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Medical students' perceptions of informed consent: Qualitative Inquiry and legal reflections on clinical education

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Introduction

An earlier edition of this journal, published an interesting empirical study investigating the medical ethics of informed consent using data collected from a sample of medical professionals in Singapore.¹ Amidst the ongoing debate as to the precise status of patient autonomy within the law and extent to which this right is (and ought to be) protected, this offered a welcome insight into how medical professionals perceive informed consent. Whilst it is undoubtedly important to assess qualified practitioners' perceptions of consent in practice, it is equally important to explore the views of those who are still in training. There have been a number of recent empirical studies which have sought to achieve this.² However, none are underpinned by a reflective legal approach. In this regard the some very important opinions have been overlooked and it now seems appropriate to unearth some of these views. This research paper explores medical students' perceptions of informed consent. It provides information about how students at one British university medical school are

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¹ Chin, G.Y. *et al.* 'Medical Ethics of Informed Consent: A Survey of Medical Professionals in Singapore' (2006) 4 PN 236.

² For discussion see Goold, S.D. & Stern, D.T. 'Ethics and Professionalism: What Does a Resident Need to Learn' (2006) 6 *Am J Bioeth* 9; Mavis, B.E. & Henry, R.C. 'Being Uninformed on Informed Consent: A Pilot Survey of Medical Education Faculty' (2005) 5 *BMC Med Educ* 12; Roberts, L.W. *et al.* 'Bioethics Principles, Informed Consent, and Ethical Care for Special Populations: Curricular Needs Expressed by Men & Women Physicians in Training' (2005) 46 *Psychosomatics* 440; Roberts, L.W. *et al.* 'Evaluating Medical Students' Skills in Obtaining Informed Consent for HIV Testing' (2003) 18 *J Gen Intern Med* 112; Roberts, L.W. *et al.* 'Assessing Medical Students' Competence in Obtaining Informed Consent' (1999) 178 *Am J Surg* 351.

educated in consent and the difficulties they feel they may encounter upon entering practice. The study concentrates on how medical students perceive consent and how confident they feel about securing it once in clinical settings. The value of this approach has previously gone unnoticed as, once in practice, they have the opportunity to improve consent procedures. Moreover, by exploring how they are educated in consent, the study uncovers why medical students perceive consent in the way they do and reflects these findings from a legal perspective, with particular emphasis on issues concerning professional liability.

Background and context

Whilst there has been a subtle change of late, historically most would agree that the medical profession has been associated with the concept of paternalism.³ Despite one of the main functions of the law being to protect rights, the courts have traditionally provided unquestioning support for medical paternalism and have been slow to second-guess doctors when it comes to medical decision making.⁴ This view was confirmed in an address given by Lord Justice Brooke to the Medico-Legal Society, where he suggested that until the 1980's there was not any 'clear cut articulation anywhere of what a patient's legal rights were.'⁵ Accordingly, the right of autonomy was often overlooked at the expense of legal reasoning underpinned by notions that the 'doctor knows best.' During the early to mid nineties, notwithstanding judicial

³ For an interesting discussion see; Tallis, R. *Hippocratic Oaths: Medicine and its Discontents* (London: Atlantic, 2004).

⁴ A classic example of judicial support for medical paternalism is found in the famous case of *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. For discussion see Teff, H. *Reasonable Care: Legal Perspectives on the Doctor Patient Relationship* (Oxford: Clarendon, 1994).

⁵ Brooke, L.J. 'Patients, Doctors and the Law (1963-2003) a Few Reflections' (2004) 72 *Medico-Legal Journal* 17 at 19.

proclamation to the contrary, it was clear paternalism was still the dominant theory.⁶ The principle of patient autonomy emerged insofar as theoretical legal terminology was concerned with various judgments mentioning the right and stressing its importance.⁷ Yet, the outcome of these cases seldom matched the rhetoric and the courts were often unwilling to carry their arguments to conclusion by providing adequate protection for patient rights via the legal mechanisms open to them.⁸

The late nineties saw a wind of change and important cases such as *Bolitho*⁹ and *Pearce*¹⁰ illustrated a subtle difference in attitude from the courts with greater recognition for patient rights generally and, more importantly, less deference being shown to the medical profession. Very recently, *Chester v Afshar*¹¹ was the first case in the House of Lords where the patient was successful. It was clear in this case that the Law Lords were prepared to manipulate the strict cause rules in order to give true

⁶ For continuing debate as to the potential values of paternalism see Glick, S. 'The Morality of Coercion' (2000) 26 *Journal of Medical Ethics* 393.

