

# Missing the Point: Rogers v Whitaker and the Ethical Ideal of Informed and Shared Decision-making

*The High Court's judgment in Rogers v Whitaker (1992) 175 CLR 479 has belatedly recognised as persuasive the values and attitudes of particular patients in what constitutes for them a significant treatment risk. The importance now attached to these subjective patient factors was shown in the High Court's determination that physicians now have a duty to disclose and warn regarding material risks specific to the particular patient. It is our belief that the Rogers v Whitaker emphasis on the requirements for disclosure underscores much of the misinterpretation of consent as a single event or action rather than as an ever-present sequela of a process which informs decision-making. What is required is a shift in focus from disclosure to understanding and from unilateral information-transfer to the integrated process of shared and informed decision-making.*

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Over the years, Australian courts have slowly shaped the requirements for informed consent. Far from being planned and carefully argued changes to medical practice which reflect evolving ethical insights and societal expectations regarding self-determination, they have instead occurred as a result of retrospective legal reviews of doctor-patient conflicts. Since the "landmark" decision of the High Court in the most recent legal conflict, *Rogers v Whitaker*,<sup>1</sup> delivered in November 1992, lawyers have rushed into print numerous commentaries which sought to explain its implications for medical practice,<sup>2</sup> and to reassure practitioners that "no new, unreasonable burden had been placed upon them".<sup>3</sup>

The High Court's judgment, while adding to the mountain of words written about "informed consent", what it means and how it might be achieved, represents yet another instance of a court decision falling short of the law's professed commitment to the value of patient autonomy or self-determination on the one hand, and to the ethical ideal of shared decision-making regarding treatment on the other. On the positive side, current law encourages health care workers to disclose important facts to patients and to seek their consent before treatment occurs. Our scepticism relates to the unlikelihood that expansions of the existing law, based as it usually is on retrospective conflicts, could ever provide an ethically ideal framework which would ensure either respect for patient autonomy or a constructive balance between the rights and values of the patient and the obligations owed by practitioners to the principle of beneficence.<sup>4</sup>

<sup>1</sup> (1992) 175 CLR 479.

<sup>2</sup> I Dunn, "What Should Your Doctor Tell You?" (1993) *Law Institute Journal* 268; R C Pincus, "Has Informed Consent Finally Arrived in Australia?" (1993) 159 *Medical Journal of Australia* 25.

<sup>3</sup> L Skene and R Smallwood, "What Should Doctors Tell Patients?" (1993) 159 *Medical Journal of Australia* 367.

<sup>4</sup> President's Commission For the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, "Informed Consent as Active, Shared Decision-making" in *Making Health Care Decisions* (Government Printing Office, Washington, DC, 1982), Vol 1, p 390 (hereafter President's Commission).

We intend to argue that the current legal requirements for informed consent (following *Rogers v Whitaker*) reflect essentially superficial changes that not only fall short of the ethical ideal of shared and informed decision-making but also serve to reinforce existing problems in the doctor-patient relationship. We preface our argument by a brief look at the history of informed consent before contrasting the post-*Rogers v Whitaker* requirements with both the patient-autonomy perspective and the more ethically desirable perspective of shared and informed decision-making.

### **Informed consent: Historical origins**

The term “informed consent” first arose in North America in 1957<sup>5</sup> and served to shift practitioner emphasis away from medical paternalism towards a “duty” to respect the autonomy of patients. Unlike previous opinions about consent to medical treatment, the *Salgo* court focused on the problem of whether or not the consent had been informed when given. The court created an “informed consent standard” and, contrary to previous practice, the nature, consequences, harm and benefits, risks and alternatives of a treatment on offer were now held to be the information needed by an ordinary patient to make a “reasonable” decision regarding its acceptance or rejection.

