Annals of Medicine and Surgery 18 (2017) 10–13

Contents lists available at ScienceDirect

Annals of Medicine and Surgery

journal homepage: www.annalsjournal.com

# A survey of doctors at a UK teaching hospital to assess understanding of recent changes to consent law

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## HIGHLIGHTS

- A survey of doctors at a UK teaching hospital regarding consent law changes.
- The majority of respondents were not familiar with the concept of material risk.
- More guidance and education may be necessary at a national and local level.

## ARTICLE INFO

*Article history:*
Received 17 January 2017
Received in revised form
15 April 2017
Accepted 16 April 2017

*Keywords:*
Material risk
Consent
Montgomery

## ABSTRACT

*Background:* The UK Supreme Court recently ruled that when consenting patients for treatments or procedures, clinicians must also discuss any associated material risks. We surveyed medical staff at a large UK teaching hospital in order to ascertain knowledge of consent law and current understanding of this change.

*Materials and methods:* Email survey sent to medical staff in all specialities at Norfolk and Norwich University Hospital in February 2016.

*Results:* 245 responses (141 Consultants and 104 junior doctors, response rate 32%). 82% consent patients for procedures at least monthly and 23% daily. 31% were not familiar with the concept of material risk. 35% were familiar with the recent change in consent law, 41% were not. 18% were "very uncertain" and 64% "a little uncertain" that their consenting process meets current legal requirements. >92% think that landmark cases and changes in law should be discussed through professional bodies and circulated better locally.

*Conclusion:* The majority were not familiar with the concept of material risk and recent legal changes. A majority were not confident that their practice meets current requirements, suggesting that recent changes in consent law may not be widely understood at this hospital. We suggest more guidance and education may be necessary than is currently available. Increased understanding of recent changes to consent law will reduce the risk taken by NHS trusts and offer patients a service compliant with Supreme Court guidance.



## 1. Introduction

The Montgomery v Lanarkshire Health Board judgement has been widely discussed in the medical literature and indeed the broader UK media because it definitively marks an end to the Bolam test era which followed Sidaway v The Royal Bethlem Hospital [1]. The Bolam test deemed that medical negligence and by extension, alleged failure in consenting practice, is judged against the position or practice that would be taken by a responsible body of medical opinion. The Supreme Court deemed that there is a 'duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended medical treatment, and of any reasonable alternative or variant treatments' [2]. A material risk is described as one that 'a reasonable person in the patient's position would be likely to attach significance to … or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to'. This has been described as a shift from

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http://dx.doi.org/10.1016/j.amsu.2017.04.013

'doctors know best' to a 'particular patient' approach [3]. Despite legal judgements from the mid 1990's onwards increasingly questioning Bolam [4,5], and championing more patient orientated approaches with regards to the depth and amount of information discussed with patients during the consenting process, Bolam persisted and was indeed supported by the Scottish courts before the Supreme Court appeal. The General Medical Council guidance began to reflect the shift in legal position regarding consent, with guidance in 2008 explicitly calling for a patient centered approach [6], reflecting the process of departure from Bolam started by Chester v Asher and Pearce v United Bristol Healthcare Trust [4,5] Hence, Montgomery has been described as 'not a new direction' in consent law [3]. Despite this, the response to Montgomery has been divided with differing interpretations of the verdict itself and there have been a variety of predictions regarding clinical practice and the changes that may be required [7]. We suggest this reflects the detailed nature of legal verdict and the intricate clinical nature of the consenting process itself. We aimed to assess current understanding of the recent changes and consent law in general amongst practicing doctors at a large UK university hospital.

## 2. Materials and methods

An 11 item online questionnaire (SurveyMonkey, USA) was emailed to the Consultant and junior doctor mailing lists (containing 417 and 347 recipients respectively) at Norfolk and Norwich University Hospital in February 2016. The survey was kept open for three months and data was collected anonymously. A pilot study of five Consultant surgeons was carried out prior to this, from which no changes were made to the final survey. The findings were reported according to the SRQR standards for reporting qualitative research [8].

