SHARED DECISION-MAKING:
CONSENT AND RECENT DEVELOPMENTS

WHAT IS CONSENT AND WHY IS IT IMPORTANT?

"Respect for autonomy is not a mere ideal in healthcare; it is a professional obligation. Autonomous choice is a right, not a duty of patients."
— Beauchamp and Childress

Consent is an agreement, approval or permission as to some act or purpose and is given voluntarily by a competent person. The concept of consent given in the medical setting is one that recognises patient autonomy, that patients have a right to freely make decisions about their health without coercion. The role of doctors and healthcare providers is to provide an environment within which the patient can make an autonomous choice, by educating the patient and providing information that may be relevant to the patient in making an informed decision.

Obtaining (informed) consent from patients is also important for doctors and healthcare providers, as properly obtained consent protects them from liability, be it criminal liability for trespass to person, civil liability for medical negligence, or professional misconduct.

SHARED DECISION-MAKING

The phrase "shared decision-making" begets the question of *who* should be involved in the decision-making process.

Ill health impacts not only the individual, but also his family and people in his sphere of influence. Do third parties have a right to participate in medical decisions for the individual? Or should the treating doctor with greater understanding of the patient's medical condition and treatment options be allowed to make medical decisions for the patient?

The Singapore Court commented on this issue in the case of *Re LP (adult patient: medical treatment)*.[1] In *Re LP*, the patient required amputation of both legs to manage her infection and to save her life. However, the patient was in a comatose state and consent could not be taken. The patient had no known relatives except for her 16-year-old son (a minor). Prior to being in a comatose state, but at a time when there was no danger of death, the patient had verbalised to her doctor her wish that they "*save her legs at all costs*".

The Singapore Court commented that a person is entitled to give or withhold consent to any medical treatment and that **doctors are to respect that person's decision. No one else, however close by reason of kinship or friendship, is legally entitled to make that decision for the patient**. However, the Singapore Court ultimately did not accept that the patient had clearly and expressly refused her consent to the amputation, given that her wish to "*save her legs at all costs*" was expressed in the absence of knowledge that an amputation was the only treatment which could save her from impending death.

The concept of shared decision-making is thus not about other persons "sharing" in the medical decisions of the patient, but rather the patient taking on a more active and participative role regarding his treatment decisions. Instead of the patient simply being given information about treatment by the doctor and then making a decision to give or withhold consent, the patient and doctor are expected to have more open and interactive communications. The doctor offers all reasonable options to the patient, including no treatment, and then discusses with the patient the advantages and disadvantages of the options. The doctor then invites the patient to provide input on factors that would affect his decision on treatment, such as the patient's job and its requirements, family's expectations, personal risk threshold and religious considerations. Based on a better understanding of the patient's unique background and concerns, the doctor advises and recommends, and the patient and his doctor have an open dialogue to answer the patient's queries to help him come to a decision on what treatment option is most suitable for him.

The challenge for medical practitioners today is in determining how this shared decision-making and the discussion that it must entail can be implemented in a busy clinic.

BOLAM AND RECENT DEVELOPMENTS ON CONSENT

The test that has been applied in Singapore in determining whether satisfactory consent has been obtained from the patient is the Bolam test, defined in the English case of *Bolam v Friern Hospital Management Committee*[2] — that is, satisfactory consent is considered obtained if the doctor had "*acted in accordance with a practice accepted as proper by a responsible body of medical men in that particular art*" when obtaining consent. The Bolam standard was adopted into Singapore law through the seminal case of *Khoo James v Gunapathy d/o Muniandy*[3] and has to date been maintained (in Singapore) as the gold standard.

Notwithstanding having originated from the UK, the Bolam test is no longer being employed in the UK in relation to the obtaining of consent. The UK Courts departed from Bolam in the recent 2015 case of *Montgomery v Lanarkshire Health Board*.[4]

In *Montgomery*, the patient, who was pregnant and diabetic, had concerns about vaginal delivery. The doctor involved failed to warn her about a 9% – 10% risk of the baby suffering from shoulder dystocia during vaginal delivery, believing that the risk of grave injury to the baby was very small, and if advised, the patient would opt for a Caesarean section, which was (in the doctor's opinion) not in the patient's interest. During the vaginal delivery, the baby suffered hypoxia and developed cerebral palsy, and also suffered a brachial plexus injury, which resulted in paralysis of his arm. It is not disputed that had the patient been warned of the risks of vaginal delivery, she would have opted for Caesarean section and the baby's injuries would have been avoided.