The *Salgo* decision did not appear to influence materially the English and Australian courts which favoured the more conservative “*Bolam* test”<sup>6</sup> as enunciated in the 1985 *Sidaway* case.<sup>7</sup> The *Bolam* decision affirmed the duty of care owed by a doctor to a patient to inform them of the risks involved in any proposed procedure or treatment. This duty of care, it was determined, was to be discharged in accordance with the practice accepted at the time as proper by a responsible body of medical opinion and came to be known as the “Professional Practice Standard of Disclosure”. However, in *Sidaway*, it was held that “currently accepted practice” would not override or excuse the non-disclosure of a particular risk of serious adverse consequences to the patient, where it is obvious to the prudent doctor that such disclosure would be necessary if the patient were to make a rational or informed choice as to whether to accept or reject the treatment offered. Failure to do so, it was opined, may provide grounds for negligence. The subsequent dimensions of the requirement for informed consent for everyday procedures continued to be slowly shaped in England and Australia by case law.<sup>8</sup>

### **Rogers v Whitaker: Current legal requirements**

During the 1980s, ethical and legal argument concerning the meaning of “informed consent” continued unabated. Ethically, the struggle was to reconceptualise the decision-making process and to determine how the competing moral imperatives of respect for patient autonomy and beneficence could be balanced and ethically justified. Legally, the focus has primarily been to clarify the requirements for grievance in trespass or negligence on the part of the patient. These requirements, particularly the extent to which information regarding harms and risks should be disclosed to a patient, were examined and

<sup>5</sup> *Salgo v Leland Stanford Jr University Board of Trustees* 317 P 2d 170 (1957) (Cal Dist Ct App).

<sup>6</sup> *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 at 587.

<sup>7</sup> *Sidaway v Board of Governors of Bethlem Royal Hospital* [1985] AC 871 at 893.

<sup>8</sup> *F v The Queen* (1983) 33 SASR 189 per King CJ; *Ellis v Wallsend District Hospital* (1988) Aust Torts Reports 80-259 (Supreme Court) and (1989) Aust Torts Reports 80-289 (Court of Appeal).

further clarified by the High Court of Australia when it handed down its judgment in the *Rogers v Whitaker* appeal.<sup>9</sup> The Court's judgment rejected use of the expression "informed consent" as "apt to mislead", introduced the term "duty of disclosure", and reaffirmed that doctors have a duty to disclose and warn patients of "material risk".<sup>10</sup> Furthermore, the basic duty to disclose was deemed to be present even when the patient does not seek information through specific questions. This was emphasised by Gaudron J when she wrote: "where, for example, no specific inquiry is made, the [doctors'] duty is to provide the information that would reasonably be required by a person in the position of the patient."<sup>11</sup> Gaudron J also pointed out that the duty to disclose or to warn of all material risks was a minimum, not a maximum. She added: "A patient may have special needs or concerns which, if known to the doctor, will indicate that special or additional information is required. In a case of that kind, the information to be provided will depend on the individual patient concerned."<sup>12</sup> Thus, disclosure of information to the patient must now take account of factors associated with the specific needs of the patient, be they wishes, anxieties or beliefs. While the judgment of the High Court has clarified the minimum legal requirements, it is fair to say that, in so doing, the law is only beginning to catch up with current ethical thinking and practice.<sup>13</sup>

The advantages of the High Court's judgment in *Rogers v Whitaker* are several. In general, it will encourage fuller disclosure of information by the doctor. In particular, the doctor is now obliged to be "reasonably aware" of what a specific patient will regard as a significant risk and there will be added pressure to determine special needs for information without which the patient could not make an informed decision. Finally, retrospective statements by the patient regarding failure by the doctor to warn of some treatment-related risk, that would have been perceived by the patient as significant, and which if known, would have led them to refuse treatment, will now be received in evidence and, if persuasive, accepted.<sup>14</sup> The High Court judgment, while moving to give further protection to patients and their interests, did not, however, address the growing complexity of medical procedures which require increasingly difficult decisions by health carers on a daily basis. The High Court's judgment may have tidied up "institutional consent" by ensuring adequate disclosure prior to patient consent, but it neither described nor defined the characteristics of autonomous decision-making.<sup>15</sup>

### Autonomous decision-making

There is no doubt that current understanding of, and requirements for, informed consent owe much to the legal system. Unfortunately, both the law and institutional guidelines for informed consent generally place emphasis on information disclosure, and on consent as an action, an autonomous authorisation, rather than as a process. Although the *Rogers v Whitaker* decision goes some way towards redressing this misinterpretation, as a legal decision which sets out legal standards for doctors in clinical practice, it is neither particularly enlightening nor clinically useful. Although adequate disclosure of risk (which is the central focus of *Rogers v Whitaker*) is essential for

<sup>9</sup> (1992) 175 CLR 479.