## 3. Results

After three months the survey was closed and all responses interpreted (see Tables 1–10). 245 doctors completed the survey (141 Consultants and 104 junior doctors (31% and 30% response rate respectively, total response rate 32%)). The majority of respondents were from surgical (38%) and medical (36%) specialities. 82% of the respondents' consent patients for procedures at least monthly and of these 64% consent patients several times a week. 23% of all the correspondents consent patients for procedures or surgery on a daily basis. 35% were not familiar with the Sidaway case. 12% of respondents were not familiar with the Bolam test. 45% were not familiar with the Montgomery case. 31% were not familiar with the concept of material risk. 35% were familiar with the recent change in consent law, 41% were not familiar. 18% were "very uncertain" and 64% "a little uncertain" that their current consenting process meets current legal requirements. 95% of respondents think that landmark legal cases and changes in consent law should be discussed through professional bodies such as defence unions. 93% think this information should be circulated better at a local level such as during patient safety or governance meetings. There was no significant difference between Consultant and junior doctor responses to any of the questions.

**Table 1**
Respondents by hospital specialty.

| | |
|---|---|
| Surgical | 94 (38.37%) |
| Medical | 89 (36.33%) |
| Radiology | 13 (5.31%) |
| Anaesthetics/critical care | 38 (15.51%) |
| Other | 11 (4.49%) |

**Table 2**
How often do you have to take consent from patients for procedures/surgery?

| | |
|---|---|
| Yearly | 44 (17.96%) |
| Monthly | 20 (8.16%) |
| Several times a month | 25 (10.20%) |
| Several times a week | 99 (40.41%) |
| On a daily basis | 57 (23.27%) |

**Table 3**
Are you familiar with the Sidaway v Bethlem Royal Hospital case (1985), which set legal precedent?

| | |
|---|---|
| No | 86 (35.10%) |
| Yes | 80 (32.56%) |
| Vaguely | 79 (32.24%) |

**Table 4**
Are you familiar with the Bolam test for assessing reasonable care in negligence cases?

| | |
|---|---|
| No | 30 (12.30%) |
| Yes | 181 (74.18%) |
| Vaguely | 33 (13.52%) |

**Table 5**
Are you familiar with the Montgomery v Lanarkshire Health Board case (2015)?

| | |
|---|---|
| No | 110 (44.90%) |
| Yes | 87 (35.51%) |
| Vaguely | 48 (19.59%) |

**Table 6**
Are you familiar with the concept of "material risk" in relation to a recommended treatment and any reasonable alternative or variant treatments?

| | |
|---|---|
| No | 75 (30.74%) |
| Yes | 90 (36.89%) |
| Vaguely | 79 (32.38%) |

**Table 7**
Are you familiar with the recent change in consent law?

| | |
|---|---|
| No | 99 (40.57%) |
| Yes | 85 (34.84%) |
| Vaguely | 60 (24.59%) |

**Table 8**
How certain are you that your current verbal and written consenting process meets current legal requirements?

| | |
|---|---|
| Very uncertain | 44 (18.18%) |
| A little uncertain | 155 (64.05%) |
| Certain | 43 (17.77%) |

**Table 9**
Do you think landmark legal cases and changes in consent law should be highlighted and discussed with doctors of your grade, for example through pan-specialty meetings with relevant bodies (e.g. medical defence unions)?

| | |
|---|---|
| No | 12 (4.90%) |
| Yes | 233 (95.10%) |

**Table 10**
Do you think this information should be better circulated at local patient safety or governance meetings?

| | |
|---|---|
| No | 17 (7.02%) |
| Yes | 225 (92.98%) |

## 4. Discussion

The extent to which consenting practice has changed during the more prolonged period of departure from Bolam is unclear with few attempts to assess what effect the shifting legal position has had on daily clinical practice. Studies around consent tend to assess the amount of detail and range of complications discussed, against a "gold standard" or expert opinion of which complications for a particular procedure merit discussion [9–12]. Published surveys of medical practitioners are small and similarly focus on the range of complications disclosed [13–17]. This approach is Bolam-like and persisted even after GMC guidance began to reflect the shift towards material risk. That the clinical literature around consent continued in the same fashion suggests that even when the legal paradigm shifts, clinical practice is slow to catch up, in opposition to what has been described by some authors [3]. The outright rejection of Bolam in Montgomery mandates that clinical practice does not continue to lag behind.