⁷ See the comments made by Lord Donaldson in *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649 at 652-63. Here a firm commitment towards autonomy was voiced. However, the actual outcome was that the courts overrode the patient's refusal of a blood transfusion on the grounds of undue influence and that fact that the patient was confused and suffering from shock and pain due to the ordeal of her accident and the drugs which had been administered. Likewise, in *Re MB (An Adult: Medical Treatment)* [1997] 2 FLR 426 the courts re-affirmed a commitment towards autonomy but still sanctioned an emergency caesarean section on the grounds the patient was temporarily mentally incapacitated. For an interesting commentary on judicial attitudes to pregnancy and autonomy see Bailey-Harris, R. 'Pregnancy, Autonomy and Refusal of Medical Treatment' (1998) 114 LQR 550.

⁸ A classic example of this is to be found in the House of Lord's decision in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871. Here the Lords grappled with the concept of patient autonomy. Despite all the Lords disagreeing on the law and the importance that ought to be attached to this right, they all came to the same conclusion which ultimately provided little if no protection for patients in respect of either the tort of battery or negligence.

⁹ *Bolitho v City and Hackney Health Authority* [1998] AC 232. For discussion see Heywood, R. 'The Logic of *Bolitho*' (2006) 22 PN 225.

¹⁰ *Pearce v United Bristol Healthcare NHS Trust* (1998) 48 BMLR 118, (CA). For discussion see Heywood, R. 'Re-Thinking the Decision in *Pearce*' (2005) 7 CIL 264.

¹¹ *Chester v Afshar* [2004] UKHL 41; [2005] 1 AC 134.

effect to the right of autonomy.¹² This backdrop of developing judicial attitudes towards patient autonomy provides the reflective legal focus for this study. As the courts are gradually altering their approach towards autonomy, are the medical profession beginning to alter theirs? If so, is the change evident within the undergraduate syllabus and is more attention being paid to the importance of consent both from an ethical and legal perspective? Finally, how does this relate to issues concerning professional liability?

Methods

a) Participants

The questionnaire was distributed to all final year medical students in their last lecture before they left to become House Officers. (N=162). The response rate was a 100 per cent.

b) Procedure

A preliminary meeting was arranged with a member of the academic teaching staff from the medical school where the survey was to take place. The Director of Teaching suggested that medical students would have little knowledge of consent issues in practice nor did they have the opportunity to take a patient's consent. Thus, the study focused on how students are educated in informed consent and how effective they felt this had been. It also explored how confident students felt about putting their acquired knowledge into practice and asked them to identify difficulties they believe may be encountered.

¹² Shortly after *Chester*, the House of Lords reverted back and sided with the medical profession over the issue of recovery for loss of a chance for misdiagnosis of cancer. See *Gregg v Scott* [2005] UKHL 2; [2005] 2 AC 176. It is a matter of academic debate whether one interprets this as reducing the significance of *Chester* insofar as respect for autonomy is concerned, or whether one prefers to construe *Gregg* as a decision based on policy considerations concerning causation in a wider context. For discussion see Green, S. 'Coherence of Medical Negligence Cases a Game of Doctors and Purses' (2006) 14 Med L Rev 1; Maskrey, S. & Edis, W. '*Chester v Afshar* and *Gregg v Scott*: Mixed Messages for Lawyers' (2005) 3 JPIL 205.

c) Design

The questionnaire comprised a quantitative and qualitative component.

