Briefing Document: Themes and Important Ideas in Consent and Decision-Making

Source: Excerpts from " 06 Francis Brooks and Jo Clift_SRT _English.srt.pdf"

Date: 26th November 2024 [Date of presentation]

Author/Speaker: Francis Brooks, *Consultant Spinal Surgeon*. Jo Clift, Medical Malpractice Underwriter at CFC Underwriting Limited.

Overview:

This briefing document summarises the main themes and important ideas discussed across the provided transcripts regarding patient consent and decision-making in a healthcare context, primarily within the NHS in the UK and Wales. It incorporates quotes from the original sources where appropriate.

The central theme across all sources is the shift from a paternalistic, doctor-centric approach to consent towards a patient-centred model emphasizing meaningful dialogue, shared decision-making, and informed consent based on what matters to the individual patient. Legal developments, particularly the *Montgomery* case, have significantly driven this change, placing a greater onus on clinicians to understand and address the specific concerns and priorities of their patients.

Key Ideas and Facts:

1. The Legal and Ethical Basis of Consent:

- **GMC Guidance as Foundation:** Simon Parsons highlights the importance of the GMC guidance on consent, noting its legal underpinning: "where the guidance says ‘you must’, that's because it's embedded in law. The law says you must." He emphasizes the principles of meaningful dialogue, providing relevant information specific to the individual, listening to patients, giving them the time and support to understand, and finding out what matters to them, directly referencing the *Montgomery* case.
- **Shift from *Bolam* to *Montgomery*:** Amelia Newbold and Jonathan Fuggle detail the historical shift in the legal test for the duty to provide information. The *Bolam* test, a peer review standard, was superseded by the *Montgomery* ruling, which focuses on "material risks" from the perspective of a reasonable person in the patient's position and what risks the clinician should reasonably be aware that the *individual* patient would find significant. They state: "It's a two-stage approach involving both an objective and a subjective assessment. So the objective part of this: What risks would a reasonable person in the patient's position be likely to attach significance to? And then the second part, the subjective bit: what risks should a clinician reasonably be aware that an individual patient would be likely to attach significance to?"

- **Materiality of Risk:** The concept of "material risk" is central to *Montgomery*. As Newbold explains, this involves considering "what risks would a reasonable person in the patient's position be likely to attach significance to?" and "what risks should a clinician reasonably be aware that an individual patient would be likely to attach significance to?" Examples include a small risk of vocal cord damage being highly significant for a singer.
- **Reasonable Alternative Treatment Options:** Following *Montgomery*, discussion of reasonable alternative treatments is crucial. While clinicians don't have to discuss every conceivable option, the courts will determine what is reasonable based on expert evidence. Fuggle notes that a case post-*Montgomery* provided a "pragmatic answer" allowing clinicians to exercise reasonable clinical judgment in not offering experimental or uncommon treatments.
- **Causation:** Even if there's a breach of duty in failing to warn of risks, the patient must also establish that they would have made a different decision if properly informed. Fuggle mentions that this has been a subject of several Court of Appeal cases since *Montgomery*.

2. The Importance of Meaningful Dialogue and Shared Decision-Making:

- **Beyond Information Giving:** Several speakers stress that consent is not just about providing information but a continuous process of dialogue. Parsons states: "We need that meaningful dialogue and to find out what matters to the patient. We need to have time to ask them questions."
- **Understanding Patient Perspectives:** Ben Thomas emphasises that "every patient is different. It's an individualised assessment." He highlights the complexity of decision-making and the need to consider the patient's unique circumstances, quoting: "Variability is the law of life and as no two face is the same, so no two bodies are alike and no two individuals react alike and behave alike under the abnormal conditions, which we know as disease."
- **Focus on the Process, Not Just the Outcome:** Thomas points out that legal reasoning often focuses on "the process followed in that decision-making," whereas clinicians might be more "outcome based."
- **Shared Decision-Making as a Goal:** Rachel Power from the Patients Association underscores the importance of "shared decision-making" and "patient partnership."

3. Practical Aspects of Obtaining and Documenting Consent:

- **EIDO Information Leaflets:** Simon Parsons, a co-founder of EIDO, advocates for their use as a "gold standard information sharing for procedures." He explains

how providing these leaflets beforehand allows for more focused and meaningful dialogue during consultations. Jonathan Webb notes that the Welsh Risk Pool has supported EIDO leaflets for 15 years and they are available in Welsh.

