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# True consent, informed consent and the English law

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ABSTRACT

*Informed consent is a new development, which has arisen from evolving patients' rights respected under International Law. It is gradually replacing the practice of true consent ("consent"), which is more familiar to practicing doctors all over the world. The impact of informed consent has overwhelmed the British practice of Medicine to an extent that the statutory regulatory body "General Medical Council" now requires that all registered doctors adhere to the use of informed consent in preference to the true consent. However the English law of consent (true consent) which has primarily evolved in stages from precedent law (case law) over a period of time, continues to regard the true consent as valid. This has resulted in a clash between the judiciary and the ethical bodies such as the GMC. The result is that the patients' rights are protected differently by the judiciary and by the ethical bodies. This article aims to describe this mismatch from both a medical as well as from a pure legal perspective. The aim is to improve the clinician's insight into this complex issue.*

**Keywords:** Consent to treatment, English law of consent, Informed consent, Refusal of consent, True consent

## Consent - What can happen in its absence?

"Consent" is a product of legal and ethical rights of one to have one's autonomy and self-determination respected. These lawfully protected rights imply that, it would be illegal for doctors to provide treatment without the patient's consent. Lord Goff stated that, for the healthcare professionals (doctors) to proceed with treatment without consent was unlawful constituting

"both the crime of battery and the tort of trespass to the person"[1].

**Box 1.** Battery means a physical assault such as hitting someone or even touching someone without permission with an ill intent. This constitutes a crime and is dealt with under criminal law. Trespass implies negligence; an example being that the doctor owed a duty of care to the patient by way of giving sufficient information before a procedure and failed to do so and thus the patient was harmed and therefore the patient can sue the doctor for negligence.

While there is no English statute setting out the general principles of consent, case law ("common law") has established that touching a patient without valid consent may constitute battery. Further, if a doctor fails to obtain proper consent and the patient subsequently suffers harm as a result of treatment, this may be a factor in a claim of negligence in a court, a complaint under the National Health Service (NHS) Complaints Procedure or under the GMC Disciplinary procedures.

**Box 2.** There is a set NHS Complaints Procedure in Britain under which the patient can complain against a doctor. The first leg of this procedure requires a resolution in-house (Local Resolution); the second leg leads to an Independent Review Panel (IRP) hearing; the third leads to a hearing by the Ombudsman (Health Service Commissioner).

The English courts recognise that a doctor-patient relationship is usually never hostile and as such the treatment of a patient usually does not lead to a charge of battery[2].

The scope of battery in a medical consent case was first tested in the English courts in *Chatterton v Gerson*, where Lord Justice Bristow asserted that

"... When the claim is based on negligence the plaintiff must prove not only the breach of duty to inform but that had the duty not been broken, she would not have chosen to have the operation. Where the claim is based on the trespass to the person, once it is shown that the consent is unreal, then what the plaintiff would have decided if she had been given the information which would have prevented vitiation of the reality of her consent is irrelevant"[3].

The rationale of this duty is to require respect for patient's autonomy and self-determination. However, the tort of negligence imposes a duty of care in order to protect an individual from exposure to an unreasonable risk of harm (injury or economic loss). Failure to provide information only gives rise to a claim in negligence if the injury would have been avoided, had it been given to the patient (an application of the 'but for' test in factual causation).

**Box 3.** the patient can say "but for the doctor's explanation and reassurance, I would not have agreed to this operation". In other words, the patient would be meaning that the doctor misled him into accepting the given operation by falsely assuring him.

In *Chatterton*, Justice Bristow rejected the trespass plea on the grounds that

".. once the patient is informed in broad terms of the nature of the procedure, which is intended, and gives her consent, that consent is real"[4].

In the House of Lords, Lord Scarman ruled

".. it would be deplorable to base the law in medical cases of this kind on the torts of assault and battery"[5].

Consent of the patient offers an appropriate defence to a charge of battery but not necessarily to a charge of negligence, as held by Lord Justice Hirst in *Hills v Potter*[6].

