INFORMED CONSENT IN COMMON LAW MEDICAL CASES

Małgorzata Magdalena Cyrych, Master of Law
Law Firm SALVAR, Plac Żelaznej Bramy 10, 00-136 Warsaw, Poland

Резюме: *Целта на настоящия документ е да даде общ преглед на общото право, признаващо правото на всеки пациент да се ползва от пълен имунитет при чужда физическа намеса. Направен е опит да се изясни защо е необходимо информирано съгласие, поради официалното споразумение между лекар и неговия/ нейния пациент, докато лекарите използват своите медицински знания, умения за постигане на желани резултати и след получаване на възнаграждение от излекуваните пациенти.*

Поради това е важно да се отбележи, че всяка медицинска процедура, която включва известен потенциален риск, изисква получаване на информирано съгласие от пациента за предварително лечение, или медицинският персонал може да бъде обвинен в нарушаване на стандарта за медицинско обслужване.

В допълнение има нерешени въпроси относно това дали съгласието за медицинско лечение включва съгласие за лечение на усложнения след лечението. За по-добро разбиране на информирана концепция се използват няколко съдебни дела в британските и във федералните съдилища на САЩ, както е показано в знаменателния случай Болам срещу Управителния комитет на болница Фрайърн и/ или делото Кентърбъри срещу Спенс от 1972 г. Въпросът за съгласието е подчертан от решението на Върховния съд от 2015 г. по делото Монтгомъри срещу Ланаркшър ХА (2015), което ефективно промени възприеманото правно определение за информирано съгласие.

В заключение се подчертава, че и двете страни по информирано съгласие са длъжни да обсъдят и обменят цялата информация по същество, която ще помогне на пациента да вземе правилно решение, свързано с конкретно медицинско лечение, което може да е в най-добър интерес за пациента, въпреки всички присъщи рискове.

Обменът на мисли действа не само в защита на лекаря от потенциално решение на съдебните заседатели за нанесени щети, но също така спомага за повишаване на автономността на пациента в процеса на вземане на решения, свързани със здравето, както и със стриктното спазване на медицинската терапия.

Abstract: *The purpose of this paper is to give an overview of the common law recognizing any patient's individual's right to enjoy complete immunity of his/her person from physical interference of others. It attempts to explain why informed consent is needed due to the formal agreement between a doctor and his/her patient, whereas the physicians are employing their medical knowledge, skills to achieve desired results and, upon receiving remuneration from the cured patients.*

Therefore it's important to point out that any medical procedure involving some potential risk, requires obtaining prior treatment informed consent from the patient or the medical staff can be charged in the court of justice with the breach of the standard of medical care.

Furthermore there are unresolved questions whether does consent to medical treatment encompass consent to treat post treatment complications. For better understanding of informed concept involved, several litigated cases in the British as well in the US federal courts are utilized, as illustrated in the landmark case of Bolam v Friern Hospital Management Committee and or 1972 case of

Canterbury v. Spence. The issue of consent is highlighted by the 2015 Supreme Court judgment in the case of Montgomery v Lanarkshire HA *[2015] which effectively changed the understood legal definition of informed consent.*

In conclusion it is emphasized that both parties to informed consent need to discuss and exchange all relevant information helping patient to undertake proper decision related to particular medical treatment which might be in a patient's best interest despite all of the inherent risks involved.

Exchange of minds is helping not only in protecting the physician from potential jury decision on damages, but also helps enhance the patient's autonomy in health related decisions process making along with full compliance with medical therapy.

This article examines the legal development of the common law doctrine of informed consent, the law's recognition that a patient is an autonomous individual who is free to authorize or refuse the administration of medical treatment. Therefore the physician's doctor's duty is to disclose all pertinent information concerning the medical care and exisitng risks. The author deals so comprehensively with the American, and British case law. The divergent standards for disclosure and proximate causation In the UK and US are compared. Emphasis is placed on concepts currently utilized in the US in relation to the effects on doctor's their patients, and the courts. The important question is whether the domestic legal provision imposes any, and if so what, different criterion as the measure of the medical man's duty of care to his patient when giving advice with respect to a proposed course of treatment. It is clearly right to recognise that a conscious adult patient of sound mind is entitled to decide for himself whether or not he will submit to a particular course of medical care proposed by the doctor, most significantly surgical medical care. Important controversial iussue remains unresolved,

mainly does consent to medcial treatment encompass consent to treat post treatment complications? It could be argued that, the patient's consent is to be fully informed, the doctor must specifically warn him of all risks involved in the treatment offered, unless he has some sound clinical reason not to do so. In turen, this would seem to be the extreme to which a truly objective criterion of the doctor's duty would lead. It seems that there is no need to warn of the risks inherent in all medical treatment including suregry under general anaesthesia, because patients may expect to be aware of such risks or that they are relatively remote.