<sup>10</sup> R Ottley, "Duty to Warn" (1993) 7 *Australasian Journal of the Medical Defence Union* 43.

<sup>11</sup> (1992) 175 CLR 479 at 493.

<sup>12</sup> *Ibid.*

<sup>13</sup> T L Beauchamp and J F Childress, *Principles of Biomedical Ethics* (Oxford University Press, New York, 1989).

<sup>14</sup> Pincus, *op cit* n 2.

<sup>15</sup> Beauchamp and Childress, *op cit* n 13; J Katz, "Disclosure and Consent: In Search of Their Roots" in A Milunsky and G J Arnas (eds), *Genetics and the Law II* (Plenum Press, New York, 1980), p 122.

informed decision-making, it does not adequately define or describe it. It is well recognised in legal, philosophical, medical and psychological literature that there is a number of components to informed consent, including competence, disclosure, understanding, voluntariness and consent.<sup>16</sup>

Unfortunately this focus of both legal and institutional medical standards on disclosure has led to considerable misunderstanding of consent in the clinical context. Consent is all too commonly regarded as an action (of “consenting a patient”), as synonymous with liability-oriented information disclosure, and as best represented by institutional consent forms. Such an interpretation often leads to a perfunctory approach to consent in the clinical context and reinforces an unsatisfactory, simplistic and unilateral model of information transfer, of physicians talking “at” rather than “with” patients.<sup>17</sup>

What is required is a recognition that consent is not so much an action as a process of shared and informed decision-making, that is, an ongoing and integral part of the therapeutic relationship. In this sense, what is at issue is not so much legal liability or the adequacy and appropriateness of disclosure as the degree of understanding, the quality of the clinical interaction and the process by which decision-making is informed. It is clear that, in providing information, the doctor is not simply meeting legal requirements or institutional standards, or providing value-neutral data, but is participating in a shared dialogue that should be responsive to the needs, wishes, capacities and expressed concerns of that particular patient. Where the process of consent embodies shared decision-making, effective communication and optimal interactional skills, it not only satisfies the legal requirements regarding subjective factors but also optimises informed decision-making. The importance of this cannot be overstated as the clinical relationship between patients and health care professionals involves a continuous flow of decisions focused on the present and future health of the patient. Any set of requirements that makes disclosure the key item or chief precondition for informed consent, incorporates dubious assumptions about medical authority, about physician responsibility, and about legal theories of liability, all of which delineate an *obligation* to make disclosures rather than a *meaning* of informed consent.<sup>18</sup>

### Shared decision-making: The ideal ethical model for clinical practice

The High Court in *Rogers v Whitaker* missed the opportunity to guide practitioners towards what is both ethically ideal and needed:

“a new and unaccustomed dialogue between physicians and their patients . . . in which both, appreciative of their respective inequalities, make a genuine effort to voice and clarify their uncertainties and then to arrive at a mutually satisfying course of action.”<sup>19</sup>

Rather than imposing the legal doctrine of informed consent in the clinical context, consent is best reconceptualised as a process of shared and informed decision-making.

<sup>16</sup> Beauchamp and Childress, op cit n 13; Katz, op cit n 15; C W Lidz, R S Appelbaum and A Meisel, “Two Models of Implementing Informed Consent” (1989) 148 *Archives of Internal Medicine* 1385; G J Riley and R L Simmonds, “Informed Consent in Modern Medical Practice” (1992) 152 *Medical Journal of Australia* 336.

<sup>17</sup> President’s Commission, op cit n 4.

<sup>18</sup> Katz, op cit n 15; Lidz et al, op cit n 16; Riley and Simmonds, op cit n 16.

<sup>19</sup> President’s Commission, op cit n 4.

The central focus of shared decision-making is that the autonomy and interests of the patient should guide clinical management. It is preferable to using consent, or the disclosure of information, as the central focus of the clinical relationship, because it avoids a simplistic physician-patient division of labour and the separation between "facts" and information on the one hand (doctor's role), and preferences, choices or beliefs on the other (patient's role).<sup>20</sup> The concept of shared and informed decision-making recognises that physicians are not simply value-neutral providers of facts regarding diagnosis, prognosis and treatment alternatives but are independent moral agents with well-defined professional roles. When physicians talk with patients, present information to them, give advice or encourage compliance, they are expressing, explicitly and implicitly, their own values and beliefs in relation to health, disease and their role as an advocate for the patients' health.<sup>21</sup> Thus, the physician cannot be entirely ethically neutral about the values implicit in choices made by patients regarding treatment, even when the patient is clearly competent.