**Box 4.** What is true consent? Broadly speaking, "consent" or "true consent" is a due process under which, the doctor explains to the patient, the nature of the treatment he intends to provide, and provides material information as would be provided by his peers in good standing, under the circumstances. He may withhold such information, as he would feel would be harmful to the patient to know (therapeutic privilege). The patient would then offer his agreement for this treatment. In short, the profession decides on what the patient needs to know! What is informed consent? 'Informed consent', on the other hand, is a similar process to some extent but lays essential emphasis on what the patient would want to know, including about adverse effects, risks of failure, alternative choices and how that individual patient could be affected by the treatment or of its lack. Here, the patient decides on what he wants to know.

## The Law On Consent

A proper exercise of rights of autonomy and self-determination in healthcare means, that for the adult patient (sixteen or over) to offer his consent, he must do so consciously, freely (without coercion or inducement) and be in possession of competence and certain amount of information[7]. An adult is a person who is 18 years of age or more[8].

Section 8 of the Family Law Reforms Act (s8 FLRA 1969)[9] reduced the age of consent for minors from 18 to 16 allowing them the right of consent to medical treatment without the need of parent's approval[10].

The landmark case "Gillick" established that even children under 16 could consent to treatment without parental authority, if they are of sufficient maturity and understanding (competent)[11].

**Box 5.** Mrs Gillick asked the Health Authority to let her know first if any of her five daughters (all under 18) were given contraceptive pills by the GP without her approval on grounds of morality and under right of parenthood. The Health Authority refused on grounds of Patient's Autonomy. The matter passed from the High Court to the Court of Appeals and then to the highest English court - the Judicial Committee of the House of Lords (HL). The judges in the HL held that if a child (no age defined) possessed enough mental maturity to understand the implications then she could be regarded as competent for the purpose of consent to treatment. This also meant that she was entitled to the same privileges of confidentiality as an adult patient. Mrs Gillick lost and since then Gillick competence has become enshrined in English Law as a precedent landmark test of competence. Thus, in law, competent children under 16 can give consent for a procedure that the doctor has proposed without the knowledge or the consent of the parents. Since Lord Fraser proposed a set of guidelines to determine competence in minors, the law is also known as "Fraser's Guidelines".

A person is deemed to be competent to consent to treatment if he possesses the capacity to firstly, receive and retain the information, secondly, to believe it, and thirdly, to weigh the information in order to reach a decision, as asserted by Lord Justice Thorpe in a case known as Re C[12].

The General Medical Council (GMC) describes patients' autonomy for consent as

"their right to decide whether or not to undergo any medical intervention even where a refusal may result in harm to themselves or their own death"[13].

## Law On Refusal Of Consent

The competent adult's exercise of the right of choice or veto is absolute even if the decision is to his own detriment, as asserted in Re T[14].

"this right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent"

Justice Wall reinforced this more recently in Re JT[15].

A competent adult's refusal is respected under the same law as that of consent. The due process of informing risks of treatment to a person over 16, to Gillick-competent children and to parents of consenting minors, is the same as in adults and the GMC[16] and the British Medical Association (BMA)[17] also advise the doctor to use the language and description in keeping with the understanding of the individual and as would be done by a body of respectable and responsible peers.

No one, not even the next of kin, is now allowed to give consent on behalf of the competent adult, under any circumstances. Not even the courts have the power to give consent in respect of a competent adult.

**Box 6.** A woman had a perforated duodenal ulcer and was in severe pain. A doctor wanted to take an informed consent from her for a laparotomy. Seeing that she was in so much pain and distress, the husband offered to sign on her behalf, in her presence. Such a consent from the husband would be illegal, if the woman were found to be competent. What the doctor and the husband could do, if the patient were extremely distressed or could not use her arms due to infusions and drips, would be to take a verbal informed consent from the patient (not from husband) and to document it in the notes, mentioning as to the witnesses present (other than the husband) by name. No witness need sign this paper. This would meet with the standards of the law both under the law of the land and under the ethical rules of the GMC.

