

Law of consent in healthcare

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Citation: Cox C (2016) Law of consent in healthcare. *Diabetes & Primary Care* 18: 174–8

Article points

1. It is a fundamental principle of health law that a healthcare professional cannot treat an individual if that person has not given consent.
2. According to the Mental Capacity Act, 2007, a person aged 16 years and above is presumed to have the capacity to consent to medical treatment.
3. When an adult lacks capacity to make a decision, then the Mental Capacity Act provides a legal framework for decision-making. You can provide treatment necessary for the preservation or improvement of health to an incapable person, provided that it is in the person's "best interests".

Key words

- Competency
- Consent
- Healthcare interventions
- Legal issues

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It is a fundamental principle of health law, as well as being at the heart of medical and nursing ethics, that you cannot treat an individual unless you have obtained their consent. This principle applies irrespective of how old the person is, although special rules apply to people under 16 years. If the adult patient refuses their consent then, provided that they are mentally competent, you cannot treat them, even if this may cause the person lasting, preventable health damage, or even death. This article summarises the law of consent and the role of competency in consenting to medical treatment.

When I first started practising healthcare law almost 25 years ago, some nurses I encountered seemed to think that the law on consent was only relevant to their medical colleagues. But this was a mistake, because the patient's consent is required for all healthcare interventions, whether undertaken by nurses, medical practitioners, healthcare support workers, physiotherapists and so on.

Another misconception, at that time, was that it was a signature on a piece of paper, often described as a "consent form", that was critical to demonstrate that a person had consented to the treatment. However, in the absence of a valid legal consent, the signature and paper are irrelevant. A written document is helpful evidence, but it does not prove that the individual consented. If there are later doubts that the person was competent, or that consent was given without duress, or that they were properly informed about the treatment, side effects and alternative treatments, then the paper is worthless.

Consent may be given both expressly, either orally or in writing, and impliedly, from the actions of the individual (for example, she rolls up her sleeve when attending the practice nurse, presenting her arm for an injection).

In the following article, I want to explore the answers to a number of questions:

1. When is consent unnecessary?
2. Who is competent to consent to medical treatment?

3. What constitutes a valid consent in law?
4. What information should be disclosed to the patient in order for them to give a valid consent?

Before offering some answers, I should make three further preliminary observations. First, even if a patient desires, and is able to consent to treatment, there is generally no legal obligation on a healthcare professional to offer treatment that the professional does not consider to be in the patient's best interests. You cannot be forced to provide treatment that you believe to be ineffective or harmful, no matter what the person thinks or demands.

Second, I am sometimes asked how long does a consent last? Clearly, consent is for some future event, which may be immediate (such as an injection), or some weeks or months ahead. The consent will generally be presumed to last until the procedure is performed, unless the patient subsequently withdraws consent, or there is a material change in circumstances, such that a fresh consent is required. If in doubt, seek a fresh consent.

Finally, there is separate legislation on capacity and consent in Scotland, and if you are practising in that country you should check the legal position. Having said that, the legal principles are broadly similar, save for principles in respect of children and young people. This article addresses the law in England and Wales.

Assessing capacity to consent

According to the Mental Capacity Act (MCA), 2005 a person aged 16 years and above is presumed to have the capacity to consent to medical treatment. You can generally assume that such a person is capable unless, for example, there is anything in their presentation that raises a doubt about their capacity, in which case you should investigate further. It may be prudent to get a second opinion, if you have continuing concerns.

The test for capacity is in two stages, set out in sections 2 and 3 of the MCA. First, a person is unable to make a decision if they are unable to:

1. Understand the information relevant to the decision.
2. Retain that information.
3. Use or weigh that information as part of the decision-making process.
4. Communicate their decision (the “functional test”).

Second, a person can only lack capacity where there is a “temporary or permanent impairment of, or disturbance in the functioning of, the person’s mind or brain and that impairment or disturbance is sufficient to render the person incapable of making a decision for himself” (the “diagnostic test”). Examples of such impairment or disturbance may include dementia, mental illness, brain injury, significant learning disability and drug or alcohol misuse.

Never assume that someone lacks capacity because of their age, appearance, or because of their condition or an aspect of their behaviour. Always judge capacity in relation to the particular decision that needs to be made. In other words, a person may lack capacity to make a decision about some complex drug or surgical intervention, but at the same time be quite capable of making a decision about more straightforward intervention, such as routine dental treatment.

Considering the patient’s best interests

When an adult lacks capacity to make a decision, then the MCA provides a legal framework for decision-making. You can provide treatment necessary to the preservation or improvement of

health to an incapable person, provided that it is in the person’s “best interests”. Section 4 of the MCA sets out a detailed framework for assessing best interests, but it should be noted that there is no single test. In particular:

1. All “relevant circumstances” must be taken into account. These will vary with each case, but may include the previously expressed view of the patient, their religious beliefs and values. It is important to consider what issues are particularly important to the person concerned.
2. All reasonable steps must be taken to encourage and enable the person to participate in the decision-making. You must take all practical steps to help the person to make a capable decision about their treatment. This may mean, in the case of temporary incapacity, that you need to delay treatment and/or take some active steps to enable a restoration of capacity.