The doctrine of informed consent

The issue of consent predated the second world war; but it was a consequence of the atrocities in nazi concentration camps when physicians carried out procedures to without any patient's (prisoners) consent. Although the specific definition of informed consent may vary in tee US from state to state, it basically means that a doctor (or other medical provider) must inform patients all of the potential benefits, risks, and alternatives involved in any surgical procedure, medical procedure, or other course of treatment, and must prior obtain the patient's written consent to proceed. The concept was based on the principle that a doctor was under a duty to disclose information to the patients so they could make a reasonable decision concerning treatment. The legal analysis of medical informed consent has evolved over the decades from an accusation of battery to an accusation of negligence. Negligence requires that four elements be established for liability of the physician-defendant, including a duty of the physician doctor to meet a particular standard of care, the physician's failure to perform that duty, a causal connection (proximate cause) between the doctor's failure and the patient's injury, and in addition an injury for which monetary compensation is adequate

relief.[1] In a medical negligence cases where the issue was as to the advice and information given to the patients as to the medical care proposed, the available options, and the risk, the courts were concerned primarily with a patient's right. The doctor's duty arises from his patient's rights. If one considers the scope of the doctor's duty by beginning with the right of the patients to make their own decision whether they will or will not undergo the medical care proposed, the right to be informed of significant risk and the doctor's corresponding duty are easy to comprehend; for the proper implementation of the right requires that the doctor be under a duty to inform his patient of the material risks inherent in the medical treatment. And it is plainly right that a doctor may avoid liability for failure to warn of a material risk if he could show that he reasonably believed that communication to the patients of the existence of the risk inlolved, would be detrimental to the health conditions of his patients.

In the law of negligence, this approach entailed a duty on the part of doctors to take reasonable care to ensure that patients are aware of material risks of injury that are inherent in treatment. This could be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a patients to a risk of injury which they would otherwise have avoided, but it is also the counterpart of the patient’s entitlement to decide whether or not to incur such risk invloved. The existence of that entitlement, and the mere fact that its exercise does not depend exclusively on medical considerations, are of great importance. They point to a fundamental distinction between, on the one hand, the doctor’s role when considering possible investigatory or medical care options and, on the

---

[1] WP Keeton, WL Prosser (Eds.) Prosser and Keeton on the Law of Torts. 5th ed. West Publishing Company, St Paul, MN, 1984

other, their role in discussing with the patients any recommended medical care and possible alternatives, and the risks of injury which may be involved.

To sum up, the doctrine of informed consent amounts, in accordance with american jurisprudence, to this: where there is a real or a material risk inherent in the proposed operation. the question whether and to what extent a patient should be warned before he gives his consent is to be answered not by reference to medical practice but by accepting as a matter of law that, subject to all proper exceptions (of which the court, not the profession, is the judge), a patient has a right to be informed of the risks in herent in the medical care which is proposed[2]

Doctor's duty to obtain patient's consent.

All patients are entitled to decide which, if any, of the available forms of medical care to undergo, and their consent must be obtained before medical care interfering with their bodily integrity is undertaken. The physicians are therefore under a legal duty to take reasonable care to ensure that the patients are aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the physicians are or should reasonably be. To avoid further legal proceedings , in accordance with the doctrine of informed consent, physicians must disclose enough information for the patients to make an "nformed decision. However, because informed consent laws and principles do not specify the amount of information that must be disclosed, doctors

---

[2] The landmark case is a decision of the US Court of Appeals, District of Columbia in the case of Circuit, Canterbury v. Spence (1972) 464 F. 2d 772. This case has been approved by the District of Columbia Appeal Court in the case of Grain v. Allison (1982) 443 A. 2d 558

might find it helpful to know what they must usually disclose to patient. Obtaining the patient's informed consent to an operating procedures and introduction of medical care is of fundamental importance not only from a medical but primarly from legal point of view, due to the issue of damages. In most cases the patient's informed consent is often obtained in a wrong and unlawful way and contrary to the nationa regulations. When seeking consent to treatment, the question of whether the information given to a patient is adequate is cocluded by the courts based on the concept of a reasonable person in the patient's position.

