Why we must stop 'consenting the patient'

Consent is a fundamental principle in medical ethics, law, and professionalism. It is widely recognised among medical professionals and wider society that it is the right of all patients to be involved in decisions relating to their treatment and care (if they are able to), and that significant harm can occur if they are not empowered to do so in an informed manner.

Accordingly, medical schools in the UK are instructed by the General Medical Council (GMC) to convey in their curricula the importance of consent as a foundational medical value, and thus produce doctors who are aware of the necessity to take valid consent from the patient before performing any examination, investigation, or treatment in their care.[1] Yet, by 'consenting the patient' – a phrase used commonly in secondary care practice and also implicitly in primary care settings – we may fail to satisfy the central components of this vitally important principle. The phraseology we use in relation to consent is of vital importance.

MEDICAL LAW

'Touching a person without her consent – however benevolently – is prima facie unlawful.'[2] Accordingly, that patients with capacity must first give consent to their medical treatment is considered to be one of the primary principles of medical law. For such consent to be lawful, *'it must be given voluntarily, by someone who has the capacity to consent, and who understands what the treatment involves'*. Consent in UK medical law requires a reasonable explanation of the nature (what) and the purpose (why) of any treatment or investigation.[2]

When consent has not been properly informed, it may be possible for a legal claim to be raised. In English law, *'the duty to obtain the patient's consent prior to the treatment is protected by the tort of battery, while the duty to ensure that the patient has been given enough information (whatever that might mean) is treated as an aspect of the doctor's duty of care'*[2] (and so may ground an action in medical negligence).

The law considers it the doctor's duty to inform the patient about material risk. Since the UK Supreme Court judgment in Montgomery v Lanarkshire Health Board,[3] the test for materiality is whether a reasonable person in the patient's position would be likely to consider the risk to be of significance, or the doctor should reasonably be aware that the patient in question would be likely to consider it so. The issue of 'causation' often leads to difficulties in 'informed consent' cases, as the claimant must prove that, had they been informed about the risk that has subsequently materialised, they would have chosen to not undergo the treatment that ultimately caused them injury (which is a speculative enquiry with the benefit of hindsight).[4,5]

MEDICAL PROFESSIONALISM

Informed consent is considered central to the ethical code of practice subscribed to by contemporary clinicians, and features clearly in the GMC's professional code for all practising doctors (*'You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research'*).[6]

The regulator has produced an entire 40-page document dedicated to the principle, in which it details and expands upon *'the seven principles of decision making and consent'*.[7] For the GMC, key features of consent include that *'decision making is an ongoing process'*, that *'doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and meaningful alternatives, including the option to take no action'*, and that *'all patients have a right to be listened to, and to be given the information they need to make a decision at the time and support they need to understand it'*.[7] Crucially, the GMC states that the process of consent should be *'focused on meaningful dialogue: the exchange of relevant information specific to the individual patient'*.[7]

Each of these key components clearly reflect those considered central to the principle of informed consent in the realm of medical law, and are accordingly designed to bolster clinicians' practice against potential legal claims while promoting ethically sound outcomes for the patients in their care.

'CONSENTING THE PATIENT'

'Go and consent the patient' was a frequently received instruction during my years as a junior doctor working across

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various secondary care specialties, and invariably originated from a clinician of greater seniority than me. The relevant tasks were subsequently performed either at the patient's bedside, or in pre-operative clinic settings in which 'consenting' was the stated aim. In both scenarios, sizeable carbon-copy documentation was provided for completion, which contained prompts for me to inform the unsuspecting patient about the risks and intended benefits of the 'proposed' clinical procedure. 'Proposed' is the key operative word here, as the process of 'consenting the patient' is supposedly designed to engage the patient centrally in major decisions regarding their care, and to provide them with all the relevant information through the 'meaningful dialogue' – meaning in an appropriate medium, at a suitable speed, and with the necessary support – that is required for the patient to make an informed choice. From this perspective, the patient's ultimate decision should be considered entirely mysterious by the 'consenting' practitioner before the process is initially embarked upon. The patient may ultimately provide consent, or they may not, and the final outcome cannot be known until the subsequent process has been completed in its entirety. Yet, the direct command to 'consent the patient' harbours strong connotations about the intended outcome of this process – that the doctor wishes to extract consent from the patient, in the form of a signature on various carbon-copy documents – and that the ultimate outcome of the process is entirely predetermined (the patient will consent) rather than being the unpredictable endpoint of a meaningful dialogue (the patient may consent, or they may not).

While consent in general practice manifests in a substantially different form from that in secondary care, the process of 'consenting the patient' appears to still be at play. While investigations and procedures performed in the surgery are generally less invasive than those in hospital, injections, intimate examinations, and the provision of emergency care all involve physical touching and therefore require informed consent to take place.

In the context of medical education, the patient's consent is also required to permit the presence of a medical student who is 'just sitting in' on what would otherwise be an entirely private consultation between doctor and patient. But the current time-pressured conditions within contemporary general practice – multi-problem consults, growing mountains of paperwork, patients struggling to book appointments and maintain continuity of care – may serve to nudge the process of consent away from the intended meaningful dialogue and towards the secondary care instruction to 'go and consent the patient'.

With a profound scarcity of time, the opportunity, and even the motivation, for clinicians to provide all relevant information, to discuss the menu of alternative options, and to lay out the likely consequences of opting not to proceed, may not be as freely available as the practitioner would otherwise choose, or as ethical practice commands.

WE MUST STOP 'CONSENTING THE PATIENT'

Informed consent – a foundational principle to legal, ethical, and professional medical practice – is an ongoing, dynamic, and evolving process between clinician and patient. It is a two-way street along which similar volumes of bi-directional traffic should continuously flow. It is an active 'doing word', a process of exploration and discovery, and an endpoint that is arrived at without any predetermination.

'Consenting the patient', on the other hand, is a one-directional, top-down, inherently domineering and paternalistic action. It is done to the patient, rather than creating an environment for it to organically emerge or, equally, for it to not do so at all. It is not the 'meaningful dialogue' that underpins the doctors' professional code of ethics, and not the voluntarily entered process that is required by medical law.

Slight changes in phraseology can dramatically alter the central meaning of a vitally important principle. By 'consenting the patient' instead of 'seeking meaningful consent', the right of our patients to be involved in choices about their treatment and care, and to make informed decisions regarding the direction of that care, is exchanged with the meaningless procedure of having the relevant forms signed quickly. Accordingly, we must stop 'consenting the patient', and instead opt for more precise wordage. In both primary and secondary care settings, this primarily requires that the senior clinician deliberately change their choice of language.

The words we use matter, as they contain an entirely pre-formed attitude relating to the process they describe. In the GP surgery, informed consent must be reclaimed as the dynamic process that it is, despite the growing pressures and competition from our time, and this principle thus re-centred at the heart of our modern professional practice.

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