So far as another adult making a decision on behalf of an incapable person is concerned, only those with a Lasting Power of Attorney (LPA), or those appointed by the court specifically for this purpose, have the power in law to consent to or refuse treatment on behalf of another adult. This is important because the families of incapable adults often, wrongly, think that they can make decisions on behalf of an incapable adult family member. The MCA, however, requires healthcare professionals to take into account (which is not the same as to comply with), if practicable and appropriate, the views of anyone caring for the person concerned, or interested in her welfare, or anyone named by the incapable adult as someone to be consulted about such a decision. This is particularly where the evidence of that person may inform the healthcare professional about the incapable adult’s previously expressed views, beliefs and values.

The MCA Code of Practice provides detailed guidance on the assessment of best interests. As will be apparent from what has already been said, best interests are not limited to best “medical” interests. Consent is then generally unnecessary when a person lacks capacity, temporarily or permanently, and treatment is necessary to

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1. You can generally assume that a person is capable of consenting to medical treatment unless, for example, there is anything in their presentation that raises a doubt about their capacity, in which case you should investigate further.
2. A person is unable to make a decision if they are unable to understand the information relevant to the decision and retain that information, use or weigh that information as part of the process of making the decision and finally, communicate the decision.
3. When an adult lacks capacity to make a decision, you can provide treatment necessary to the preservation or improvement of health to an incapable person, provided that it is in the person’s “best interests”.

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1. Between 16 and 18 years, a child in England and Wales has been able to consent to medical treatment since 1969, provided that they have capacity as if they are an adult.
2. Children under 16 years can also consent to treatment so long as they are able to understand the general nature and effect of what is proposed and, as with adults, are able to balance the factors for and against treatment. Capacity in these circumstances means that the child is able to consent even if the parents object.
3. Children under 16 years without capacity may be treated with the consent of those with parental responsibility, or with the agreement of the courts.

safeguard or improve health, and is in the adult person’s best interests.

As with all healthcare interventions, a proper written note of the assessment of a person’s capacity, and the subsequent actions taken by the healthcare professional, is critical. Consent is also unnecessary in relation to certain treatments under the Mental Health Act, 1983 (section 63) for persons detained under that Act. However, note that those treatments are intended to alleviate or prevent a worsening of the mental disorder, or one or more symptoms or manifestations of the disorder, giving rise to the compulsory detention. Physical health problems may only be treated without consent if they are part of, or ancillary to, the treatment for mental disorder (for example, treatment for self-starvation or self-inflicted wounds). Consent for other types of physical health problem must be in accordance with the general legal principles described above.

Consent in children

Between 16 and 18 years, a child in England and Wales has been able to consent to medical treatment since 1969, provided that they have capacity as if they are an adult. Is someone under the age of 16 years able to consent to medical treatment? In my experience, I have found that this is an area where there is often uncertainty among both healthcare professionals and parents. Since 1985 (*Gillick v West Norfolk and Wisbech AHA* [1985] 3 All ER 402) the law has recognised that a child (under 16 years) can consent to medical treatment, even if those with parental responsibility are unable or unwilling to give their consent, provided that they have sufficient maturity and understanding to take a decision, in accordance with the seriousness of that decision. So long as the child is able to understand the general nature and effect of what is proposed and, as with adults (as described above) is able to balance the factors for and against treatment, they are able to consent. Depending on the nature of the treatment, the level of mental ability of the child concerned may vary. For example, the more serious the decision and consequences of receiving or declining the treatment, the higher the level of cognitive ability

expected of the child.

Capacity in these circumstances means that the child is able to consent even if the parents object. It is, however, prudent to exercise some caution in a situation of dispute and ultimately it may be sensible to seek the assistance of the court where the differences are intractable and a decision either way is likely to cause lasting damage to family relations.

Where a child with capacity to consent to medical treatment refuses treatment, the law allows either those with parental responsibility or the courts to override the decision of the child and impose treatment. This may strike some readers as odd (and the legal position in Scotland is different here), given that the child is able to consent to the treatment, by demonstrating sufficient intelligence and understanding. However, the closer the child is to 18 years, the more weight the courts will undoubtedly give to the wishes of the young person and the current state of the law may be open to challenge in the light of human rights legislation.

Children under 16 years without capacity may be treated with the consent of those with parental responsibility, or with the agreement of the courts. Where a parent refuses to consent to treatment which, in the opinion of the healthcare professionals, is in the child’s best interests, the courts may override the parent’s decision.