## Law On Refusal Of Consent In Minors

The situation with refusal is entirely different with minors, regardless of whether they are Gillick-competent or not. Unlike his right of consent which is protected, the child's right of refusal is circumscribed in English Law. Lord Justice Balcombe asserted in Re W

"... In logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment..."[18]

However despite this explanation parents, proxy parents or courts can veto a child's refusal on the 'welfare' principle and the doctor can also act under the doctrine of necessity in life-threatening situations in the absence of the child's consent. However, those with parental rights still retain the right to be informed on behalf of the child. Their right does not diminish. A similar decision ensued in Re R[19].

**Box 7.** Welfare principle means that those authorised can give permission for a procedure which a doctor has proposed for a child but which the child has refused due to their belief that that procedure will be good for the child. It means that the child is stubborn and does not appreciate the full benefits and needs of the procedure.

To apply the welfare principle and to offer treatment to a child who refuses consent places a very high moral and ethical value on medical opinion especially if it is speculative. It can be argued that this negates the Child's autonomy. If a child is mature enough to appreciate the implications of the process of informed consent then that child can be said to be equally mature with refusals. It is interesting to note that in 2000, Dame Butler-Sloss LJ qualified the legal value of a child's best medical interests in Re A, where she said

". In my judgment best medical interests encompass medical, emotional and all other welfare issues"[20]

There are some real-life situations, where it is difficult to establish if the patient's capacity to understand or retain the information is sufficient. This is seen in situations where in the eyes of a doctor the patient seems to possess some but not all of the relevant aspects of Capacity. In English law, sanctity of life is balanced against adult's autonomy and capacity tips the balance. In Re C, Thorpe J decided in favour of the patient whose general capacity was reduced but in respect of the issues in question, it was sufficient. He said, "If the patient's capacity to decide is unimpaired, autonomy weighs heavier but the further capacity is reduced, the lighter autonomy weighs"[21].

**Box 8.** In Re C, a paranoid schizophrenic prisoner sentenced for seven years, who felt he was a messenger of God, who had stabbed his common-law wife and was in a secure mental hospital with a gangrenous leg was told by the doctors he needed an amputation to save his life. He refused. Doctors went to court and lost. The court asserted that even though his capacity was reduced due to schizophrenia but for the purpose of the current illness he 1. was able to receive and retain information, 2. was able to believe in it. 3. Was able to mentally process the available options and was able to choose an option that suited him. Thus because he fully understood that without an amputation he would die and that with an amputation he might live, he did possess the desired capacity. He won the case successfully refusing his consent and prevented the doctors from amputating against his wishes. This explains to what great extent the English court goes to protect patients' autonomy.

## Legal Argument

It would thus seem that English Law allows for some flexibility in the law of consent where the mental capacity is partially impaired. However it is quite clear that autonomy in adults always prevails and that the benefit of the doubt is given to the patient. The presumption in law is that the adult patient is competent unless proven otherwise by someone else. When a patient refuses consent for treatment for a condition that the doctor feels strongly as necessary, the interaction between the patient and the doctor may become fairly hostile. At such junctures it is not always easy to impart sufficient information and often the patient may not make enough efforts to critically analyse the doctor's information. Even in such ethically difficult situations, the law now requires a respect for autonomy for the adult. Looking at the judgment in Re S, it could be said that the judgment was flawed. In that case (Re S[22]), a non-consensual urgent Caesarian section was

performed to remove a dead foetus from a competent mother. One could now argue that this had breached Sidaway[5] and Articles 3, 5, 8 and 9 of the European Convention of Human Rights (ECHR)[23].