The UK Supreme Court heard evidence from expert witnesses, and had the Bolam standard been applied, it may be argued that the doctor's decision to omit mentioning the risk of shoulder dystocia to avoid unnecessarily alarming the patient may be in "*accordance with a practice accepted as proper by a responsible body of medical men in that particular art*". However, the Supreme Court held that the doctor's duty is to "*take reasonable care to ensure that the patient is aware of any **material** risk involved in any recommended treatment, and of any reasonable alternative or variant treatment*", and that a risk is considered material if "*in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that **the particular patient would be likely to attach significance to it***". The Supreme Court's rationale for departing from Bolam is that patients are now more capable of understanding medical matters and are generally more well-informed, thus able to decide on the risks to their health that they would be prepared to undertake.

PROFILE

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WHAT DOES THAT MEAN FOR SINGAPORE?

In light of the change in judicial sentiment in the UK and other Commonwealth countries (for example, Australia and Malaysia have adopted a more patient-centric test) there can be no assurance that the Bolam standard will continue to remain the prevailing standard of care for doctors in Singapore. We need to proceed with an awareness that given a climate of increasing patient involvement in treatment decisions, better education in a generation of patients who have access to information around the clock, and changing approaches to patient care, the law will seek to keep pace with these developments. While in pre-*Montgomery* cases such as *D'Conceicao Jeanie Doris v Tong Ming Chuan*[5] and *Tong Seok May Joanne v Yau Hok Man Gordon*,[6] the Singapore High Court had resolutely dismissed the idea of a patient-centric test to replace the Bolam standard, in the first post-*Montgomery* case of *Chua Thong Jiang Andrew v Yue Wai Mun*,[7] the Singapore High Court acknowledged the shift in the position in the UK, but did not address *Montgomery* directly, citing that it was unnecessary to deal with *Montgomery* given that the results (of that case) would have been the same on the application of the Bolam test.

PRACTICAL SAFEGUARDS ON HOW CONSENT SHOULD BE TAKEN

For doctors in Singapore, the uncertainty lies in the fact that the manner in which you take consent today may be scrutinised by a different standard in the future, should the law in Singapore change. In this regard, we suggest some good practices in relation to how consent should be taken:

- Consider the nature of the treatment or procedure;
- Ascertain and consider the motives of that particular patient for undergoing the procedure. Is the procedure an emergency or elective procedure?
- Disclose information that a reasonable and competent doctor might think necessary in the same circumstances;
- Disclose information that the patient specifically asks about;
- Disclose (i) key known risks;
  (ii) any substantial risk of minor adverse consequences;
  (iii) any remote risk of grave adverse consequences;
  (iv) in appropriate cases, even remote risks of minor consequences;
- Consider and discuss alternatives with the patient. If a non-standard procedure would be relevant to the patient's specific circumstances, they ought to be considered and discussed with the patient; and
- Discuss limitations of the procedures. ◆

THE CHALLENGE FOR MEDICAL PRACTITIONERS TODAY IS IN DETERMINING HOW THIS SHARED DECISION-MAKING AND THE DISCUSSION THAT IT MUST ENTAIL CAN BE IMPLEMENTED IN A BUSY CLINIC.

References

1. Re LP (adult patient: medical treatment) [2006] 2 SLR 13; [2006] SGHC 13.
2. Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.
3. Khoo James v Gunapathy d/o Muniandy [2002] 1 SLR(R) 1024.
4. Montgomery v Lanarkshire Health Board [2015] UKSC 11.
5. D'Conceicao Jeanie Doris v Tong Ming Chuan [2011] SGHC 193.
6. Tong Seok May Joanne v Yau Hok Man Gordon [2013] 2 SLR 18.
7. Chua Thong Jiang Andrew v Yue Wai Mun [2015] SGHC 119.