1. *The quantitative component*

The quantitative section consisted of twelve questions covering the following areas: the perceived basis of informed consent; the perceived importance of informed consent; the importance of informed consent and different treatment options; informed consent and clinical education; perceived factors affecting informed consent in practice. Questions were scored using a modified Likert scale. This usually incorporates a scale of 1-5 ranging from very important to not important at all. There is usually a neutral option for example 'unsure.' After careful consideration it was decided that this neutral option should not be included on the questionnaire because it may have served as a 'get out' clause allowing students to select the easy option and it was thought that this may adversely affect the data set. Thus, an adapted variant of the Likert scale was used: participants were given only four options - very important, important, unimportant and not important at all.¹³

2. *The qualitative component*

At the end of the questionnaire a qualitative component was included asking the students to provide a definition of informed consent. The student definitions were collected and compared to the Department of Health definition in their recent guidelines on obtaining consent.(Does this need referencing?) This definition was preferred to the guidance issued by the GMC. Whilst the General Medical Council's guidelines potentially have greater impact on doctors insofar as the GMC has disciplinary powers, the Department of Health guidelines provide a more

¹³ In some questions the wordings of the options changed yet the scale remained the same. For example, when dealing with difficulties the students perceive they will face in practice the choices ranged from very easy, easy, difficult and very difficult.

comprehensive definition which was easier to break down into a number of individual components.

3. Pilot study

Due to time constraints the study was not piloted amongst medical students. Prior to the questionnaire being distributed, it was circulated amongst a sample of the postgraduate researchers at Sheffield Hallam University (N=12). They were asked to complete the questionnaire with a view to assessing the ease with which the questions could be understood, and the appropriateness of the language used. The feedback was mainly positive, though some redrafting was undertaken to clarify meaning.

d) Data analysis

1. Quantitative

The data from the questionnaire was inputted into an SPSS software package, which generated basic percentage frequencies for each question. To test whether the differences in responses to each question are significant, a chi-square goodness of fit test (often referred to a chi-square test of independence) was computed where the data merited it. However, in some instances the differences were so apparent that statistical testing would have been redundant.

2. Qualitative

The student definitions were collected and compared to that given by the Department of Health in their recent guidelines on obtaining consent. The working definition is set out below:

'Consent is a patient's agreement for a health professional to provide care. For consent to be valid, the patient must be competent to take that particular decision, have received sufficient information, and must not be acting under duress. Sufficient information should include information about the risks and benefits of the proposed treatment, and information about alternative treatments.

If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.¹⁴

The definition in the Department of Health's Guidelines was broken down into eight constituents:

1. Patient's agreement
2. Competence to make a particular decision
3. Received sufficient information
4. Must not be acting under duress
5. Information about risks
6. Information about benefits
7. Information about alternatives
8. Information in a form they can understand

All of the students' definitions were read through in their entirety and the scores were recorded based on how many of the above components each of the students' mentioned. Also, the number of occasions each particular constituent was mentioned was collected.

¹⁴ Good Practice in Consent Implementation Guide: Consent to Examination or Treatment. (London: Department of Health Circular, 2001) at 9-10.

Part one – the quantitative section

a) Results

1. Basis of informed consent

Table one: The most important basis of the doctrine of informed consent.

<u>Basis</u>	<u>Very Important</u>		<u>Important</u>		<u>Unimportant</u>		<u>Very unimportant</u>	
	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>
Ethical Obligation	132	81.5%	29	17.9%	1	.6%	N/A	N/A
Legal Obligation	101	62.3%	61	37.7%	N/A	N/A	N/A	N/A
Professional Obligation	109	67.3%	52	32.1%	1	.6%	N/A	N/A

* N/A means no students selected the category. This applies to all questions.

The differences in the level of importance attached to each basis of informed consent, shown in the above table were statistically significant. $X^2 (2, N=162) = 9.94, p=.007$.

The results indicate that 81.5 per cent of the students perceive the ethical side of informed consent as 'very important.' Whilst their legal obligations are still important clearly for them it is not *the* most important basis underpinning the concept of consent.

2. Importance of consent

All but one of the 162 medical students (99.4 per cent) said that informed consent was important (42) or very important (119). Evidently it is not just the leaders of the medical profession who are responding to greater demands for openness and accountability: it may also be those who are charged with educating medical students.

3. *Informed consent and different treatment options*

Table two: treatment areas where informed consent is most important.

<u>Treatment</u>	<u>Very Important</u>		<u>Important</u>		<u>Unimportant</u>		<u>Very Unimportant</u>	
	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>
Surgery	158	97.5%	4	2.5%	N/A	N/A	N/A	N/A
Non - Surgical Intervention	82	50.6%	77	47.5%	3	1.9%	N/A	N/A
Drug Therapies	65	40.1%	90	55.6%	7	4.3%	N/A	N/A

The differences in the level of importance attached to informed consent in different treatment areas were statistically significant, $X^2 (2, N=162) = 75.61, p < .001$. Surgery was perceived to be the most important area.

