Neil Saunders outlines research he undertook around the area of patient consent.

Introduction
The NHS and the allied healthcare professionals have transferred control from themselves to the patient, thereby empowering the ultimate consumer to have complete autonomy on how their diagnosis, care and treatment are managed.

It is a fundamental human right to have control over one’s destiny. Giving sufficient information to a patient can allow them to make an informed choice as to whether to refuse or accept a proposed examination or treatment, as seen in Sidway v Bethlem Royal Hospital Governors1 (see Case Study 1).

Empowerment can take many shapes and forms. An area central to the patient population, and now central to clinical practice, is that of consent. This has been espoused as a judicial concept since a British case in 1767 (Slater v Baker & Stapleton2 – see Case Study 2). The ratio decidendi of the case was that obtaining a patient’s consent was customary, and should be obtained as part of the duties of a professional practitioner.

There is much confusion and misconception surrounding consent, as is shown in legal dictionary definitions as well as the multiple descriptions and definitions given in legal cases.

Human Rights Act 1998
On 2 October 2000, the Human Rights Act 1998 came into force, incorporating the articles of the European Convention on Human Rights into our law in England and Wales. The Act:
◆ Requires all public authorities to implement the articles of the European Convention on Human Rights;
◆ Gives a right to anyone who alleges that a public authority has failed to respect those rights to bring an action in the courts of this country3.

Although the articles do not cover consent specifically, some of the articles relate to issues that arise from the laws on consent. These are:
◆ Article 2: Right to life
◆ Article 3: Prohibition of torture
◆ Article 5: Right to liberty and security
◆ Article 8: Right to respect for private and family life.

A healthcare professional who falls below the standards set, and who does not respect the principles of autonomy, may be liable to both

What do you do if a patient withdraws consent mid-way through an examination?
CASE STUDY 1
Sidway v Bethlem Royal Hospital Governors (1985)

Mrs Sidway underwent an operation for a recurring pain in her neck, right shoulder and arm, performed by a senior neurosurgeon at the Royal Bethlem Hospital. There was a 1-2% risk of damage to the spinal nerve root and the spinal column. Although the risk of damage to the spinal column was less than to the nerve root, the consequences were more severe.

The plaintiff was left severely disabled after the operation. She brought a negligence claim against the surgeon, saying that she had not been given adequate warning of the risks. During the hearing, it was revealed that while the surgeon had told her of the risks of damage to the nerve root, he had not told her about the risk to the spinal column. In acting in this way, he was conforming to what, in 1974, would have been accepted as standard medical practice by a responsible and skilled body of neurosurgeons.

The House of Lords rejected the claim. An ‘informed consent’ approach was rejected by all the Law Lords, except Lord Scarman. Some support was given to the suggestion that the test which a court should use in deciding whether the advice given was negligent was the same as that used in deciding whether medical treatment was negligent – the Bolam test, which says that a healthcare practitioner ‘is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men’.

CASE STUDY 2
Slater v Baker & Stapleton (1767)

The physician in this case initially set the patient’s femoral fracture in accordance with practice at the time but, at a follow up visit, rebroke the healing fracture and placed the rebroken bone in a mechanical device with teeth.

Physicians called into court to testify reported that physicians usually secured their patients’ consent before embarking on a medical intervention, but there was little said in the judge’s written opinion about what should be said to patients before an experimental intervention, as opposed to a clinical one.

The judge concluded that obtaining a patient’s consent was a custom of physicians, and ruled for the patient that consent should have been obtained. It was much later that the notion of information became linked to consent.

Obtaining consent

It should first be noted that there is an assumption of competency/capacity for every adult, unless it has been rebutted by a qualified psychiatrist, or through a state of unconsciousness. Obtaining consent should not be viewed as an isolated event, and should be seen as a continual process, shared between the practitioner and the patient. During the consent process, practitioners should remain emotionally detached/impartial so as to allow the patient’s decision/choice to be made voluntarily.

The information, when presenting the risk, benefits and alternatives to the patient, will have a greater resonance if it is put into the context of their expressed objectives. Risks were quantified by lawyers at a level of 1:100,000, which HPA guidelines state to be minimal to very low risk. This level of risk should be held as a gold standard when giving reference to risk because it can be easily quantified either in terms of natural radiation days or in terms of risk of a malignant change.

