Information, knowledge and wisdom

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Paul Nisselle explains the importance of ensuring that information provided to a patient has been received and understood, and that whatever decisions the patient makes are properly informed.

'Where is the wisdom we have lost in knowledge; Where is the knowledge we have lost in information?'
T.S. Elliot: The Rock

Less poetically expressed, but more dramatically, the author Robert Theobald has written in many articles that ‘When information doubles, knowledge halves and wisdom quarters’. Transmitting information is one thing; checking to see if it has been absorbed as knowledge is another, and helping patients to make ‘wise’ (for them) decisions requires time and skill (Figure 1).

We tend to forget that the word ‘doctor’ means ‘teacher’, not ‘healer’.

It is not our legal duty to tell every patient everything about a proposed treatment. In the USA, the ‘doctrine of informed consent’ is interpreted as meaning that doctors have a duty to tell every patient, in exhaustive detail, everything known about recommended procedures or treatments, and all alternative treatments. Failure to do so is called in the USA ‘disclosure malpractice’. Elsewhere it is generally referred to as ‘failure of informed consent’ or ‘negligent failure to warn’.

However, it is impossible to tell every patient everything. Judgment is always required to decide what this patient needs to know, to which is added what this patient wants to know. What patients need to know is the what and why and how of the proposed treatment, what alternative treatments are available, why the doctor suggests this treatment rather than any of the others, and what could happen if the patient adopts the ‘null’ option (ie no treatment). What they want to know can be a moveable feast.

In most jurisdictions, two questions must be considered when assessing claimed negligent failure to warn:
- Was the information enough, and appropriately delivered, to preserve the patient’s right to make an autonomous, informed decision?
- Would the patient have done something different if he or she had been warned of a particular risk? (In some jurisdictions, this might apply even if the omitted risk did not occur.)

WAS THE INFORMATION ENOUGH FOR THE PATIENT TO MAKE INFORMED DECISIONS?

In some parts of the world, a ‘Bolam’ defence (named after a 1957 English case), which is also called the ‘peer professional acceptance’ defence, applies to informed consent as much as it does for diagnosis and treatment. As McNair J. wrote in his judgment, '[A doctor] is not guilty of
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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.'

However, when 'How much information is enough?' was considered by the Australian High Court in 1992 (Rogers v. Whitaker), it took a different view. That judgment has been 'cited with approval' in many judgments around the world. Effectively the court said that a judge – a lay person – could not stand in the shoes of the doctor and decide whether the processes of diagnosis and treatment were appropriate, and hence Bolam should apply. However, the judge could stand in the shoes of the patient to decide whether the information provided was 'enough'. Therefore the court in Rogers said peer opinion was not relevant in determining whether the information provided was 'material' or 'relevant' to that patient's decision making.

Without quoting large tracts from the judgment, the following is a three-step summary, noting that all three levels of information are required:

- the reasonable patient test
- the reasonable doctor test
- the particular patient test.

The reasonable patient test
This is all the information that a reasonable person in the position of the patient would think 'material' and 'relevant' to making a decision. This is called an 'objective test' (all patients). The next two are 'subjective tests', applicable to this patient.

The reasonable doctor test
This is any additional information that any reasonable doctor would add, knowing the circumstances of this patient: for example, that he is obese, a heavy smoker or drinker, immunocompromised, or has impaired renal or hepatic function.

The particular patient test
This is any additional information the patient has sought, having been given the opportunity to seek it. Two questions should always end this section:

- Do you have any questions?/Is there anything else you'd like to know?
- Is there anything you don't understand?/Is there anything you'd like me to go through again?

When I was a student, I did two general surgical terms, one in a professorial unit ('gown') and one in a unit headed by a visiting medical officer (VMO; 'town'). As it turned out, both heads of unit gave us tutorials on large bowel obstruction. The VMO talked about three common causes (strangulated hernias, adhesions and carcinomas); four uncommon causes (intussusception, sigmoid volvulus, mesenteric artery thrombosis and gall stone ileus); and then told us to forget them by prevalence. The professor put the causes into perspective, ranking them by prevalence. The professor's approach was academically exhaustive – but provided no perspective. Gall stone ileus ranked equally to carcinoma!