All the students recognised the overall importance of consent as regards invasive surgery. In contrast, they attached less importance to it in non-surgical intervention and drug therapies. In relation to drug therapies only 40.1 per cent considered informed consent as very important.

4. *Consent and clinical education*

Table three: The effectiveness of training and preparation to deal with informed consent in practice.

<u>Effectiveness of Training</u>	<u>Frequency</u>	<u>Percentage</u>
Very Effective	3	1.9%
Effective	76	46.9%
Ineffective	77	47.5%

Very Ineffective	6	3.7%
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This evidence suggests that over half (51.2 per cent) of the participants in this sample feel ill-equipped to obtain informed consent. The majority indicated that they felt their consent training had been ineffective. There may well be a number of difficulties associated with providing effective education here. These are highlighted in the discussion.

Table four: Levels of confidence in dealing with informed consent issues in practice.

<u>Levels of Confidence</u>	<u>Frequency</u>	<u>Percentage</u>
Very Confident	3	1.9%
Confident	57	35.2%
Unconfident	94	58%
Very Unconfident	8	4.9%

The majority of medical students (62.9 per cent) did not feel confident in obtaining informed consent in practice. This may be linked to the fact that most of them, as indicated earlier, thought their consent training was ineffective or to the fact that they have no practical experience of it.

5. Perceived difficulty of obtaining informed consent in practice

Curiously, most of the students (62.9 per cent) said they thought that obtaining informed consent would be easy once in practice. This does not mirror the finding that a majority of students felt unconfident in obtaining informed consent. This is strange: ordinarily speaking the easier something is, the more confidence one would expect to have in undertaking the task.

6. Perceived factors affecting informed consent in clinical settings

Table five: The perceived difficulty of dealing with various factors which may affect the obtaining of informed consent in practice.

<u>Factors</u>	<u>Very Easy</u>	<u>Easy</u>	<u>Difficult</u>	<u>Very Difficult</u>
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	Freq	%	Freq	%	Freq	%	Freq	%
Patient Understanding	3	1.9%	69	42.5%	81	50.0%	9	5.6%
Patients' Lack of Communication	1	.6%	39	24.1%	107	66.0%	15	9.3%
Patients' Misconceptions about illness	38	23.5%	105	64.8%	19	11.7%	N/A	N/A
Patients' Unwillingness to Ask Questions	4	2.5%	44	27.2%	91	56.1%	23	14.2%
Identifying Patients' Objectives	1	.6%	76	46.9%	78	48.1%	7	4.4%
Ability to Explain Treatment	11	6.8%	119	73.5%	26	16.0%	6	3.7%

Due to the small numbers in the 'very easy' category which would invalidate the chi-square test, 'very easy' and 'easy' were collapsed as were 'difficult' and 'very difficult' for statistical testing. Thus the tested factors are easy vs. difficultly. The differences are very significant. $X^2 (2, N=162) = 163.27, p < .001$. Students perceived it to be difficult to deal with patient understanding, with lack of communication, patients' reluctance to ask questions and identifying patients' objectives. They perceived it as easy to deal with patients' misconceptions about their illness and their ability to explain treatment. They were equally split about identifying patients' objectives.

The majority of students (55.6 per cent) recognised that dealing with patient understanding is a difficult factor in the consent process. When asked about the perceived problems with lack of communication from patients, 75.3 per cent recognised the difficulties this may cause, while 70.3 per cent agreed that patients' unwillingness to ask questions is also problematic. However, a large majority (88.3 per cent) of the medical students perceived patients' misconceptions about illness as being an easy factor to deal with in the consent process. Just over half (52.5 per cent)

thought identifying patients' objectives is a difficult factor in relation to consent. Finally, the majority (80.3 per cent) of students perceived it to be easy to explain treatment to patients when attempting to obtain informed consent.

b) Discussion: *informed consent and clinical education*

It is encouraging that medical students recognise the importance of informed consent, which has become an issue for the courts in recent years. Jones has commented: '...the leaders of the medical profession have begun to respond to the demands for greater openness and accountability, and are now issuing much more detailed guidance to the profession about information disclosure.'¹⁵ Despite this, the students in this sample felt ill-equipped to obtain informed consent. This may be due to a number of reasons. They may be nervous, poor communicators, not fully understand informed consent, or have insufficient understanding of medical procedures. At least two of these factors are linked to the way in which these medical students are educated in terms of informed consent. The majority felt their training in this regard had been ineffective.