**Box 9.** Sidaway is a landmark case. In this, a patient with neuralgic limb pains and cervical canal stenosis saw a neurosurgeon. He took her consent for cervical cord decompression but did not include in his explanation the fact that less than 1% of decompression caused paraplegia. What he did was what other Neurosurgeons like him were routinely doing. She developed paraplegia after the spinal operation and went to court. She lost. Judges held that under English law consent did not require an elaborate explanation of remote side effects]. This approach is now criticised. Now the GMC, the BMA and the Department of Health all advise doctors to take informed consent, which includes a detailed explanation of all significant risks.

A particular difficulty arises when the patient is not competent and medical opinion is divided on the choice of treatment (some good doctors saying one thing and some good doctors saying the opposite - thus there could be two Bolam standards!). In such situations, the simple application of Bolam principle[24] would be equivocal. The Court of Appeal has resolved this contentious issue in Re SL[25] by adopting a two-stage approach. First, assessing the medical opinion on a Bolam standard. Second, whether it is in the patient's 'best interests'. The judges and not the doctors, then decide on the choice of treatment[26].

**Box 10.** Bolam standard means that a practice is right if a body of respectable and responsible peers under the same circumstances is following it in similar conditions.

Let us now critically look at how true consent (consent) stands under current English law and where it compares unfavourably with the doctrine of informed consent.

Essentially, the law of consent has evolved through common law, offering justification to doctors to provide treatment to willing patients whilst protecting the patients against unwarranted treatment. Francis and Johnston describe this doctrine as

"The common law purpose of the doctrine of consent is to provide a framework for justifying necessary medical treatment rather than to enforce a requirement that proper information be given to the patient, which is the realm of the duty of care and the cause of action of negligence."[27]

**Box 11.** In the absence of a written constitution, as is the case in England, judicial matters are decided on the basis of legal precedence. This is also called case law or common law.

Under English law, the common law doctrine finds no culpable fault in the doctor who obtains consent for treatment without offering information in respect of possible adverse effects or the likelihood of failure. The doctor is protected in law from the allegation of assault and battery, even if competent professional practice requires such information to be given, as was asserted in Chatterton and Gerson.[28]

## What is already known on this topic

Most practicing doctors are familiar with the formalities of consenting but some do not realise that a basic explanation by the doctor and a patient's signature on the form do not necessarily imply that an informed consent has been obtained. The impact of Human Rights in the last four years has

influenced English law substantially. [Human Rights Act 1998 (HRA) promulgated in Britain in 2000 led to the adoption of the various Articles of Law already agreed by the European Convention of Human Rights (ECHR) applicable to all of the European Union States. The British Parliament now cannot make a national law contravening any of the Articles of the ECHR and judges in the British courts must now view the British Law from the window of the HRA]. English law confers the rights of adulthood to a 16 year old for the purpose of consenting to treatment and case law stemming from the landmark case of Mrs Gillick (For details, see below) now allows even very young children to enjoy that privilege as well. However the right of a child (below 16) is circumscribed in English law with regard to refusal of suggested treatment. Thus the child can independently consent if he is legally competent but if he refuses treatment then the parent or the court can override that refusal provided that that treatment is in the best interests of the child.

## What This study adds

The true consent may protect the doctor only against the criminal charge of battery (assault) on the patient but the patient may prove and win against the doctor arguing that the doctor had failed in his duty of care, which includes giving the patient a satisfactory explanation of the procedure including risks, side effects, disadvantages and alternatives. The paper also shows a mismatch of parental rights. A mother can veto a child's refusal of consent but an unmarried father cannot. Under English law a competent adult is entitled to choose an option of treatment, which may seem irrational, illogical or immoral to others. This paper compares the true consent (which is incorporated in the English Law) with the modern "informed consent", which is strongly recommended by the ethical bodies such as the GMC. This paper goes to some lengths to emphasise that under English law if an adult (over 16) is legally competent then no one including a court can consent on his behalf. There appears to be a clash of the English law with the European Convention of Human Rights where religious beliefs (Article 9) and right to raise a family according to one's liking (Article 8) are protected. Although the Human Rights Act 1998 has come in force in the UK in 2000 thus overriding English law, the English Courts still allow Jehovah's witness children to be transfused with blood under the welfare and the best interests principles against parental refusal. [Jehovah's Witness is the practice of a faith in which the use of blood, blood products or any donated human organ part is banned totally even if such a denial means death. This religious community claims to have its root from Christianity]

However, in not giving relevant information to the patient where taking his consent, he may be liable for negligence in the discharge of his duty of care, if the patient subsequently suffers harm as a result of treatment received.

