How much is too much information?
The dose response curve of informed consent

“While the over-informed person is inconvenienced, the under-informed has his/her autonomy violated.” – United States Medical Ethicist, Robert Veatch.

“A patient may make an unbalanced judgment because he is deprived of adequate information. A patient may also make an unbalanced judgment if he is provided with too much information and is made aware of possibilities which he is not capable of assessing because of his lack of medical training, his prejudices or his personality.” - Lord Templeman in Sidaway[1] (1985)).

It has now been 25 years since the High Court of Australia[2] decided the case of Mrs Whitaker – the unfortunate lady who developed sympathetic ophthalmia in her left eye following an operation on her right eye. The High Court held that the surgeon, Dr Rogers, was liable for failing to warn Mrs Whitaker specifically about this rare, but devastating, risk of the procedure.

And so, it became established law in Australia that a medical practitioner has a duty to inform a patient of material risks inherent in treatment, so that the patient can make an informed decision about whether to undergo the treatment. This obligation has since been restated – and reworded – in legislation[3], professional standards[4] and government policy[5].
A risk will be material if a reasonable person in the patient’s position would be likely to attach significance to the risk. It will also be material if the medical practitioner knows, or should reasonably be aware, that the particular patient is likely to attach significance to the risk.

However, the concept of informed consent goes beyond the obligation to warn of the risks of a proposed treatment. Truly informed consent to medical treatment involves a two-way discussion between doctor and patient of all of the information reasonably necessary for the particular patient to make an informed decision about the treatment.

How much information?

The Clinical Excellence Division of Queensland Health has published comprehensive guidelines[6] about the information that should be provided to patients or decision makers so that they can make an informed decision.

The list of information is long and is set out at the end of this article. It includes information about the condition, the proposed treatment, alternatives, and the potential risk and benefits of all options.

Scrolling through the list, it is hard to dispute that the information listed is important. Some issues will be more important to one patient than another. The consenting practitioner is expected to identify these individual differences and tailor the information accordingly[7].

The amount of information required varies depending on the circumstances. Generally a greater level of detail and discussion is expected for complex interventions, treatment involving greater risk or uncertainty, and elective or cosmetic procedures.
The courts have also considered the types of information that is required for informed consent, finding that the patient should be advised about factors impacting the nature and character of the act to be performed. In some situations, the courts have held that this includes the identity of the surgeon that will be performing a procedure - read *Consent to surgery - who will be my surgeon?* here. Commentators suggest that this may also extend to disclosing performance data in certain circumstances[8].

**Too much information!**

Hospital based clinicians may feel a degree of apprehension when considering these requirements. How does this obligation sit with the practical reality of a busy hospital? Time - especially that of the most experienced clinicians who are best placed to meet the information requirements - is at a premium.

Also, there seems to be a real risk of information overload. There are a number of factors that can limit the amount of information that a patient can take in. These include:

- Patient specific factors, such as language and education levels.
- Cultural factors. In some cultures, providing too much or too explicit information can be detrimental. For example, it has been suggested that in “high context” Spanish and Arabic speaking cultures providing too much information during the consenting process can paradoxically cause the patient to suspect that the doctor is withholding information.[9]
- Psychological factors during the consultation, including the impact of stress and emotion on the patient’s capacity for comprehension and memory. A patient’s willingness to ask questions may be impacted by deference to the doctor, or by not wanting to appear ignorant.
- The manner in which the information is presented. Even an educated and intelligent patient may struggle to absorb pages of printed text, particularly if medical terms are not clearly explained.
- Timing and context. Patients need time to process and weigh up options for what can potentially be a life changing decision. The issues presented when a patient is consented for a procedure on the trolley outside the operating theatre need little explanation.
- The ability of the consenting doctor to answer questions or anticipate areas of concern. As a matter of resources, the consenting process can often be
delegated to the more junior doctors. The consenting doctor may or may not have performed the relevant procedure before.

- Individual doctor factors. Currently, the amount and nature of information provided can vary considerably depending on the doctor. Discussions may be influenced by physician bias, including an unconscious bias toward providing a particular treatment (rather than doing nothing) [10], or concerns about limiting information about risk to avoid “putting the patient off” undergoing a procedure.

The answer?

Effective communication is the key. Informed consent requires a two-way process as the information must be tailored to the particular patient’s circumstances, and the patient’s understanding should be confirmed.

It has been suggested that genuine consent is apparent where patients can control the amount of information they receive [11] - enabling them to focus on the aspects that are important to them, and to avoid information overload.

If this sounds like a Utopian concept, consider the age that we live in. Technology is used in many areas of modern life to present information in clear and interactive ways, and to facilitate communication where time and physical location previously were barriers. It may not be long before the traditional pitfalls of the consenting process are a thing of the past.

The Clinical Excellence Division, Queensland Health, recommends that the following minimum level of information be provided in order to obtain informed consent:

- The possible or likely nature of the patient’s condition (diagnosis and prognosis)
- The degree of uncertainty about the diagnosis and prognosis, and whether any other investigations may reduce this
- The options for investigation, management and treatment, and for each option:
  - What the proposed health care involves including its purpose, nature and complexity
  - Potential benefits and likelihood of success
  - The potential complications, risks, long and short-term side effects, including when a potential adverse outcome is:
    - Common even though the harm is slight
- Significant even though its occurrence is rare
  - Other consequences, such as any significant long term physical, emotional, mental, social, sexual, or other outcome which may be associated with a proposed intervention
  - The degree of uncertainty about the therapeutic outcome, including whether the intervention is unconventional, experimental or part of a research program
  - The time involved in the health care, the recovery period and likely time the patient’s function will be restricted
  - The need for follow up
- The likely consequences of not choosing the proposed intervention or health care
- The people who will be mainly responsible for and involved in their care and what their roles are
- The extent that trainee/student health practitioners may be involved in their health care, and that they have a right to decline to take party in teaching or research
- Their right to seek a second opinion
- Any conflicts of interests for the practitioner or the organisation
- Any bills or known out-of-pocket expenses they will have to pay

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