There may be a number of difficulties associated with providing effective consent education. While the focus in undergraduate training is on patient communication,¹⁶ there is no separate unit within the undergraduate curriculum at this medical school that is dedicated to consent training *per se*.¹⁷ Moreover, there are questions about the overall *aim* and *type* of communication. It seems that the central

¹⁵ Jones, M. 'Informed Consent and other Fairy Stories' (1999) 7 *Med L Rev* 123 at 130.

¹⁶ See Goold *et al*, above, note 2; Sedgwick, P. & Hall, A. 'Teaching Medical Students and Doctors How to Communicate Risk' (2003) 327 *BMJ* 694; Makoul, G. & Altman, M 'Early Assessment of Medical Students' Clinical Skills' (2002) 77 *Acad-Med* 1156.

¹⁷ Richardson, N. 'Should House Officers Obtain Consent for Operation and Anaesthesia?' (1996) 28 *Health Trends* 56. For further discussion see Ubel, P.A. *et al*. 'Don't Ask, Don't Tell: A Change in Medical Student Attitudes After Obstetrics/Gynecology Clerkships Toward Seeking Consent for Pelvic Examinations on an Anaesthetized Patient' (2003) 188 *Am J Obstet Gynecol* 575.

purpose of doctors' communication training is to reach an accurate and effective diagnosis in as short a time as possible.¹⁸ Thus, for the most part, these students were educated to communicate in a way which gets them to where they want to be in terms of making a diagnosis. Accordingly, themes which are central to the informed consent process, such as the communication of risks and alternatives, have the potential to be inadvertently de-prioritised.

The results also show that a majority of these medical students do not feel confident in obtaining informed consent in practice. This may not be too surprising given that they have been trained in the theoretical aspects of medicine for the best part of five years and were now reaching a point in their careers where they would have to implement their acquired skills in practice. The relative calm and tranquillity of academia was about to be exchanged for the 'hustle and bustle' of NHS hospital practice where there is little margin for error. This clearly is a daunting prospect. Accordingly, these results could simply reflect anxieties about going into practice. It may well have been different if the survey had been conducted at an earlier or later stage in the students' careers.

The Director of Teaching pointed out that students do not have any practical 'consenting' opportunities before they leave medical school and that their first experience of obtaining a patient's consent may be presented to them in their role as a House Officer. Technically this should not happen. Paterson suggests that 'the task of obtaining signed consent should not be delegated to a junior doctor whose own knowledge of the procedure is limited.'¹⁹ There are two reasons for this. Firstly, they may not know enough about the procedure and secondly, they are unlikely to have

¹⁸ Godolphin, W. 'The Role of Risk Communication in Shared-Decision Making' (2003) 327 *BMJ* 692.

¹⁹ Paterson, I.C. 'Consent to Treatment: Somebody Moved the Goalposts' (1994) 6 *Clin Oncology* 181. See also Roberts *et al* (1999), above, note 1.

direct experience of communicating the necessary information about the procedure to the patient.²⁰ Nonetheless, on-the-job consent training carries with it some benefits. Students have the advantage of observing and learning from the experience and knowledge of senior colleagues who are likely to be more adept in the consultation and communication process, are experts within their specialisms and who may be well versed in both the underlying legal and ethical objectives of informed consent. But, if consent training on the wards is overlooked for reasons of time or laissez-faire attitudes of senior colleagues, medical students will not develop confidence in handling the consent process, which may have detrimental effects on doctor/patient relations.²¹

Perhaps most surprising was the fact that the students in the study thought obtaining informed consent would be easy. It is strange that a majority of the students think obtaining informed consent will be easy, whilst also feeling unconfident in the process. Compared to complex surgical procedures and diagnosis, obtaining consent may well be perceived as being '*easier*', but obtaining a true informed consent is far from '*easy*'. This is something the students need to be made aware of very quickly upon entering practice, if not before. Once again, there is of course the possibility that students may become anxious when anticipating practice. This may affect the responses and explain the inconsistency.