As the law evolved, in many other jurisdictions, the concept of consent changed to one where the giving of necessary and elaborate information of relevance and importance to the patient on an individual basis became an integral part of the consent process itself - "informed consent". A reflection of this impact is often seen in English case law (such as Lord Scarman's minority views[29] in Sidaway), which is increasingly leaning towards the realm of informed consent.

The scope of information needed to make an informed choice, is still a matter of some controversy, because patients differ in their levels of understanding and in their abilities to safely cope with the volume of information provided. Traditionally, doctors exercised therapeutic privileges (withheld some information from the patient which in their opinion could psychologically harm the patient), which often led to lack of uniformity in the degree of information, which needed to be given to

patients. The doctrine of informed consent is a logical consequence of the right of autonomy, under which the amount of information, which needs to be given to the patient, is what the patient would want to know (informed consent), rather than what the doctor thinks he needs to know (true consent). It was asserted in *Riebl v Hughes*[30] that the doctrine is intended to allow freedom of choices and for this freedom to be meaningful, people must have the right to make choices that accord with their own values regardless of how unwise or foolish these choices may appear to others. This aims to largely do away with the concepts of therapeutic privileges and what a respectable body of medical opinion (Bolam standards[31]) would feel, which are the two important aspects of "true consent" under English law.

In Sidaway[32], Lord Scarman was basically in agreement with the relevant assertions in the Canterbury case of USA relating to informed consent

" . The consent is the informed exercise of a choice and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant on each"[33]. The judgment went on to describe the role of providing information as

". The doctor must, therefore, disclose all material risks"[34];

what risks are 'material' is determined by the 'prudent patient' test, which was formulated by the court:

" A risk is .. material when a reasonable person, in what the physician knows or should know to be his patient's position, would be likely to attach the significance to the risk . in deciding whether or not to forego the proposed therapy"[35].

It is important to note that to be 'significant' a risk need not be one, which would have altered the patient's decision to consent to the treatment. The risk must be the one that a 'reasonable patient' would consider relevant to, rather than determinative of his decision.

Sidaway[5] also stated that it was open to the courts to decide that information about a particular risk was so obviously necessary that it would be negligent not to provide it, even if a "responsible body" of medical opinion would not have done so. Courts therefore become the final arbiter of what constitutes a "responsible body" of medical opinion, although the standards set by the profession for their members will still be influential though not binding.

The law imposes the duty of care but the standard of care is a matter for medical judgment. Applying Bolam, this is the case under English law.

**Box 12.** Bolam standard when considered in the context of duty of care means that under the law of negligence, the doctor owes the patient a duty of care. It also means that under the duty of care the care he would offer should be a current practice amongst the practicing doctors with similar experience and expertise. Thus it could be said that a senior house surgeon on a ward should have done what other senior house surgeons in good standing on similar wards would have done. That particular senior house surgeon would not be expected to have done what the best Senior House Surgeon in a teaching hospital or the Consultant would have done in his place. This rule is now applied universally in all trades, such as Accountants, Architects etc.

In *Hills v Potter*[36], Hirst J interpreted the Bolam Standards as being applicable to pre-operative advice, diagnosis and treatment but he qualified the pre-operative advice as including the necessary information.

It is clear from Sidaway that when asked specifically, it is the doctor's duty to provide information. This duty does not extend to a non-enquiring patient under English law, but does so in the spirit of an informed consent.