The US approach to the informed consent

Currently, the majority of courts in common law system almoust unanimously characterize lack of informed consent as a matter of negligence of the doctor to disclose necessary information to patient. It is accepted that no common law jurisdiction either American or British which has espoused the doctrine of informed consent appears to have suggested that the doctor was under a duty to warn his patient of such general risks which, rare though they may be, do happen and they are real risks. Traditionally, courts held that a doctor's duty to disclose information to the patients depended upon community disclosure standards—whether the majority of physicians within a particular community would customarily make such a disclosure. The main exposition of the basis of the requirement to obtain consent to therapeutic intervention, including the tortioius consequences which flow from default, in that regard was formulated by Judge Cardozo J in the 1914 case of *Schloendorff v Society of New York Hospital*.[3] Before this decision, medical intervention without the consent of the patient was considered as battery. The decision made by the justice Cordazo rein-forced the principle of autonomy.

---

[3] judgment in the case of *Schloendorff v Society of New York Hospital* 105 NE 92 (NY, 1914)

The justice ruled that every human being of adult years and sound mind shall have the right to determine what shall be done with his own body and a physician who performs an operation without his patient's consent, commits an assault, for which he is liable in damages. In 1957 following the decision of California District Court of Appeals for the First District in in the case of Salgo v. Leland Stanford, Jr. University of Trustees, the court ruled that a doctors violated duty to their patients and subjected themselves to liability if they withholded any facts which were necessary to form the basis of an intelligent consent by the patient to the proposed treatment. [4] Later the courts have acknowledged problems with the community disclosure standard, chiefly that it created an incentive for doctors to protect themselves by collectively limiting the standard disclosures, which wass not in patients' best interests.

This was the reason that in 1972 the D.C. Circuit Court of Appeals altered the physician's duty to disclose in the case *Canterbury v. Spence*[5] *and* the minority of states courts have chosen to follow the lead given by U.S. Court of Appeals, District of Columbia Circuit[6] by adopting the objective prudent patient test. But the majority of states courts have adopted the traditional test and determined the question of disclosure of risks by applying the reasonable doctor' test.[7] In 1972 Canterbury v. Spence, judgment the Court held that that as a part of the physician's overall obligation to the patient, there is a duty of reasonable disclosure of

---

[4] judgment in the case of Salgo v. Leland Stanford. Civ. No. 17045. First Dist., Div. One. Oct. 22,1957

[5] judgment in the case of *Canterbury v Spence*, 464 F2d 772 (DC Cir 1972)

[6] U.S. Court of Appeals, District of Columbia Circuit, judgment in the case of Canterbury v. Spence (1972) 464 F. 2d 772.

[7] judgment in the case of SIDAWAY (A.P.) (APPELLANT) V. BETHLEM ROYAL HOSPITAL AND THE MAUDESLEY HOSPITAL HEALTH AUTHORITY AND OTHERS (RESPONDENTS) JUDGMENT Die Jovis 21° Februarii 1985

the choices with respect to proposed therapy and the dangers inherently and potentially involved. The judges ruled also, that the duty and required scope of disclosure standards in the medical profession must be established by expert medical testimony but tested by general considerations of reasonable disclosure under all the circumstances will materially affect the patient's decision to proceed with the treatment. [8] Court concluded that in the case of emergency, when the persons are unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment the impracticality of conferring with the patient dispenses with need for it. Judges concluded that there should be no criticism of the physician unless the fact-finder determines that the information was inadequate. In *Canterbury case*, the decision outlined several important informations to be disclose by the doctor, mainly condition being treated, nature and character of the proposed medical care or surgical procedure; Other information icnluded anticipated results, recognized possible alternative forms of treatment; and recognized serious possible risks, complications, and anticipated benefits involved in the medical care or surgical procedure, as well as the recognized possible alternative forms of treatment, including non- medical care.[9] In further informed consent cases following *Canterbury*, doctors have been also required to disclose not only personal or economic interests that may influence their judgment, as mandated in the 1993 case of *Gates v. Jenson*[10] but also, as judges ruled in the 2010 case of *Jandre v. Physicians Insurance*

---

[8] See also Comment, Informed Consent in Medical Malpractice, 55 Calif. L.Rev. 1396, 1397 n. 5 (1967), Waltz Scheuneman, Informed Consent to Therapy, 64 Nw.U. L.Rev. 628 n. 1 (1970)

[9] judgment in the case of Barcai v. Betwee, 50 P3d 946 (Haw. 2002), 26 MPDLR 888. 44.

