topic was "Vaginal Birth after Caesarean Section" or VBAC as we call it.

The lecture was interesting, involving six cases, some of which were pushed through an incredibly long period of labour, causing awe and astonishment among many of us. But the interest of the entire group was totally ignited when the discussion came to the question of how to obtain consent for the VBAC, leading to the discussion on the procedure of taking consent in general.

One member who had been taken to court recounted how his consent form, which was taken by him in the presence of a staff member, was totally voided when the patient said she did not understand the contents of the document she had signed.

The discussion was intense and it was concluded that the patient has to be taken through the consent form line by line, with each line initialled in the presence of a witness. Or else, the patient has to write (in her own handwriting) the concept of what the procedure entails. Or, the entire session has to be videotaped as is done in the US.

Some of us are old enough to remember that the old consent form had a line which said "and any other procedure that the surgeon may deem fit", giving him a carte blanche. This is now obviously obsolete.

When medical negligence cases first appeared in courts, the learned judges felt that they were not able to judge medical issues regarding competence, so they decided to appoint expert witnesses acting as amicus curiae. Hence the cases were judged based on sworn testimony of doctors and the precedents were known by their names, eg, Bolam, Bolitho, etc.

In 1999, a Scottish obstetrician managing a short (150 cm) insulin-dependent diabetic with a macrosomic baby estimated at 3,600 g at 36 weeks was so unhappy at being asked how large the baby was that she decided to stop doing measurements. She decided to do caesarean only if the baby was over 4.5 kg (how she would be able to estimate that after stopping measurements is unfathomable). Labour was induced at 38 weeks (baby guestimated at 3.9 kg) and when there was no progress, more oxytocics were given. When the os was full and no descent was made, forceps were applied and only half the head emerged. General anaesthesia was given to allow the head to be repositioned for caesarean (Zavanelli manoeuvre), but she decided to continue to pull the head out, resulting in extreme shoulder dystocia.

Failed attempts at symphysiotomy followed by massive accouchement force resulted in the delivery of Sam Montgomery, a 4.25 kg quadriplegic, hypoxic brain-damaged individual.

Of course, this case went through two courts where obstetric colleagues ("expert witnesses") swore that it was unfortunate and unpredictable, and their testimony won the day on the two occasions. But in 2015, the Supreme Court found that there was no proper advice given and so we now have the Montgomery case that hangs over our heads.

My conclusion

1. The obstetrician flagrantly flouted the ethical principles of patient autonomy, beneficence and non-maleficence.
2. The learned judges who could not rebut the testimony of the "expert witnesses" changed the law.
3. Therefore we do not really need "expert witnesses" any more.

What we needed in 1999 were some truthful obstetricians to testify that the management was totally unacceptable and that the monumental disaster that crippled little Sam should have been settled with compensation to the mother.

Then the law would not have been changed and we could keep to the old Bolam-Bolitho-Whitaker precedents. We cannot change the law so we have to live with it. We only need to pray that we do not have any mishaps during surgery, and we do need good videotaping equipment and videos dubbed in the four official languages, if we do any procedures.

I welcome all comments. ◆