**Box 13.** It can be said that the amount of information given to the patient before a procedure is carried out is the chief difference between true consent (English law) and the informed consent.

The GMC has robustly set professional standards[37] required of all registered medical practitioners for disclosure of information, which includes truthful and unambiguous replies to questions when asked, to provide sufficient information for patients to decide, based on individual needs and priorities, including risks to which they may attach significance. Most of these aspects are attributes of an informed consent. Since The GMC's guidelines are literally binding on all registered medical practitioners, no doctor will go against such advice, and it can be said that a substantial body of respectable and responsible medical opinion already exists in this form, to satisfy the consent process on Bolam standards in English law. When the English law of consent is viewed from this perspective, it will look no different to what an informed consent is. Although courts have, on some occasions in the past, disregarded the Bolam principle, the current trend is leaning towards the application of informed consent[38].

The GMC issued guidelines in 1999[39] to all doctors to seek an 'informed consent' before a medical intervention and the force of this guideline is such that no responsible medical practitioner would depart from it.

This is also reflected in the BMA guidelines, which also support and recommend the use of "informed consent".[40]

Information on alternatives to treatment, although not specifically mentioned in the guidelines of the GMC, is clearly implied, as reflected in the advice that doctors must offer advice on "options for treatment". This is further explained by the Department of Health (DoH) advice on consent[41].

Thus it can be seen that increasingly, the peer practice and public preference are in favour of applying the terms of informed consent rather than true consent.

Lord Scarman's 'reasonable patient test' in Sidaway[42] seems to make it clear that the law does not make the duty to disclose absolute, but leaves the doctor with some discretion (therapeutic privilege[43]). However the doctor must justify non-disclosure as being in the patient's best interests, under Lord Scarman's (and the North American) view.

**Box 14.** This makes the understanding of consent confusing. The law demands giving of some information without being asked essential but answering of any questions in full details. However the law also says that the doctor can withhold some information, which in his opinion can harm the patient. However the law goes on to say that the doctor should give such information that is being given by other good doctors in similar circumstances (Bolam). Since all of the registered doctors in the UK are following the GMC guideline on informed consent (giving comprehensive information), the Bolam standard is already for informed consent and not for true consent.

## Are there any faults of informed consent?

Looking at some of the faults of the informed consent, it is interesting to see that although the Law Lords in Sidaway treated the case as whether or not to adopt this North American doctrine, even in the USA, there is a lack of uniformity. Mason and McCall-Smith[44] noted that although the majority of 51 independent jurisdictions in the USA continue to invoke the professional standards (informed consent), there is a 'recognisable national drift' towards the 'prudent patient' standards (in keeping with the English law of consent).

**Box 15.** In other words, some States in the USA (a few) are already saying that informed consent is not all good and that the doctors should maintain some degree of therapeutic privilege.

British medicine views the doctrine of informed consent as having the potential of promoting defensive medicine with all of its attendant dangers of unnecessary treatment, over-investigations and costs.

**Box 16.** An example of defensive medicine - the doctor takes informed consent for removing the appendix. During the appendicectomy he also finds a long Meckel's Diverticulum, which in the future would be likely to cause serious problems. Because this Meckel's Diverticulum is not classed as an immediately life-threatening finding, he must leave the Diverticulum alone, complete the appendicectomy and discuss the need for another operation in the future with the conscious and competent patient. The doctor is being defensive here against potential litigation that he had exceeded the scope of his informed consent, which was for appendicectomy alone. In the old days he would have just gone ahead with removing the Diverticulum as well, in the patient's best interests, saving the patient a second anaesthetic and a formal surgical hazardous procedure.

The ethical bodies are acutely aware of a new English law introduced two years ago following in the transatlantic footsteps, which has allowed "conditional fee arrangement" between solicitors and their clients. This is in line with the American popular legal practice where the client only pays his legal fee if the solicitor wins the case for him. This "no win no pay" gives incentive to litigate and there has been an upsurge of motor vehicle accident injury claim cases in particular and other medical cases in general. Heightened awareness of patients' rights - an encouragement from the present Government policy, and easy internet access of information have already led the British doctors to become over-defensive.

