

**Patients and Doctors Working Together in Partnership: Birch v UCL  
Hospital NHS Foundation Trust [2008] EWHC 2237 (QB)**

**INTRODUCTION:**

Of the myriad of pressing topics current in medical law and ethics, the issue of informed consent appears to be the 'plainer sibling'. The decision by Cranston J in *Birch v UCL Hospital NHS Foundation Trust* in 2008 has brought into sharp relief that which many commentators already held to be true. Far from being the 'plainer sibling' when weighed against other prominent issues in medical law and ethics, the doctrine of informed consent, is one of the most significant principles to emerge in recent years. The doctrine, aimed at both enabling and empowering patients who have traditionally been largely mute and powerless in the face of medical expertise and authority<sup>1</sup>, places upon clinicians legal and professional obligations regarding informed consent. The doctrine therefore mandates the provision of information upon which patients can fashion their own views and decisions about the nature and manner of their medical care. Informed consent is therefore at the forefront of the patient autonomy movement. And through this movement a general restructuring of the relationship between patient and clinician has taken place. The decision in *Birch* is indicative of the courts increasing willingness to erode clinician autonomy; although it is somewhat questionable as to what extent this erosion has benefited or strengthened patient autonomy in anything more than an illusionary sense.

**BACGROUND**

Mrs Birch suffered a stroke caused by a cerebral catheter angiogram at the defendant's Hospital in 2003. The angiogram was undertaken to exclude the possibility that Mrs Birch had a posterior communicating artery aneurysm, a potentially life-threatening condition. Given her history and presentation, Mrs Birch contended that the defendant Trust was negligent in deciding to

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<sup>1</sup> Katz, J. 1981. Disclosure and consent in psychiatric practice. In *Law and ethics in the practice of psychiatry*, edited by C. K. Hofling, 91-117. New York: Brunner/Mazel.

undertake an angiogram and that the investigation of her condition should have been through the non-invasive method of magnetic resonance imaging (MRI). The claimant also contended that in failing to disclose the comparative risks of the angiogram as compared to the MRI her consent to the procedure was vitiated.

The court was asked to consider whether, in discharging their duty to obtain the informed consent of the claimant, the defendant was simply required to describe the technique and make the claimant aware of the risks associated with the procedure; or alternatively, whether informed consent in fact legally required that the defendant make the patient aware of the different imaging modalities available and also discuss with her their relative strengths and weaknesses in investigating her condition. Dismissing the claimant's first argument, Cranston J went on to find the defendant liable in negligence for their failure to disclose the comparative risks of the cerebral catheter angiogram as compared to the MRI.

**COMMENT:**

Whilst the judgment of Cranford J does not make specific reference to the professional guidelines, it is in the opinion of this author no unhappy accident that updated GMC guidelines on consent had come into force some months earlier. These revised guidelines make specific reference to the disclosure of comparative risks.

*"The potential benefits, risks and burdens, and the likelihood of success, for each option."<sup>2</sup>*

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<sup>2</sup> Paragraph 9(e) Consent: Doctors and Patients Working in Partnership GMC Guidelines 2008

The 2008 GMC guidelines envisage clinicians working in partnership with patients to make treatment decisions.

“You must work in partnership with your patients. You should discuss with them their condition and treatment options in a way they can understand, and respect their right to make decisions about their care. You should see getting their consent as an important part of the process of discussion and decision-making, rather than as something that happens in isolation”<sup>3</sup>

These guidelines are robust, detailed and aspirational in nature, which is of course wholly appropriate for good practice guidelines; after all the law provides the base line below which clinicians should not fall. Yet this author finds herself asking are we not entitled to expect more than mere baseline conformity with regard to clinical disclosure? The profession itself appears to have answered this question in the affirmative, and as such the GMC guidelines create an overriding duty to disclose comparative risks. The decision in Birch appears to finally give this overriding duty a legal footing.

The justification for giving prominence to the issue of the onerous detail of these guidelines, relates to an argument promulgated by Staunch<sup>4</sup>, who submits that it may simply be a matter of time before these diligent and onerous guidelines become transformed via the Bolam test into a legal requirement. This in itself presents no difficulty provided that professional guidelines are always sufficiently calibrated to the clinical reality of modern medical practice. In short they must be reasonably attainable in a resource and time deficient NHS. A failure to calibrate guidelines to such constraints may result in clinicians being judged according to an unattainable legal standard.

Turning back once more to the decision in Birch, the judgment of Cranford J, is - with the greatest respect - ambiguous in one crucial aspect, and that is

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<sup>3</sup> Consent: Doctors and Patients Working in Partnership GMC Guidelines 2008 p04

<sup>4</sup> Staunch, M, 'Causation and confusion in respect of medical non-disclosure: Chester v Afshar (2005) 14 Nott LJ 66:

with reference to *when* a duty to disclose comparative risks will arise: Cranford J glosses over this important issue at paragraph 77 when he states:

“As a matter of law it is difficult to state in general terms when the duty to inform about comparative risk arises. Suffice to say that in my judgment, in the special circumstances of Mrs Birch's case, there was a duty to discuss the comparative risks of the catheter angiography alongside MRI”.

This decision will do little to comfort clinicians already struggling to ascertain what the law requires of them with regard to informed consent. This decision is however, consistent with the chronology of case law, which gradually appears to be eroding clinician autonomy, but, crucially, it is consistent with the professions' own mandate.

## **CONCLUSION**

If we accept that patient autonomy and the right to self-determination are concepts of value and are worthy of protection, the quest for more appropriate legal protection than that which is offered by the law of negligence should not be abandoned. Reform which imposes liability for the dignitary harm caused by interference with the patient's ability to reach an autonomous decision offers promise both in terms of tempering the 'central ambiguity'<sup>5</sup> inherent in non-disclosure claims, and significantly enabling clinicians to practice more safely and effectively through transparency.

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<sup>5</sup> Cane, P, A Warning about Causation (1999) 115 Law Quarterly Review 21-7, 23