²⁰ Houghton, D.J. *et al.* 'Informed Consent: Patients' and Junior Doctors' Perceptions of the Consent Procedure' (1997) 22 *Clin Otolaryngol* 505.

²¹ See Godolphin, above, note 18; Ubel *et al.*, above, note 17.

Part two – The qualitative study

Results

1. *Total number of constituents mentioned in each definition.*

<u>Number of Constituents Mentioned in Each Definition</u>	<u>Frequency</u>
0 Constituents	15
1 Constituent	21
2 Constituents	40
3 Constituents	51
4 Constituents	29
5 Constituents	5
6 Constituents	1
7 Constituents	0
8 Constituents	0

These results demonstrate that most of the students' definitions included at least two (N=40) or three (N=51) constituents contained in the Department of Health's guidelines. No students managed to identify seven or all eight constituents. Only one student managed to achieve six. In the main, most definitions centred on recognising three components (N=51).

2. *Number of times individual constituents were mentioned within each definition.*²²

<u>Individual Constituent</u>	<u>Frequency</u>
Risks	113
Understanding	82
Patient's Agreement	73
Benefits	60
Alternatives	22
Competence	18
Not Acting Under Duress	17
Sufficient Information	16
No Constituents Mentioned	15

²² For example, risks were mentioned in 113 of the 162 definitions and understanding was mentioned in 82 of the 162 definitions. 15 of 162 the definitions contained none of the individual constituents.

The majority of student definitions covered three constituents, and in the main these individual constituents were made up of risks (N=113), understanding (N=82) and agreement (N=73). However, as can be seen from above, benefits were not far behind (N=60).

a) Discussion: *student definitions compared to the 'gold' standard*

There is perhaps cause for concern given that the majority of students identified only three key components out of a possible eight. However, this could be for a number of reasons.

First, it is possible that the Department of Health's definition is not widely known or referred to in undergraduate teaching. The guidelines are both elaborate and detailed. It is unlikely the professionals in charge of educating the students teach informed consent issues to the black-letter text book definitions and they may be forgiven for not doing so. The more experienced the tutor the less reliant they may be on text book meanings and the more likely they are to use their own skill and knowledge to sum up the essentials that the students will need in practice. At this point a potential problem becomes apparent. Although the Department of Health's definition can be classed as a 'gold-standard', it may be of little use in practice. The advice provided is only a guide, yet if the standards expect too much and are unachievable they will defeat their purpose; medical practitioners may choose to overlook what they perceive to be an unrealistic working model of consent. The direct effect on medical education is, of course, that if the guidelines are not utilised by medical professionals, the chances are they may not attain the status they deserve within the undergraduate curriculum. In this regard it may be interesting to conduct

further research using the guidelines issued by the General Medical Council.²³ There may be a greater awareness of these amongst practitioners, educators and students alike given that the GMC has the power to discipline doctors.

Second, there are a number of difficulties associated with the Department of Health's guidelines concerning the potential overlap with some of the components. For example, the phrase 'sufficient information' is prone to mislead. If the students had mentioned the separate components such as risks, benefits and alternatives they may well perceive this as constituting 'sufficient information' and thus may not have felt the need to name it separately. Likewise, issues such as capacity and not acting under duress are legal issues in their own right. These elements one may not immediately associate within a more general definition of informed consent.

What the results do show is that the majority of students have grasped 'the gist' of informed consent. Despite the limited time in which to construct a thorough definition, there was common identification of the patient's agreement, the requirement to disclose risks and the assessment of patients' understanding. Most of the definitions concentrated on explaining the risk/benefit ratio of any treatment in order that the patient can understand what they are consenting to.²⁴ This is encouraging and reinforces somewhat the findings in the quantitative section that the medical students recognise the importance of informed consent from an ethical rather than a mere legal basis.

²³ Seeking Patient's Consent: The Ethical Considerations. (London: GMC, 1998).

²⁴ Chee Saw, K. *et al.* 'Informed Consent: An Evaluation of Patients' Understanding and Opinion.' (1994) 87 *J Roy Soc Med* 143; Smith, D.K. *et al.* 'Informed Consent to Undergo Serum Screening for Down's Syndrome: The Gap Between Policy and Practice.' (1994) 309 *BMJ* 776.