Much the same principle applies to the reasonable doctor test. In essence, a decision to warn of a particular side-effect or complication is made by balancing the frequency with which it occurs against its potential severity when it does occur.

The content of information to satisfy the reasonable doctor test is often provided in handouts drafted by professional societies. Even when written perfectly, providing a handout is not enough, as it addresses only the first of the three tests, and providing written information does not ensure it is acquired as knowledge. There could be a language barrier. The patient may not have the intellectual capacity and maturity both to understand the information you provide and to process it. If not, that does not excuse failure to obtain proper consent. Unless a decision must be made urgently, in which case 'emergency privilege' might apply, you need to obtain a competent interpreter, or an 'alternate decision maker'.

WOULD THE PATIENT HAVE DONE SOMETHING DIFFERENT IF WARNED?
Generally, when someone sues in negligence, they must not only satisfy the court that there was a negligent act or omission, but that the negligence caused a 'damage'. In another Australian case (Rosenberg), the High Court found that even though there was a negligent failure to warn of a possible complication, which later did occur, the patient was so determined to have the operation that she would have agreed to have it, even if she had been warned of that complication. It is called a failed 'but for' test. Causation is present if 'but for' the negligence, the damage would not have occurred. The test must be applied prospectively, in the context of the state of the patient's mind when the treatment or procedure was still being contemplated, not when the patient stands in the witness box and says 'If I had known this was going to happen, I'd never have agreed to have the operation.' Chief Justice Gleeson talked about not applying the 'prism of hindsight', which I interpret as the legal equivalent of that 100 per cent accurate diagnostic instrument, the retrospectoscope.

Rosenberg, unlike Rogers, has not been adopted widely outside Australia. For example, a causation counter argument was not accepted in England in Chester in 2004. While it may be an appealing defence, it cannot be relied upon. It has led to some interesting variants. For example, a patient is not warned about complication A, which does not

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occur. The patient does suffer complication B. He argues that he would not have had the operation at all, or had it at a different time and with a better surgeon, if he had been warned of complication A. Hence complication B was caused by failure to warn of complication A. There is no consensus emerging from judgments dealing with this argument.

Transferring the VMO’s approach to information disclosure, there is clearly some information that is so important or generally applicable that it clearly must be provided to all patients. There is other information you will add in the light of your knowledge of the patient’s past medical and present social and occupational history. Finally, good medical practice requires that you not only check to see that the information you provided has been understood by the patient, but also offer the patient an opportunity to seek such further information or clarification as he wishes.

‘Informed consent’ is very much a legal construct. It invites an approach based on:
- this is what I recommend
- this is what could go wrong
- if you are happy to go ahead, sign here.

A better clinical construct is the concept of ‘shared decision making’. A basic set of premises underscore this construct:
- a patient can request treatment
- a patient can refuse treatment
- a patient cannot demand treatment.

Paternalistic doctors tell patients what they need. They make passive patients very happy. An informative doctor provides information and then gives patients what they want. They make active, assertive patients very happy. Neither of these medical styles is appropriate. Shared decision making is an interactive process.5–7

CONCLUSION

From the above, you can see that it is your task to check that the information you provide is received and understood by the patient, ie that it has been acquired as knowledge. Do you have a duty to ensure or check that your patients make ‘wise’ decisions? Respect for your patients’ autonomy means accepting their right to make their own decisions – good or bad. Your task is to ensure that whatever decisions they make, good or bad, are properly informed.

I will let Justice Benjamin Cardozo have the last word: ‘Every human being of adult years and sound mind has a right to determine what shall be done with his own body.’8

REFERENCES

1. Bolam v. Friern Hospital Management Committee (1957) 1 WLR 582.