Electronically generated or pre-filled consent forms are frequently studied and are increasingly used in NHS trusts [16,18,19]. Ensuring full provision of all the potential complications of a treatment and indeed the patient-signed consent form does not in itself guarantee valid consent, as recently outlined in Jones v Royal Devon, where the material risk approach is not adhered to or inadequate time is provided for the patient to consider decisions or changes [20–22]. However it does appear that pre-printed written material has a role to play; failure to provide written material regarding the signs and symptoms of post-operative deep vein thrombosis contributed to the failure in considering material risk as cited in Spencer v Hillingdon [23].

In order to meet increased demand for economic efficiency and to improve service provision NHS trusts can implement time efficient strategies such as pooled operating lists [24], non-operator or anaesthetist led pre-assessment clinics [25] and even surgery with no pre-operative outpatient clinic beforehand [26]. The advantages can include reducing waiting times and improved patient experience. However, we argue that such initiatives do not allow the unique challenges posed by Montgomery to be tackled. This is supported by The Royal College of Surgeons; guidance states that complying with the standards set out by Montgomery may involve "setting aside more time for discussion" [27] and it is argued that with already existing time pressures, institutional level adjustment is needed to support such a change [28].

This small study is nevertheless the largest published assessment of attitudes and knowledge around consent pre or post Montgomery. The survey results suggest that a large proportion of doctors at the hospital do not understand the material risk approach. The approach to consent established during the Bolam era, based on supplying varying amounts of relatively non-specific information to the patient (often the complications of a procedure) is described as prevailing in UK practice [20], and the results from this survey, whilst reflecting local knowledge, are in keeping with this prediction of the national trend. The response rate for the survey was low (32%), but as there is a large total number of medical staff at the institution, and a lack of previous literature, the 245 responses nevertheless present a useful opportunity to assess understanding of consent law at a single institution. The surveyed hospital is representative of other large UK teaching hospitals in terms of both staff and patient numbers, and the range of specialties available. There was an equal proportion of Consultant and junior responses, but respondents in both groups consented patients for procedures frequently, and so there may be bias against non-respondents who do not carry out procedures or retain less interest in consent law or recent negligence cases. The changes in law following Montgomery apply to all medical practitioners who council patients before new treatments of any kind. If these findings indeed represent a subgroup of doctors who retain an interest in consent law, the lack of understanding of recent changes is of even greater importance.

We suggest that the previously described "messiness' of clinical practice and distinction between which parts of consent are dependent on medical expertise and which are not [7]", the intricate interpretation of complicated national guidelines [2,22], the changing landscape of the NHS patient pathway (and provision of time to fully discuss consent with the patient), when combined with divergent interpretations of Montgomery [3,7] creates a complicated medium from which the busy practicing clinician needs to extract information and introduce change where needed into their daily practice. It has been previously suggested that the Bolam era approach to consent is firmly entrenched and there is a lack of education around material risk based consent in the UK [20]. The findings from this survey suggest that, at one large teaching hospital at least, these assertions are correct.

## 5. Conclusion

The procedural nature of the Montgomery clinical detail has resulted in most discussion focusing on procedures and surgeries. Expanded recent guidance from the Royal Colleges [27] is welcome, but Montgomery has changed the way consent for all treatments, procedural or not, is practiced. We agree that further educational interventions are needed at an institutional level [29], for example medical schools and service quality regulators [20]. This survey suggests that at a single institution at least, consenting practice prior to Montgomery v Lanarkshire Health Board may not have been already moving towards an approach based on material risk, and that more guidance and education may be necessary than is currently on offer, at both a local and national level. Increased understanding of recent changes to consent law will reduce the risk taken by NHS trusts and offer patients a service compliant with Supreme Court guidance.

## Ethical approval

Not needed.

## Sources of funding

No funding & no sources/sponsors.

## Author contribution

J.W. O'Brien, M. Natarajan, I. Shaikh, All equal: study concept or design, data collection, data analysis, writing paper, checking & finalising manuscript.

## Conflicts of interest

J.W. O'Brien-None to declare.
M. Natarajan-None to declare.
I. Shaikh-None to declare.

## Registration of research studies

Researchregistry2083.

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## Consent

No patients or volunteers, so no consent needed.

## Acknowledgements

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

All authors have seen and approved the manuscript and are fully conversant with its contents. The authors thank the medical staff at Norfolk and Norwich University Hospital who responded to the survey.

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