[10] judgment in the case of Moore v. Regents of Univ. of Cal. - 51 Cal. 3d 120, 271 Cal. Rptr. 146, 793 P.2d 479 (1990) The court held that a physician who is seeking a patient's consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient's informed con-

Co of Wisconsin all diagnostic tests that may rule out a possible condition[11]. However in the California Supreme Court decision in the case of *Arato v. Avedon*, judges ruled, that A doctor has a legal duty to disclose all material information to a patient so the patient may make an informed decision regarding the suggested operation or treatment. But physicians were not required to disclose particular statistical life expectancy rates to a patient suffering from pancreatic cancer, mainly on the grounds that statistics do not usefully relate to an patient's future.[12]

What interesting, in the decision in *Nixdorf v. Hicken*[13] Court ruled that doctors must also disclose information that a reasonable person in the patient's position would find important.[14] Other courts have underlined two additional exceptions to the requirement that physicians elicit and document informed consent. The first applied when both the patients were unconscious or otherwise incapable of consenting and the benefit of treating the patients outweighed any potential harm of the medical treatment. Under such circumstances, the doctors were not required to obtain informed consent before treating, but must do so a.s.a.p it is

---

sent, disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment.

[11] judgment in the case of *Jandre v Physicians Insurance Co of Wisconsin*, 330 Wis 2d 50, 792 NW2d 558 (Wis Ct App 2010). Plaintiffs brought a medical malpractice action against the physician. A jury determined that the physician did not negligently diagnose the patient with Bell's palsy. However, the jury found that the physician breached her duty under Wis. Stat. § 448.30 (2007-08) by failing to inform the patient of a diagnostic test that was available to rule out the possibility of an ischemic stroke. The court of appeals upheld the judgment. On review, the court, applying the reasonable patient standard to the facts and circumstances, concluded that the trial court could not have determined, as a matter of law, that the physician had no duty to inform the patient of the possibility

[12] judgment in the case of *Arato v Avedon*, 5 Cal 4th 1172, 858 P2d 598 (1993)

[13] judgment in the case of *Nixdorf v Hicken*, 612 P2d 348 (Utah 1980) In this case, a doctor left a surgical needle in his patient and was held to have a duty to disclose any information pertinent to the patient's treatment, including the patient's physical condition following medical care

[14] Johan Bester, Cristie M. Cole, Eric Kodish, The Limits of Informed Consent for an Overwhelmed Patient: Clinicians' Role in Protecting Patients and Preventing Overwhelm AMA J Ethics

medically possible.[15] The second exception applied only when disclosing medical information would pose a threat to the patient, including the situation where a patient has become so emotionally distraught that would become incapable of making a rational decision.[16] But if disclosure wass likely to cause psychological harm to patients, doctors were not under duty to disclose.[17] However, a doctors could not use the exception to withhold information merely because they thought the information may cause the patient to refuse a specific medical treatment. In other words, a doctor must disclose information that a reasonable person would want to have for decision making, even though that information may cause the patient to refuse medical care that the physician believes is in the patient's best interest.[18] It mus be remember, hovewer that the reasonable person standard endorses the obligation of the physician to disclose all information that a reasonable person would want to know about a proposed treatment. This standard evolved in part from mentioned above decision in the case of Canterbury v Spence, where court underlined that the patient must be able to rely on information, whereas the physician holds that would be material to the patients in making an informed treatment decision in their best interest. Canterbury decision profoundly affected future litigation, well beyond broadening the definition of informed consent.The major legal implication of the decision was that it largely shifted legal culture from a professional practice standard to a reasonable person standard in malpractice cases, undermined the tradition and practice of doctors not testifying against