## Some Less Well-Known Issues And Further Argument

From the perspectives of morality and ethics it is obvious that when an informed consent is negotiated with the patient, special circumstances concerning his belief, culture, social issues and his religious convictions should receive due emphases.

The patient in question may attach special significance to these issues. English law only looks at these perspectives from the viewpoints of the 'best interests' principle and the Bolam standards." From the Human Rights perspective, Articles 2, 3, 5, 8 and 9 of the ECHR[45] can be easily breached in many such instances.

**Box 17.** Article 2, ECHR: Right to life Article 3, ECHR: Prohibition of torture (inhuman or degrading treatment) Article 5: Right to liberty and security Article 8, ECHR: Right to respect for private and family life Article 9, ECHR: Right to respect thought, conscience and religion

Contrary to the spirit of Article 8 of the EHCR, under English Law, consent relating to a child's treatment can be taken from the mother but not from the unmarried father.

The real purpose of an informed consent is to involve the parents and the child on what is on offer and what the choices are, with relative merits, and then to allow the family to make a choice. Existing English law can be said to be discriminatory and unfair in this context. It seems rather odd to note that in paternity suits and where matters of immigration claims arise, it is mandatory to rely on genetic evidence to discover the biological father. It would thus seem that biological ownership of a child does have an evidential value. It can be argued that the evidence of paternity in the English law of consent revolves around the morality and sanctity of marriage. This is at odds with Human Rights.

Religious rights under Article 9 of the ECHR are regularly breached in accordance with the best interests doctrine in minors, especially with Jehovah's Witnesses. Clearly the process of consent has failed in this situation. Giving prohibited blood transfusion to such children may infringe Article 8 for their parents as well.

**Box 18.** Jehovah's Witness is a recognised religion. the tenets of religion include a ban on the use of blood, blood products and human tissue. Most followers of religion carry a prohibitory card, which advises a doctor that even in an emergency that person would not accept the banned products. In English law, a competent adult has an inviolable right of refusal and the courts are powerless against him. But in children, English courts have leaned in favour of the doctors who wanted to give life-saving blood transfusions under "best interests" doctrine. In Canada a doctor who found a prohibitory card in a child's pocket gave urgent blood transfusion to save life under the "best interests" principle. In subsequent litigation he was fined $20,000 for ignoring the child's (and parental) wishes.

Reflecting on the New DoH consent forms used now regularly in hospitals for surgical procedures, neither verbal nor written consent, even by way of a signature affixed by the patient on the consent form, is absolute proof of the real meaning of informed consent to treatment. For informed consent to be valid, the patient must be offered relevant information including that, which relates to possible failures or risks.

**Box 19.** It used to be common practice in the UK for a House Surgeon to hand in a consent form to a patient to sign with minimal information given. It is now customary that detailed explanation in the spirit of informed consent is given before a signature is requested. If the patient insists on signing without listening to these details the doctor will insist on explaining because without such information his signature will be meaningless in the eyes of the court.

Giving of 'appropriate and necessary' information as part of seeking consent to treatment is an integral part of the consent process and withholding of such information is regarded as negligence in English Law as asserted in Sidaway [46] in which the plaintiff brought her action against the doctor in negligence, no doubt in the light of Chatterton v Gerson[47] and Hills v Potter[48] alleging

that he did not tell her that the intended operation on the spine for pain-relief could damage the spinal cord. Her action failed.