Legal reflections

The results in this study are interesting given that they have come at a time when the courts themselves are showing a renewed appetite to respect patient autonomy.²⁵ As was suggested earlier, recently the House of Lords manipulated the legal rules in relation to information disclosure to give better effect to the patient's right to self-determination. For the first time ever at the highest appellate level, a patient was successful in a disclosure action.²⁶ An ethical commitment towards patient autonomy is demonstrated in this study. It seems that it is not just the courts who recognise the importance of self-determination.²⁷ The results seem consistent with Jones's assertion that:

'Doctors are familiar with the principle of informed consent as an ethical requirement of their practice, though they are less familiar with the legal ramifications. The underlying ethical principle of informed consent is that one should respect the patient's autonomy.'²⁸

It contrasts with suggestions that medical practitioners perceive informed consent as nothing more than a medico-legal formality that requires them to obtain a signature on a form in order to escape legal liability.²⁹ This study suggests that students look beyond mere conformity with the black-letter legal doctrine.³⁰ To them, informed

²⁵ For discussion see Heywood R. 'Informed Consent Through the Back Door?' (2005) 56 NILQ 266.

²⁶ *Chester v Afshar*, above, note 11.

²⁷ Above, notes 14 and 23

²⁸ Jones, above, note 15 at 123.

²⁹ Kessel, A.S. 'On Failing to Understand Informed Consent.' (1994) 52 *Br J Hosp* 235; Kerrigan, D. *et al.* 'Who's Afraid of Informed Consent?' (1993) 306 *BMJ* 298.

³⁰ The legal doctrine of informed consent originated from the American case of *Canterbury v Spence* (1972) 464 F 2d 772. It is the obligation to provide all the material risks that the reasonable patient would want to know in the circumstances. The patient can sue in battery and/or negligence if the medical professional fails to do this. This prudent patient standard of disclosure, as of yet, has not been accepted unequivocally by the English courts. However, it does operate in other jurisdictions. See *Reibl v Hughes* (1980) 114 DLR (3d) 1 (Canada); *Rogers v Whitaker* (1992) 109 ALR 625 (Australia).

consent is about something more than just the law and these results may indicate an encouraging move towards a more patient-centred system of shared-decision making.

Whilst the status of autonomy within the law seems to have been elevated in comparison to its counterparts, diagnosis and treatment³¹, it is only protected in the loosest sense by the law; this is achieved by placing emphasis on just one aspect of informed consent, risk disclosure. This in itself is not without its problems as the courts have been far from clear as to whether this disclosure ought to be dictated by the standards of the medical profession themselves, the reasonable patient or the particular patient.³² Risks are afforded significant attention within the students' qualitative definitions. This is perhaps due to the perception of the law rather than a real understanding of it. Jones highlights the dangers with this. He suggests the tendency is to perceive informed consent as mainly a medico-legal concept centred on the requirement to get a signature on form.³³ He goes on to say that 'if giving patients information is perceived as merely a means of avoiding a trip to the courtroom it is likely to be done in a formulaic manner which does not achieve of providing the information.'³⁴ Yet, it is possible, given the results in the quantitative element of the study that the emphasis on risk is underpinned by ethical considerations. In this sense the students may recognise this is potentially where patients may suffer harm, and consequently they are entitled to be made aware of the risks they are running beforehand in order to comprehend the magnitude of any procedure and to make a fully informed decision. Too much emphasis on risk is, however, where things

³¹ See Green; Maskrey & Edis, above, note 12.

³² See *Sidaway*, above, note 8; *Pearce*, above, note 10; *Rogers*, above, note 30. For further discussion see Heywood, above, note 10.

³³ Jones, above, note 15 at 105.

³⁴ *Ibid* at 130.

become problematic. Other equally important aspects of informed consent may be inadvertently overlooked to the detriment of patient autonomy. Beauchamp and Childress remind us that although the term informed consent was born in a 'legal context, from a moral viewpoint, it has less to do with liability of professionals as agents of disclosure and more to do with the autonomous choices of patients and subjects.'³⁵