---

[15] judgment in the case of *Dunham v Wright*, 423 F2d 940 (3rd Cir 1970)
[16] judgment in the case of *Salgo v Leland Stanford Jr Univ Bd of Trustees*, 154 Cal App 2d 560, 317 P2d 170 (Cal Ct App 1957).
[17] Minnesota Supreme Cour judgment in the case of *Cornfeldt v Tongen*, 262 NW2d 684 (Minn 1977)
[18] Hawaii Supreme Court judgment in the case of *Carr v Strode,* 79 Hawai'i 475, 904 P2d 489 (1995)

each other. The prolification of medical malpractice suits in the US has led some federal courts to curtail or even to reject the operation of the doctrine and to restrict the liability of the doctor and so dampen the practice of defensive medicine.[19] The physicians are therefore under a duty to take reasonable care to ensure that the patients are aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the physicians are or should reasonably be aware that the particular patient would be likely to attach significance to it. The physicians are however entitled to withhold from the patients information as to a risk if they reasonably consider that its disclosure would be seriously detrimental to the patient's health. The physicians are is also excused from conferring with the patients in circumstances of necessity, as for example where the patient requires medical care urgently but is unconscious or otherwise unable to make a decision.

The UK approach to the informed consent

The foundation of the doctrine of informed consent has led in certain British jurisdictions to decisions to dicta, on which the appellant relies, which would oust applied by the Court's in its 1957 decision in the case *Bolam v Friern Hospital Management Committee*[20] known as Bolam test and substitute an objective test

---

[19] It meant the practice of physician advising and undertaking the medical care which he think is legally safe even though he may believe that it is not the best for his patients.

[20] judgment in the case of *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583 TORT The defendant was the body who employed a doctor who had not given a mentally-ill patient (the claimant) muscle-relaxant drugs nor restrained them prior to giving them electroconvulsive therapy. The claimant suffered injuries during the procedure. The claimant sued the defendant, claiming the doctor was negligent for not restraining them or giving them the drug.

of a doctor's duty to advise the patient of the advantages and disadvantages of undergoing the medical care proposed and more particularly to advise the patient of the risks involved. Basically *Bolam* test, has in cases involving consent, replaced medical opinion with the informed decision of the patients. *Bolam* has traditionally been applied in the situation, where the nature and extent as to what, if anything, the patient should be told in respect of a medical procedure that the doctor suggests or proposes be performed, including as to disclosure of risk. In such scenario For a physician was not liable in negligence so long as what the physician said or did not say, including as to risk, was in line with a respectable body of medical opinion.

In Bolam case the Court stated and applied Bolam principle, whereas a a doctor who followed conduct advocated by a reasonable proportion of their respective profession will not have failed to take reasonable care Bolam brought an action against the Hospital committee in the tort of negligence. The claimant argued the physicians had been negligent in not warning him about the risks of the therapy. Additionaly they failed to administer a relaxant drug, and failed to use more manual control (beyond shoulder control) to avoid the claimant falling off the bed. Judges decided that a physician is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. In others word a proffessional is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view. The Judge McNair J He held that what was common practice in a medical field was highly relevant to the standard of care required. A physician falls below the appropriate standard, and is negligent, if he fails to do what a reasonable person would in the circumstances. But when a

person professes to have professional skills, as doctors do, the standard of care must be higher.[21]

Bolam test was rejected in the 2015 Supreme Court decision in the case of of *Montgomery v Lanarkshire Health Board*[22], where the Court departed and overruled the House of Lords earlier decision in the case *Sidaway v Board of Governors of the Bethlem Royal Hospital*, in reconsidering the duty of care of a doctor towards a patient on medical treatment. The latest case changed the *doctors resposnibility* to a greater test in medical negligence by introducing the general duty to attempt the disclosure of risk invlolved. *In 1985 decision Sidaway v. Board of Governors of the Bethlem Royal Hospital* [23], concerning the duty of a surgeon to inform a patient of the risks before undergoing an operation, House of Lords UK appellate court upheld a ruling that a surgeon who had performed an operation resulting in severe spinal cord damage, without having advised the patient of the risk of such an occurrence, was not liable. The doctor duty of care was discharged by revealing enough information to enable the patient to make a rational decision, with the extent of disclosure to be based on accepted medical practice. The judges rejected, as not in accord with british law, the American doctrine of informed consent based on the patient's right to disclosure of all material risks of significance to a prudent patient.[24] The case established rule in English

---

[21] The only real modification arose as a result of judgment in the case of *Bolitho v City and Hackney Health Authority* [1998] AC 232, a case which propounded that the body of the medical opinion must be "reasonable, responsible or respectable" and have "a logical and defensible basis".