To summarise so far:

1. A person aged 16 years or over is presumed to be competent to consent to medical treatment.
2. A child under 16 years may be competent to consent to medical treatment, so long as they have sufficient intelligence and understanding.
3. A competent adult (those 18 years and above) may refuse treatment, even if the healthcare professional believes that medical intervention is necessary to safeguard or maintain health.
4. An incompetent adult may be treated lawfully in accordance with the provisions of the MCA, generally where it is in their “best interest”.
5. A person under 18 years (in England and Wales), even if competent to consent to medical treatment, may not withhold their consent to treatment, which may be overridden by either those with parental

responsibility or the courts.

6. Whatever decision you make about an individual's mental capacity to consent to medical treatment, and the subsequent actions you take as a result, it is critical to record your investigations into capacity and consequential decision in healthcare records.

Lawful consent to medical treatment

If your patient is competent, in what circumstances will their apparent assent to medical treatment be lawful? There are two critical further conditions for a valid consent. First, the person's consent must not have been obtained through any fundamental deception on the part of the healthcare professional, such as to the nature of the treatment to be provided, or the identity of the professional, and the individual's consent must have been made of their own free will. For example, when a person is particularly vulnerable to the influences of a third party, the healthcare professional should proceed with caution if it is thought that the consent (or withholding of consent) is made under some form of duress.

It is not always easy to determine whether a person's free will to decide has been overborne to such a degree as to amount to duress or undue influence. Of course people will invite and/or receive advice from family members, partners, close friends and others, and this is natural and wholly acceptable. An individual may have needed some persuading from a loved one to proceed with the treatment. The critical question for the healthcare professional, however, is to ask whether the person "really means what they say" or, perhaps given extraneous factors, such as fatigue, pain or depression, there is evidence that they may be overborne by another.

The second condition for a valid consent, and one which has assumed more significance in the light of recent case law, is whether the individual received sufficient information about the treatment, the possible side effects and alternative treatment options, so that consent was properly "informed".

When a patient has asked a specific question about the treatment they are always entitled to a full and honest reply. However, in deciding what

advice or information should be disclosed to a patient, until recently the courts have erred on the side of "paternalism", which is the traditional test for negligence in health care. In other words, was the information disclosed by the healthcare professional acceptable to a responsible, reasonable body of relevant professional (often medical) opinion?

The contrast to this approach would be to ask the question: "What would be acceptable to a reasonable person in the position of this particular patient?" In many instances the outcome would be the same. For example, if the risk of a serious, unwanted side effect is 20%, then both the reasonable healthcare professional and reasonable patient would presumably believe that the risk should be disclosed. However, when the risk is very low and the healthcare professional is anxious not to discourage the patient from receiving the treatment, would the outcome be the same, applying both tests?

This issue has recently been addressed by the Supreme Court in *Montgomery v Lanarkshire Health Board* (2015). Ms Montgomery gave birth to a baby with severe disabilities, as a result of complications during the delivery. She argued that her consultant obstetrician/gynaecologist was negligent in failing to advise her of the known risks associated with a natural birth, and the alternative of a caesarean section, given her small stature and diabetes. In both the Scottish Court of Session and the Inner House, she lost, but the Supreme Court allowed her appeal.

In the context of advice given to patients, the Supreme Court rejected the paternalism of the test that is used to decide liability in clinical negligence in diagnosis and treatment. Patients should be treated as adults, capable of understanding risks and of accepting responsibility for choices. The duty on the healthcare professional is to take reasonable care to ensure that a patient is aware of material risks of injury and of any reasonable alternative treatment. Would a reasonable person in the patient's position be likely to attach significance to the risk? If so, it is material.

To summarise so far, the elements of a valid consent in law are that:

1. The patient is legally competent.
2. The patient is suitably informed.

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“The Lasting Power of Attorney (personal welfare) can be used by someone aged 18 years or over to appoint another adult to make certain decisions on their behalf, once they have lost the capacity to make such a decision.”

3. The patient’s consent is freely given.

Lasting Power of Attorney and Advance Decisions

Finally, I should mention two ways in which adult patients may either appoint someone to make a decision on their behalf, or may refuse specified medical treatment at some point in the future, when they lack capacity to consent to that treatment.

The Lasting Power of Attorney (personal welfare) can be used by someone aged 18 years or over to appoint another adult to make certain decisions on their behalf, once they have lost the capacity to make such a decision. The LPA must be registered and the Court of Protection has extensive powers to determine questions and

give directions as to the meaning and effect of an LPA.

Advance Decisions allow someone with capacity to refuse future specified treatment. It will have the same effect as if the maker of the decision had capacity at the relevant time when the decision is required. It may be oral or written, and guidance is given in the MCA Code of Practice.

In conclusion, for any healthcare professional, a clear understanding of the principles of the law on consent, is a critical prerequisite to treatment. ■

Acknowledgement

This article has been modified from one previously published in the *Journal of Diabetes Nursing* (2015, **19**: 314–7).