HOT TOPIC

SHOULD SERIOUS RISKS OF DEATH AND DISABILITY BE DISCUSSED WITH ALL PAEDIATRIC PATIENTS?

SUMMARY OF KEY POINTS

- Following the Montgomery ruling, consent processes for adults has changed and we should consider what a reasonable patient would want to know and tailor information to their individual needs.
- There is no well-defined translation to paediatrics. However in order to comply with adult standards, significant changes are required to what many anaesthetists consider normal consent practice.

REVIEW OF EVIDENCE

Introduction

In 2015 the Supreme Court ruled in favour of Mrs Montgomery vs. Lanarkshire Health Board in what became a landmark case changing the way informed consent is practiced in England.

There are now many papers describing how the Montgomery ruling changed consent for adult patients but very few discuss the impact on consent in paediatrics. The consent process for children is more complex due to considerations of Gillick competence and best interests. Here we will briefly set out the background of consent before and after Montgomery and discuss the possible implications for children's practice. However, there are no firm answers to the latter.

Background

In 1999 Mrs Montgomery gave birth to her child by normal vaginal delivery. Cerebral hypoxia occurred as a result of shoulder dystocia. She argued that she was not informed of this risk and possible alternatives such as caesarean section. Although her initial challenges failed as the Bolam test was upheld, in 2015 the Supreme Court ruled in her favour.

The Bolam test originated from a case in 1957 and had previously set the standard for negligence cases. Bolam was a patient undergoing electro-convulsive therapy who suffered extensive fractures as result of the induced seizures. The judge, McNair, ruled in favour of the hospital and negligence claims relating to incomplete consent were judged against what a body of medical professionals would consider to be reasonable.

What has changed?

Montgomery changed the focus of consent practice from a reasonable body of doctors to a reasonable patient. Now we must consider what a patient would find significant and attempt to tailor our consent to their individual priorities. For example, a piano player may be more concerned with finger dexterity than most. The importance of discussing alternative treatments is also stressed to make consent informed.

Any reliance on risk incidence to guide us has been removed. For example, previously, risks less than in 1% or 0.1% could be overlooked. Now the term 'material risk' is used to describe what should be explained to a patient. A material risk is one that a reasonable person in that patient's position would consider to be significant. Or one that the doctor knowns the patient would likely consider significant.

The term 'therapeutic privilege' stemmed from the Bolam case and described withholding information if it would cause harm to the patient. While this still stands, a warning from the Supreme Court explains it should be limited to extreme circumstances and should not be abused by health care professionals.

Considerations for Children

The Family Law Reform Act (1969) set the age of consent in England at 18, but it is presumed this can be extended to 16 years if the person is competent.

The Gillick, or Fraser case, of 1985 amended this law to extend to children less than 16 if they were deemed to have capacity. Named after the mother or Judge respectively, the House of Lords ruled against Gillick who argued that contraceptive advice should not be given to children under 16 years old without the knowledge of their parents. Now children who have competence to understand, retain, weigh and communicate a decision can consent for a specific treatment. However, a child cannot legally dissent to treatment. There is no lower age limit but Lord Fraser advised that doctors should attempt to involve parents in decision making and act in the child's best interests.

In England, if a child refuses to consent or lacks capacity, consent is sought from a proxy. Usually the patient's legal guardian or a court if this fails. The laws in other parts of the UK are slightly different but are not discussed here. The focus of the consent process is acting in the child's best interests. This differs to adults where preserving autonomy is the first rule. Where a competent adult can refuse what is seen as the best or logical treatment, a child cannot if it thought to be in the child's best interests.

Discussion

Since this situation is set by common law, meaning it relies on precedent from judge rulings on significant cases, the translation of the Montgomery case to paediatric consent is yet to be tested. We could find no guidance by any medical bodies specifically related to children or any papers written from a medical perspective. In 2019, Cave and Purshouse published a paper in *Medical Law Review* which discusses the question from the point of view of the legal system. This makes it clear it is a far more complicated and undefined subject than most doctors likely realise. Over the last five years since Montgomery, cases of negligence from non-disclosure in children have increased, but the number of successful claims has decreased. This possibly highlights that while patient expectations may have risen, the legal system is ambiguous on how to deal with claims from children.

A significant problem for paediatric claimants is the concept of best interests. Whereas an adult can argue they would have avoided a risk had they known of alternatives, children or parents may find this more challenging since their refusal to consent can be overruled by a proxy. It is also unclear how the use of therapeutic privilege would be applied to paediatric cases. There is guidance to limit its application in adults but as children are not treated under the same laws, there is more ambiguity.

For children over the age of 16 it seems reasonable to treat them as adults and follow the principles set out by the Montgomery ruling. Below the age of 16 we could split patients into those with Gillick competence and those without. As having capacity was an important factor in the judges' rulings it seems difficult to apply the precedent to children lacking Gillick competence. However, in both these groups do the parents not require the same level of information? This has not been tested in legal cases but would it not be wise for anaesthetists' to use the same high level of disclosure for everyone?

The definition of material risks likely requires far more detailed discussion than is currently most anaesthetist's practice. What patient doesn't consider death significant? Yet how many of us mention this routinely? At least two tertiary paediatric hospitals in England have produced extensive consent forms with videos attached describing in great detail the possible risks of an anaesthetic. They include risks such as death, brain damage and cricothyroidotomy to numbers as small as six per million. It does not seem appropriate; nor will time permit such disclosure on the day of surgery. From a legal perspective, warning patients about risks such as nausea and sore throat on the day of surgery is of no use to anyone.

At the time of writing in early 2022, the Covid-19 recovery is the focus of theatre activity in the UK. The short time between listing and day of surgery, and the high degree of last-minute list alterations are limiting the time available for pre-operative assessment. We are therefore operating at a time when achieving informed consent in a timely, thorough and personalised manner is extremely difficult.

Conclusion

Montgomery was a landmark ruling that changed informed consent processes for adults. The key elements are considering the individual patient's priorities with a focus on alternative options and the aim of increasing patient autonomy. The situation is clouded in paediatrics by variability in capacity and a focus on patient best interests. The introduction of material risk means we must disclose much greater detail for consent to be valid. To facilitate this detail, and to give the patient time to consider risks, this process needs to be well in advance of the day of surgery and probably in written or video form. We think the current norm for many of listing basic risks on the day of surgery is of no use for either patient autonomy or our legal protection. Although it seems national guidance does not currently advise this in paediatrics, we believe consent for children and their parents should follow the changes brought about by the Montgomery case for adults.

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