[22] Montgomery v Lanarkshire Health Board [2015] UKSC 1 For the purposes of consent, the ruling from Montgomery replaced the previous tests founded in Bolam and refined in Sidaway

[23] judgment in the case of *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] AC 871

[24] judgment in the case of *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] AC 871 This was a case where a patient was left with paralysis after an operation to relieve a

common law that a has a physicians are under the duty provide to their patients sufficient information for them to reach a balanced judgement, because patients should be informed how necessary a procedure is, any alternatives, and any common or serious consequences of it.

In 2015 Montgomery[25] case the Supreme Court affirmed the requirement of informed choice and/or informed consent by patient in medical treatment that rested fundamentally on the duty of disclosure by medicalprofessionals. The judgment represented an important clarification of the law in respect of consent in clinical negligence cases which was highly relevant in not only in the US, but most imprtant on the British soil. The judges decided that the *Bolam* test based on doctor's duty to warn patients of risks was based on whether they had acted in line with a responsible body of medical opinion, did not apply in further consent cases. *The decision* confirmed that patients are well informed and capable of understanding medical meandres. They have rights, including the right to have the risks of treatment properly discussed with them so that they could make an informed decision on how to proceed. This of course does not affect the situations where treatment is necessary and consent cannot be obtained or where disclosure of a risk might be detrimental to a patient's health. The ruling recognised that patients are entitled to make decisions about treatment options which could affect them for the rest of their lives. In partucalar the Judges hold, that a person could

---

trapped nerve. In the court of appeal, the patient claimed negligence as she had not been informed of the risk of this outcome. The judges rejected the appellants claim as a respectable body of medical opinion agreed that it was not necessary to warn a patient of every risk involved.

[25] judgment in the case of *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 The court accepted that if Mrs Montgomery been told about the risk of dystocia, she would have chosen to have a caesarean. Her appeal was successful and the judgment held that the assessment of whether consent was adequate in a clinical negligence claim would not be assessed by the Bolam test.

of course decide that she does not wish to be informed of risks of injury and that a phisicians are not obliged to discuss the risks inherent in treatment with a person who makes it clear that would prefer not to discuss the matter. Deciding whether a person is so disinclined may involve the doctor making a judgment; but it is not a judgment which is dependent on medical expertise. It is also true that the doctor must necessarily make a judgment as to how best to explain the risks to the patient, and that providing an effective explanation may require skill. But the need for Bolam test kind of skill and judgment does not entail that the question whether to explain the risks at all is normally a matter for the judgment of the doctorphysicians. The Supreme Court therefore concluded that the Bolam test was not appropriate in consent cases stating at paragraph 87 of the judgment: *'An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significant to the risk, or the doctor is or should reasonable be aware that the particular patient would be likely to attach significance to it.*[26]

[26] judgment in the case of *Montgomery v Lanarkshire Health Board* [2015] UKSC 11

Conclusion

There are still challenges ahead for the medical staff, and lawyers and judiciary. Ethically and legally, all medical prosssional are under the duty to understand the medical informed consent processm which allows for the exchange of ideas in medical practice that will yield informed decisions and will lead to the best outcomes on the basis of shared information. What most important, informed consent limits the potential for negligence cases brought for lack of informed consent, therefore the medical staff directly involved in the proposed medical care should always discuss the severe risks, such as death, paralysis, loss of cognition, or loss of a limb, even if the probability of occurrences is small. This put the requirement on physicians involved in the proposed medical care to disclose less severe risks that occur frequently, because courts do not place emphasis only on consequences; they take into considerations frequency as an important component of risk involved.

Concluding, all patients undergoing medical medical care need adequate information to make knowing and intelligent decisions about their health care. The doctrine of informed consent developed to insure that this needfor information is met. The doctrine recognized that every patient has the right to decide what will be done to his body. The current controversy relates to the standard utilized to measure what must be disclosed. At one extreme, the doctor is given discretion consistent with accepted medical practices to decide what must be disclosed. At the other hand, the individual patient decides how much information is necessary to meet his own particular needs. A middle ground, applying the standard of the reasonable patient or objective standard, places emphasis on what the reasonable person in the patient's position would want to know. Refinement of the standards should be a judicial goal in informed consent cases. In coming future, the issues will become more complex requiring set standards to decide informed

consent cases. The dilemma of informed consent for all patients will continue to exist until judiciary and national law might resolve the existing issues.