- **Documentation is Crucial:** Multiple speakers, particularly Amelia Newbold and Jo Clift, stress the critical importance of thorough documentation. Newbold states that documentation "is going to protect you in terms of showing what discussions you've had about risks and benefits with a particular patient." Clift reinforces this with the adage: "no notes, no defence. Poor notes, poor defence." Documenting the provision of leaflets, the discussion of risks and benefits, and the patient's understanding is essential medico-legal protection.
- **Delegated Consent:** Parsons addresses delegated consent, highlighting that trainees can obtain consent if properly trained (mentioning EIDO's training package) and have access to consultant support for complex questions. Trainees are advised to "act within your area of competency" and seek help when needed.
- **Considering Changes in Patient Condition:** Parsons reminds clinicians that patients on long waiting lists may have had changes in their condition, necessitating a reassessment of the decision-making process on the day of surgery.
- **Checking Patient Understanding:** Newbold emphasises the need to go beyond simply providing information and actively "checking the patient's understanding." The *Mordel* case highlighted that even seemingly fluent patients in a second language may not fully grasp medical information.
- **Addressing the "Day of Surgery" Scenario:** Charles Ranaboldo raises the common issue of patients arriving for surgery having not read or understood the provided information. Amelia Newbold suggests that if there are concerns about the patient's understanding on the day, the procedure should not go ahead, allowing more time for reflection.

4. Collaboration and Resource Utilisation:

- **All Wales Approach:** Jonathan Webb and Ben Thomas highlight the collaborative approach in Wales to improve decision-making and consent through the All Wales peer review framework, a model consent policy, and standardised consent forms. Webb praises the "amazing collaboration" across health bodies in Wales.
- **Peer Review for Quality Improvement:** Thomas describes the peer review process as a method to measure the quality of the consent dialogue and process, moving beyond simple consent form audits.

- **Utilising Available Resources:** Simon Parsons notes with concern that "the resources that are available to the clinicians aren't being used," highlighting a gap between available tools (like EIDO leaflets) and their consistent application.
- **Collaboration in Information Development:** Julie Smith from EIDO emphasises the collaborative nature of creating patient information, involving clinicians, patient information experts, and patient groups. Omar Mulla, an ENT surgeon, shares his process of reviewing and writing EIDO leaflets, including seeking feedback from patients and even his daughter.

5. Challenges and Future Directions:

- **Digital Consent:** Julie Smith initiates a discussion on digital consent, with Omar Mulla expressing strong support for its potential to enhance patient understanding and engagement. Tim Johnson highlights the advantages of digital formats in allowing patients to customise how they consume information. Rachel Power cautions that digital access needs to be equitable and that patients should be supported in using digital tools.
- **Addressing Health Literacy:** The discussion with Omar Mulla and Tim Johnson touches upon the "curse of knowledge" and the need to communicate complex medical information in a way that is accessible to individuals with varying levels of health literacy. Using analogies, visual aids, and plain language are suggested.
- **Managing Risk and Litigation:** Francis Brooks and Jo Clift highlight the high cost of medical litigation in the UK, with consent-related claims significantly increasing post-*Montgomery*. They emphasise the importance of understanding "material risks" for each patient and the ongoing nature of the consent process.
- **Training and Competency:** The discussion around trainee involvement in consent and new surgical techniques raises questions about ensuring adequate training, supervision, and transparent communication with patients about who will be performing the procedure and at what level of competency.
- **Patient Profiling and "Red Flags":** Jo Clift provides insights from an insurer's perspective, suggesting "red flags" in patient profiles (e.g., serial patients, secretive patients, unrealistic expectations) that might indicate a higher risk of dissatisfaction and potential litigation. She stresses the importance of bedside manner and emotional intelligence in building trust and facilitating open communication.

Quotes Highlighting Key Themes:

- **On the legal duty:** *"where the guidance says 'you must', that's because it's embedded in law. The law says you must."* (Simon Parsons)

- **On the shift to patient-centred consent:** *"the guidance was updated and we'll come back time and again to that meaningful dialogue and the exchange of relevant information specific to the individual patient."* (Simon Parsons)
- **On the definition of material risk:** *"What risks would a reasonable person in the patient's position be likely to attach significance to? And then the second part, the subjective bit: what risks should a clinician reasonably be aware that an individual patient would be likely to attach significance to?"* (Amelia Newbold)
- **On the importance of dialogue:** *"We need that meaningful dialogue and to find out what matters to the patient."* (Simon Parsons)
- **On individualised assessment:** *"every patient is different. It's an individualised assessment."* (Ben Thomas)
- **On the value of EIDO leaflets:** *"they are seen as the gold standard information sharing for procedures."* (Jonathan Webb)
- **On the necessity of documentation:** *"if you don't write it down, it doesn't matter."* (Jo Clift)
- **On the benefits of digital information:** *"it enables the patient or the recipient of the information to choose how they consume that data."* (Tim Johnson)

This briefing document provides a comprehensive overview of the key themes and important ideas raised in the provided transcripts, highlighting the evolving landscape of patient consent and decision-making in modern healthcare. The emphasis on patient autonomy, meaningful communication, and thorough documentation is crucial for both ethical practice and mitigating medico-legal risks.