Masterclasses

M15.3	What Matters? — Perspectives and Challenges for Better Patient and Staff Experience	14:30	Convention Hall C

Patient Consent – Any Consensus Among Ourselves?

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Not long ago, informed consent is considered a panacea for promoting patient autonomy. Medical staff should disclose everything whenever possible, it has been posited. Is it true?

The famous UK story of Nadine Montgomery[1] relates a diabetic lady of short stature expecting her first baby predicted by ultrasound to weigh more than 4kg when labour was induced. She expressed anxieties about delivery to her obstetrician on several occasions, but had not specifically inquired about caesarean section. After the vaginal delivery complication of severe shoulder dystocia and then cerebral palsy, the Supreme Court opined that women have a right to information about "any material risks" in order to make an autonomous decision about how to give birth, and that it was inappropriate that disclosure of risk be based on (the doctor's) clinical judgement.

At first glance, this implied the dogma to disclose everything. The key question is to hit a balance between information overload and patient's right to know.[2] The former situation leads to unnecessary patient anxiety, whereas the latter raises concerns about ethical and legal process. Another area of controversy is the question as to how much our patients want to know.[3]

Stated another way, we want to give the information not too little, not too much, but just right. The corollary is that Goldilocks wanted her porridge not too hot, not too cold, but just right. She wanted her bed not too hard, not too soft, but just right. This has been termed the Goldilocks Effect, assuming that there is a "right" metric of patient autonomy and paternalism.[3,4]

At this moment, we are uncertain how to tackle the dilemma. One proposed strategy is to explore the patients' value and assess the nature of decision. As pointed out by a recent New England Journal of Medicine perspective article[4], "Common sense suggests that clinicians are more likely to leave decisions to patients when they don't have strong feelings about the best course of action. These, however, are the decisions for which patients may benefit most from a recommendation."

References:

1. *Heywood R. Patient-oriented disclosure – a standard worth waiting for? Montgomery v Lanarkshire Health Board [2015] UKSC 11. Med Law Rev 2015; 23: 455-66*
2. *Whitney SN, McGuire AL, McCullough LB. A typology of shared decision making, informed consent, and simple consent. Ann Intern Med 2003; 140: 54-59*
3. *Rosenbaum L. The paternalism preference – choosing unshared decision making. N Engl J Med 2015; 373: 589-92*
4. *Fried TR. Shared decision making – finding the sweet spot. N Engl J Med 2016; 374: 104-5*