

L.2 The use to be made of various categories of data

5.7 In 1984, no mention was made in the BMA guidance of the importance of providing any particular data to patients or parents. The paragraph entitled "communication" from the 1984 guidance makes clear that doctors should answer questions unambiguously but again leaves open how much information doctors should volunteer if no question is posed. It states that side effects should be explained "where appropriate" but again evaluation of appropriateness would have been considered to fall within clinical discretion.

5.8 Even now, the BMA does not specify the particular categories of data which should be discussed with patients or parents. Indeed, the Association would avoid doing so precisely because it would expect doctors to tailor the scope of the information they provide to the patients/parents' requirements. The graver the decision and the riskier the procedure, the greater the need for well informed consent to be provided. Nevertheless, patient or parental consent never absolves the doctor from the responsibility of ensuring that all reasonable steps are taken to reduce risk and that the proposed procedure is more likely to benefit than harm the patient. The BMA expects doctors to base their recommendations for treatment on the most reliable evidence available about benefit and there is a clear expectation in the BMA's 1993 advice that doctors should not conceal any piece of information materially relevant to the patient's decision.

L.3 The nature of a surgeon's obligation to refer to specific factors such as outcomes data

5.9 This was not an issue for discussion in 1984. A not uncommon argument during the period (although not one endorsed by the BMA) was that doctors had moral obligations to promote hope of recovery. In the 1993 version of its advice, the BMA noted that a past concern of doctors had been to avoid worrying patients and that historically this had led to a reluctance to

tell them the full implications of an illness or the different options for treatment. While the Association assumed that this approach was increasingly being seen as outdated by 1993, it noted a continuing reluctance on the part of some doctors to discuss uncertainties in medicine. It is very likely that this idea about the duty for beneficence was interpreted by some members of the profession as a justification for not discussing risk, despite the ever-increasing emphasis placed by courts and by professional guidance on informed consent. In addition at the beginning of the period in question, it is possible that some doctors were discouraged from drawing comparisons with outcomes from other colleagues or other facilities because of a perception that this could potentially undermine patient confidence or risk improper disparagement of colleagues. Hopefully such attitudes would have been uncommon by the 1990s when greater awareness was developing about the duties to audit outcomes and whistle-blow on substandard practice.