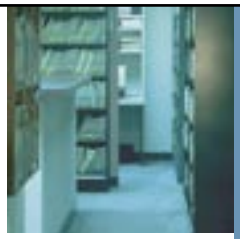
Consent to medical treatment



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Case histories are based on actual medical negligence claims, however certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

Obtaining patient consent is good medical practice and a legal necessity. This article examines the duty of general practitioners to obtain consent from patients for medical interventions and outlines the process of obtaining consent.

Case history

Ms Kate Paterson, 22 years of age, presented to her general practitioner requesting the removal of two skin lesions from her upper chest. The patient was concerned about the cosmetic appearance of the lesions, especially when she was wearing 'low cut' clothing. The GP, Dr Walker, examined both of the lesions and noted that they appeared to be benign intradermal naevi. He explained to the patient that neither of the lesions were of any clinical concern and therefore they did not require removal for medical reasons. Kate was adamant that the lesions were unsightly and she wanted them removed for cosmetic reasons. After some discussion, Dr Walker asked Kate to book a long appointment for removal of the lesions under local anaesthetic. A few weeks later the patient re-attended. The naevi were removed under local anaesthesia using standard elliptical excisions. Both lesions were sent for histopathology which confirmed benign naevi.

Six months later, Kate returned to see Dr Walker. She was extremely angry about the scarring left by the excisions. She was also upset about the cost of the pathology tests that had left her 'considerably out of pocket'. The GP examined the patient and noted two keloid scars, each approximately 1 cm in length. He suggested referral to a plastic surgeon for review and possible re-excision of the scars. The patient advised that she could not afford the additional costs of plastic surgery. A few weeks later, the GP received a letter from solicitors acting on behalf of Ms Paterson. The solicitors sought compensation for the 'negligent scarring' of their client. The claim included the costs of plastic surgery and an amount for economic loss for her work as a bikini model.

Medicolegal issues

Dr Walker's medical records for the consultations were brief, as follows:

'1/4/04 – x2 benign moles upper anterior chest. For removal.

22/4/04 – E/O x2 moles. Lignocaine w adrenaline. Pathology. ROS 10/7.

5/10/04 – keloid scars. Ref Dr Britten.'

The GP felt he was not responsible for the poor cosmetic outcome because the patient had 'demanded' the removal of the two naevi. While he had not recorded any discussion about the benefits and risks of excision of the naevi in the medical records, he felt certain that he would have advised the patient about the possibility of unsightly scarring. However, he had no specific recollection of a discussion with the patient and the medical records were silent on this issue.

An expert opinion was obtained from a GP. She expressed concerns about Dr Walker's process of obtaining consent for the procedure. The GP expert report noted

that in view of the cosmetic nature of the procedure, a detailed discussion about the pros and cons of excision should have taken place to enable the patient to decide whether or not to undergo the intervention. The discussion of the benefits and risks of excision should have included the possibility of keloid scarring, particularly in view of the site of the excisions. Based on this opinion and the absence of any documentation of the consent process, the claim against Dr Walker was settled.

Discussion

Patients are entitled to make their own decisions about medical treatments or procedures and should be given adequate information on which to base those decisions.[1] The aim of obtaining consent should be to enable the patient to determine whether or not to undergo the proposed intervention. Information should be provided in a form and manner that help patients understand the condition and treatment options available. This information needs to be appropriate to the patient's circumstances, personality, expectations, fears, beliefs, values and cultural background.

Risk management strategies

The National Health and Medical Research Council's *General guidelines for medical practitioners on providing information to patients* provides useful guidance for GPs on obtaining patient consent for interventions. In part, the guidelines state:

'Doctors should normally discuss the following information with their patients:

- the possible or likely nature of the illness or disease
- the proposed approach to investigation, diagnosis and treatment
  - what the proposed approach entails
  - the expected benefits
  - common side effects and material risks of any intervention (see below)
  - whether the intervention is conventional or experimental
  - who will undertake the intervention
- other options for investigation, diagnosis and treatment
- the degree of uncertainty of any diagnosis arrived at
- the degree of uncertainty about the therapeutic outcome
- the likely consequence of not choosing the proposed diagnostic procedure or treatment, or of not having any procedure or treatment at all
- any significant long term physical, emotional, mental, social, sexual, or other outcome which may be associated with a proposed intervention
- the time involved, and
- the costs involved, including out of pocket costs.

Informing patients of risks

Doctors should give information about the risks of any intervention, especially those that are likely to influence the patient's decisions. Known risks should be disclosed when an adverse outcome is common even though the detriment is slight, or when an adverse outcome is severe even though its occurrence is rare. A doctor's judgment about how to convey risks will be influenced by:

- the seriousness of the patient's condition, eg. the manner of giving information might need to be modified if the patient were too ill or badly injured to digest a detailed explanation
- the nature of the intervention, eg. whether it is complex or straightforward, or whether it is necessary or purely discretionary. Complex interventions require more information, as do interventions where the patient has no illness
- the likelihood of harm and the degree of possible harm – more information is required the greater the risk of harm and the more serious it is likely to be
- the questions the patient asks – when giving information, doctors should encourage the patient to ask questions and should answer them as fully as possible. Such questions will help the doctor to find out what is important to the patient
- the patient's temperament, attitude and level of understanding – every patient is entitled to information, but these characteristics may provide guidance to the form it takes, and
- current accepted medical practice.'[1]

What are material risks?

A risk is material if:

- 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 reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it (*Rogers v Whitaker*[2]).

In general terms, a known risk should be disclosed when:

- an adverse outcome is a common event even though the detriment is slight
- an outcome is severe even though its occurrence is rare.

Summary of important points

- A competent adult patient has a right to give (or withhold) consent to a medical examination, investigation, procedure or treatment.
- A patient should be informed of the 'material risks' associated with an intervention. A medical practitioner who fails to provide this information risks a medical negligence claim for 'failure to warn'.

Conflict of interest: none.

References

1. National Health and Medical Research Council. General guidelines for medical practitioners on providing information to patients. NHMRC 2004. Available at: www.nhmrc.gov.au.
2. Rogers vs Whitaker [1992] 175 CLR 479.

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