### *Physician as advocate*

We believe physicians are correct in seeing themselves as advocates for their patients' health. Of necessity, physicians in their role as medical professionals are committed to preserving, promoting and restoring health and preventing and treating disease. This advocacy, however, must be seen as limited by respect for the self-determination of competent patients. It is this interest of patients in making important decisions about their own lives that requires physicians to respect and not to interfere with patients' treatment choices, even if those choices will be bad for them. If a patient's decision-making capacities are sufficiently defective to warrant a determination that he or she is incompetent to decide for himself or herself, a surrogate must make the decisions. The two values of patient well-being and self-determination together require a balancing of the physician's role between value-committed advocacy for the patient's health and a willingness to accept a choice that fails optimally to secure the patient's health. Shared decision-making does not imply a value-neutral role for physicians; it requires of them a more delicate balancing. They must act as advocate for their patients' health and well-being, while also being prepared ultimately to respect patients' self-determination, even when they disagree with their patients' treatment choices.<sup>22</sup> This altruistic commitment of physicians to their patients' interests, and the setting aside of the interests of all others, including their own, is the most striking characteristic of medical practice.

Decision-making is unavoidably shared because each participant brings to the therapeutic relationship their own beliefs, values, perspectives and knowledge in a way that defines the very particular nature of that interaction. Shared decision-making implies a complex recursive relationship that may involve counselling, education, significant personal interaction or clinical disagreement. It is a deeply contextual process responsive to the desires, needs, wishes and capacities of the patient.<sup>23</sup> For example, one patient may request

<sup>20</sup> R M Veatch, "Models for Ethical Medicine in a Revolutionary Age" (1972) 2 *Hastings Center Report* 5.

<sup>21</sup> D W Brock, "Shared Decision-making" (1991) 1 *Kennedy Institute Ethics Journal* 28.

<sup>22</sup> R Sherlock, "Reasonable Men and Sick Human Beings" (1986) 80 *American Medicine* 47.

<sup>23</sup> *Ibid.*

extremely detailed information about alternative therapies or prefer to maintain a “distance” from their physician, making decisions in isolation, whereas another may autonomously authorise their physician to make decisions about medical treatment for them. Indeed, it is not infrequently the case that sick but not incompetent patients wish to put their treatment in the hands of physicians they can trust. Ethical clinical practice demands much more of the physician than a superficial recognition of patient self-determination. What is needed is a recognition that a professional commitment to the patient’s health and well-being (and the underlying principles of beneficence and non-maleficence) may determine the manner and extent to which the physician should respond to and serve the patient’s wishes and desires. This does not suggest that the process of shared decision-making undermines patient autonomy; rather it simply recognises first, that there exists a number of ethical principles underlying therapeutics (that is, autonomy, beneficence, non-maleficence, justice) and that these may occasionally come into conflict,<sup>24</sup> and secondly, that physicians, as moral agents, act in part as advocates for their patients’ health, this role being framed in reference to the competent patient’s autonomy or self-determination.

## Conclusion

By shifting the focus of consent from the doctor or hypothetical “reasonable patient” to the individual patient, the *Rogers v Whitaker* decision goes some way toward the ethical ideal. However, by maintaining an emphasis on the requirements for disclosure rather than understanding, communication skills and the interpersonal relationship that exists between health care professionals and patients, *Rogers v Whitaker* ultimately fails to address the central core of ethical decision-making in clinical practice. Although consent is in its simplest sense an action, an authorisation of a medical intervention, in a much deeper, more pervasive sense it is an integral and continuing part of the daily process of shared and informed decision-making embedded in the clinical context. When seen in this light, the important thing may be not so much the elucidation of legal standards of disclosure, or patient self-determination and the development of institutional guidelines for consent, but better teaching of interactional and communication skills to health care professionals.

<sup>24</sup> Beauchamp and Childress, op cit  
n 13.