Thus, it was encouraging to see that within the students' definitions other parts of informed consent were highlighted such as understanding and the disclosure of benefits. Although understanding is a very important element in the obtaining of informed consent, it has not been given the attention it deserves in law.³⁶ Very little consideration has been paid to defining the reasonable steps a doctor must take to ensure some level of understanding.³⁷ One of these steps is, of course, to discuss things using the risk/benefit ratio so the patient can conceptualise and place into context the nature of the procedure they are agreeing to. Consideration of risk/benefit ratios are at the heart of negligence calculations and are of central concern in questions of breach of duty generally.³⁸ Since doctors presumably want patients to take their advice it would be surprising if they did not emphasise why the procedure they recommend is a good idea. It is this commitment towards understanding and disclosure of benefits that takes us further than the legal definition of informed consent and may well be the inherent difference between the way in which medically

³⁵ Beauchamp, T.L. & Childress, J.F. *Principles of Biomedical Ethics* Fifth Edition (New York: Oxford University Press, 2001) at 81.

³⁶ Williams K. 'Comprehending Disclosure: Must Patients Understand the Risks they Run?' (2000) 4 *Med L Int* 97.

³⁷ *Smith v Tunbridge Wells Health Authority* [1994] 5 *Med LR* 334. See Grubb, A. 'Medical Negligence: Information and *Bolam*' (1995) 3 *Med L Rev* 198.

³⁸ See *Bolitho*, above, note 9. For further discussion see Brazier, M. & Miola, J. 'Bye-Bye *Bolam*: A Medical Litigation Revolution?' (2000) 8 *Med L Rev* 85.

trained individuals and lawyers themselves view the concept. In a wider sense these findings are pleasing and are best reflected in Jones's assertion that 'as professional attitudes to the question of information disclosure change patients will become entitled to more information.'³⁹

Conclusions & recommendations

The results in this study provide an interesting insight into how medical students perceive informed consent. It is encouraging that they value the importance of the concept, both ethically and legally. They also identify key components such as disclosure of risks and benefits, and also recognise the importance of patient understanding. Whereas traditionally training in communication skills may not have been given the same attention as other more substantive elements of the medical curriculum, it now appears this attitude is slowly changing. A number of the existing papers cited within this study stress the importance of effective communication between doctor and patient highlighting the fact that this is an essential part of undergraduate training. Moreover, there is some evidence that researchers are beginning to investigate how junior doctors cope with issues relating to consent upon entering practice. However, the attention given to consent training *per se* in the *undergraduate* syllabus remains questionable. Important medico-legal issues should feature significantly across all areas of medicine, be it in training or in practice. Reflecting on this study from a legal perspective, it is clear that, of late, the courts have begun to sit up and take note of patient rights by playing an active role in protecting autonomy, thereby demonstrating a commitment towards the ethical imperative of self-determination. The precise extent to which they will continue to do this remains uncertain. However, an argument can surely be made out that it is now

³⁹ Jones, above, note 15 at 125.

time to include more substantive consent training for undergraduate medical students. This springs from the fact that the majority of the participants in this study recognise the importance of consent, but do not feel their training has been effective causing them to lack confidence in this important area of practice. The exact way in which this training should be implemented is perhaps an issue for those involved in the teaching and design of undergraduate programmes. Indeed, this would perhaps provide the basis for further research. As such, the authors make the following recommendations:

- More attention ought to be given to consent training in the undergraduate medical syllabus. Further research ought to be conducted as to how best this could be achieved. For example, it may take the form of focus groups, role playing activities and legal CPD days.
- Consideration should be given to a specific undergraduate module being created which focuses exclusively on medico-legal issues in practice. This should not only focus on consent, but also on other important issues such as confidentiality, access to records and human rights.
- Whilst it seems evident that a certain amount of emphasis is placed on communication skills, the focus of this training should not be aimed exclusively at communication with a view to diagnosis. Broader issues should be considered such as educating students about the wider benefits of effective communication in respect of effective consent procedures and also adherence to treatment regimes.
- The idea the junior doctors should not be involved in consent procedures at all is misplaced. Junior doctors should *not* be allowed to consent for procedures which they cannot perform on their own and of which they have little knowledge. However, they should be allowed to engage in consent procedures whilst being supervised by senior colleagues as on-the-job training is an effective way to learn and gain experience.
- Further research ought to be carried out exploring whether or not medical students' perceptions of informed consent change at a later stage in their careers when they have entered practice, and to what extent, if indeed at all, their knowledge of the law and professional guidelines improves as they are given the opportunity to experience consent in a clinical environment.