As to British experience in the field of informed consent, in 2015 Montgomery case the UK Supreme Court reasoned that the previously accepted model of the physicians -patients relationship no longer reflected reality and patients are capable of understanding medical issues. Jduges decided held that physicians are under the duty to take reasonable care to ensure that patients of sound mind are aware of material risks inherent in treatment and of reasonable alternatives. The Supreme Court's ruling outlined the new test of materiality, which is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it. The rejected by the court Bolam test was deemed unsuitable for cases regarding the discussion of risks with patients, as the extent to which a doctor may be inclined to discuss risks with patients is not determined by medical learning or experience. The ruling might have aso impact on amercian jurisprudence in evolving the traditional concept of informed consent. The UK Supreme Court ruled that the assessment of risk to a patient cannot be reduced to percentages but is fact-sensitive and sensitive to the characteristics of a particular patient. Therefore doctor phisicians shall engage in dialogue with a patients and patients should be able to make a decision about whether to undergo a proposed course of treatment, even where liable to a choice which a physicians considers to be contrary to their best interests. The judgment emphasised the importance of phsicians and patients reaching decisions in partnership and the need for physicians to consider what risks might be important to an individual patient rather than what a reasonable physician would consider important. The UK decision might have persuasive authority when the issue of informed patient consent is considered by the american courts. If the

Montgomery prudence is followed in the US then it is likely the plea that a known risk, which was warned of and consented to by the patients, will increase where the risk manifests. What is clear is that in the UK there is now a full, recent, authoritative, disapproval of the *Bolam* test, which might be welcomed by all patients, and it is hoped the *Montgomery* decision will be followed by majority courts in common law countries.

Refernces

WP Keeton, WL Prosser (Eds.) Prosser and Keeton on the Law of Torts. 5th ed. West Publishing Company, St Paul, MN, 1984

Comment, Informed Consent in Medical Malpractice, 55 Calif. L.Rev. 1396, 1397 n. 5 (1967)

Waltz Scheuneman, Informed Consent to Therapy, 64 Nw.U. L.Rev. 628 n. 1 (1970)

Johan Bester, Cristie M. Cole, Eric Kodish, The Limits of Informed Consent for an Overwhelmed Patient: Clinicians' Role in Protecting Patients and Preventing Overwhelm AMA J Ethics 2016

US courts decision

judgment in the case of *Jandre v Physicians Insurance Co of Wisconsin*, 330 Wis 2d 50, 792 NW2d 558 (Wis Ct App 2010)

judgment in the case of *Arato v Avedon*, 5 Cal 4th 1172, 858 P2d 598 (1993)

judgment in the case of *Nixdorf v Hicken*, 612 P2d 348 (Utah 1980)

judgment in the case of *Dunham v Wright*, 423 F2d 940 (3rd Cir 1970)

judgment in the case of *Salgo v Leland Stanford Jr Univ Bd of Trustees*, 154 Cal App 2d 560, 317 P2d 170 (Cal Ct App 1957).

Minnesota Supreme Cour judgment in the case of *Cornfeldt v Tongen*, 262 NW2d 684 (Minn 1977)

Hawaii Supreme Court judgment in the case of *Carr v Strode,* 79 Hawai'i 475, 904 P2d 489 (1995)

judgment in the case of *Schloendorff v Society of New York Hospital* 105 NE 92 (NY, 1914)

judgment in the case of Salgo v. Leland Stanford. Civ. No. 17045. First Dist., Div. One. Oct. 22, 1957

judgment in the case of *Canterbury v Spence*, 464 F2d 772 (DC Cir 1972)

U.S. Court of Appeals, District of Columbia Circuit, judgment in the case of Canterbury v. Spence (1972) 464 F. 2d 772

US Court of Appeals, District of Columbia judgment in the case of Circuit, Canterbury v. Spence (1972) 464 F. 2d 772.

UK courts decisions

judgment in the case of Barcai v. Betwee, 50 P3d 946 (Haw. 2002), 26 MPDLR 888. 44.

judgment in the case of Moore v. Regents of Univ. of Cal. - 51 Cal. 3d 120, 271 Cal. Rptr. 146, 793 P.2d 479 (1990)

judgment in the case of *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583 TORT T

judgment in the case of *Bolitho v City and Hackney Health Authority* [1998] AC 232,

judgment in the case of *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] AC 871

judgment in the case of *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 T