Sir John Donaldson MR (Master of Rolls), in the Court of Appeal, commented on the scope and application of consent in English law

"..I am wholly satisfied that as a matter of English law a consent is not vitiated by a failure on the part of the doctor to give the patient sufficient information before the consent is given. It is only if the consent is obtained by fraud or by misrepresentation of the nature of what is to be done that it can be said that an apparent consent is not true consent.[49]"

Lord Justice Dunn in the same case categorically distinguished between "consent" and "informed consent" asserting

". The first argument was that unless the patient's consent to the operation was a fully informed consent the performance of the operation would constitute a battery on the patient by the surgeon. This is not the law of England. If there is consent to the nature of the act, then there is no trespass to the person".[50]

In Freeman v Home Office, Sir John Donaldson reiterated his earlier views expressed in Sidaway, even more robustly.[51]

The doctor must ethically, although not legally, inform the patient of his options and must then let him decide. It is this need of awareness of the choices, which requires relevant information to be given to the patient in the way that he understands it, to make a choice. This is the doctrine of informed consent in which what the patient would want to know is what is offered, in addition to the basic details of the treatment contemplated.

Lord Justice Thorpe in Re C was more emphatic in his expression of what the patient needed to know, by way of information, to make a choice. He said that to do so, the patient must understand "the nature, purpose and effect" of the treatment.[52]

The law of negligence has been adapted in other jurisdictions in the last 20 years, to impose a duty to provide information, potentially beyond that sufficient to make the patient's consent valid. The doctor's duty to inform the patient in law comes from the assumption of doctor-patient relationship. He would be negligent by omission, if he failed to properly inform the patient, in the pursuit of obtaining the patient's consent for treatment. This is a continuing duty, so if the doctor intends to embark on a new course of action or if the patient's condition materially changes, then there is a fresh duty to inform and to obtain a fresh consent[53]. The scope of the given consent must therefore not be breached unless a life-threatening event arises.

**Box 20.** This limitation of scope of consent means that when a Gynaecologist takes an informed consent from a patient with dysmenorrhoea and takes the consent for a dilatation and curettage and Laparoscopic evaluation and gives the necessary detailed information, if he finds numerous suspicious fibroids, he must not proceed to a hysterectomy. His intervention with a hysterectomy even on grounds that he genuinely felt it was necessary and that he saved the patient from a second anaesthesia will fail in law. He must, under the doctrine of informed consent, stay within his "scope", do his proposed operation (D&C and Laparoscopy) and then on recovery advise the patient of what he found and then take a fresh consent for a further procedure, if agreed.

## Summary

True consent, as it stands under English law today, does not explore alternatives, implications of adverse effects and special considerations of values, to which the patient in question would attach importance. Informed consent, on the other hand, already encompasses these attributes, as is clear from the GMC's guidelines to doctors.

English law of consent is based on the Bolam principles and the professionals assess what needs to be offered as information, retaining therapeutic privilege, whereas the essence of informed consent is on what the patient's own perspective is, in wanting to know, as a reasonable patient.

Admittedly, the side effects of informed consent are propagation of defensive medicine, which may not be in the country's best interests. However when the application of consent process is viewed from the perspectives of Human Rights and autonomy, which are valued so much in society today, it is unfair to ignore the patient's perspectives.

If medicine is evolving constantly, then choices should be evolving too. To limit consent (which is described as a continuing process) to the rigid bounds of 'true consent' in a dynamic world, is not compatible with modern life. Human Rights are catching up fast with such rigid laws. English law of consent is lagging behind time and does not seem to be keeping pace with other progressive jurisdictions. When the professional bodies such as the GMC and the BMA and the administrative bodies such as the DoH have revolted, and have imposed informed consent on the doctors, and when the public through representative bodies, have all expressed a desire to adopt informed consent, it is time for the parliament to enact new law and for the courts to view this through the window of Human Rights in the interim.

The recommendation of this research paper is that whereas it is not so as yet, informed consent should become incorporated into English Law.

## Competing Interests

None, as declared by the author.

## Observation

In this research article the references (called citations in legal terms) are described in the prescribed judicial manner and any one can access the full text through law libraries. The names of some cases (such as those who are minor or those who do not possess legal capacity) are abbreviated for anonymity by order of the Court e.g. Re C would mean "Regarding "C", whoever C might be."

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