Just providing information is not sufficient – a patient needs to have an understanding of the information in order to make an informed choice/decision. The practitioner has to take into account the ability of the patient to comprehend what s/he has to say – if a patient has not understood, they cannot be said to have given informed and valid consent.

If a patient refuses the examination after explanation, check their understanding, and try to address any concerns. If the patient still refuses the examination, you cannot proceed. Do not be forceful in your approach as consent obtained under duress is invalid.

If the patient withdraws consent during the examination, it must stop, and concerns addressed. If the patient does not consent again, the examination will have to be discontinued. It is noted that the patient is autonomous and has self-determination; therefore, s/he is free to make any choice, even if it is seen to be irrational.

Communication skills

It is recognised in Scott et al that expressed and implied consent are both valid forms of consent. However, the consensus is that the ideal level of consent is that of informed consent. Professional or responsible bodies, ie, the General Medical Council (GMC), Nursing and Midwifery Council (NMC), and the Health Professions Council (HPC), all produce their own guidelines on obtaining consent and
yet all professionals are bound by the same duty of care and legal expectation. Whether the practitioner is an assistant practitioner, radiographer or doctor, the time, consideration, sensitivity, understanding, and level of consent should be universal.

The consent process can also be seen as a fundamental communication skill, which should be taught, enhanced and instilled into practitioners at an early juncture in the respective training programmes (author's beliefs). As in the Bolam test, all practitioners are judged (in consent terms) by that of a responsible body of professionals (ie, other practitioners). As patients’ expectations increase, so will the level consent (through education and evidence based practice), thereby increasing the level of proof/burden.

Radiographers should not wait for pressure to be exerted upon them by professional/responsible bodies, nor from the threat of legal action. They should work in partnership with patient groups, learn from past experiences, and individual patient feedback. This is essential, because there has been minimal research inclusive of patients, and the necessity to establish patient needs11,13.

Areas of uncertainty
Consent itself can be said to be uncertain, due to it being founded on precedent and therefore susceptible to change via the courts, rather than by any Act or Statute. However, there are areas that have a greater uncertainty, primarily due to the lack of research and explanation.

One such area is that of refusal or withdrawal of consent. This is covered in legal textbooks and journals, but literature aimed at healthcare professionals fails to cover this topic in any great detail. In most cases, no reference has been made as to the patients’ rights in this area. Another area of uncertainty is that of the volume/nature of information given to patients. Throughout the literature, there are discrepancies. Some authors define risks in terms of quantifiable information11, whereas others have left the level of information in an interpretive state with descriptive words such as ‘sufficient’ or ‘reasonable.’ Ultimately, if there is a dispute, the decision as to whether the information provided to a patient is ‘sufficient’ or ‘reasonable,’ will be taken by the courts.

To date, no cases involving radiographers through either background research or via the literature review have been found. Thereby, the tenuous position of the radiographer has not been challenged through legal proceedings. However, as current practice stands, and noted in Mathers et al11, informed consent for examinations is seldom obtained. Therefore, as patients become more aware of their rights, practices have to be questioned and altered. It may only be a matter of time before a health professional finds themselves charged with battery.

Recommendations
There is a dearth of literature relating to consent and the consent process. This has been recognised by both Mathers et al11 and Leino-Kilpi et al11. This has led to a lack of empirical data and it is difficult to assess the current level of knowledge held by healthcare practitioners, but also the degree to which patients are informed participants in the consent process. Therefore, studies in the following fields would be a firm recommendation (also recognised by Duman and Charnock11):

◆ Patients’ uptake of information
◆ Their perception of its value, and the extent it adds to their knowledge base, and
◆ How it influences their preconceived constructs.

Also, in conducting primary research in the field of consent, the author believes that a national survey of radiology departments and radiographers should be conducted to establish the current level of awareness and practice by both parties. This information could then be analysed in conjunction with the legal framework (current at the time). This would allow a snapshot of radiology consent practices to be formulated, which would be invaluable. A national survey would also show any regional variation of practices. If current practices are falling below legal standards, measures/recommendations should be introduced to address the situation.

About the Author
Neil Saunders is a radiographer in functional MRI at the Medical Research Council – Cognition and Brain Sciences Unit, which looks into a number of conditions. Recent research has involved patients in a vegetative state, which made national news in the latter part of last year for its pioneering research. This research was undertaken for a BSc from Suffolk College, validated by the University of East Anglia.

References for this article are at: www.sor.org/members/pubarchive/pub_search.htm