Consent

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Abstract

Morally, 'consent' allows an autonomous patient to determine what treatments they will accept or refuse. The law relating to medical consent protects such self-determination, and allows for treatment decisions to be made for patients who cannot decide for themselves. Consent is valid if it is given voluntarily by a competent patient and is based on the information provided to them. Information is provided about what is to be done and why, and what the foreseeable risks and consequences of treatment are. The onus is on the clinician to explain material risks that are significant to the patient. Competent patients understand, remember and use the information provided to them to either consent to, or refuse, treatment. Patients lacking capacity are protected by The Mental Capacity Act 2005, which obliges that medical treatment decisions made by third parties (doctors, defined proxies or the courts) to be both necessary and in the patient's best interests, in the absence of a valid advance directive. Consent relating to children, pregnant women, the mentally ill, emergencies and teaching requires special consideration.

Keywords Ethics; informed consent; mental capacity; montgomery ruling

Royal College of Anaesthetists CPD Matrix: 1F01; 1F05

Learning objectives

After reading this article, you should be able to:

- explain the central importance of consent in providing patient-centred care
- describe the legal frameworks and provisions relating to consent for medical treatment
- describe how to proceed when obtaining consent is not straightforward

The process of consent enables patients to indicate which treatments they are willing to accept from their anaesthetist, protecting patients against medical paternalism. It has evolved to become one of the cornerstones of modern medical practice and is fundamental to the practice of patient-centred care and maintenance of patient autonomy. Society has continuously reinforced the importance of such protections through the development of common (judge-made) and statutory (government-made) laws relating to consent,[1] such that if a treatment is administered to a patient without their consent, the anaesthetist is liable in battery and assault. Legal sanctions, including awards of damages and in severe cases imprisonment, are used to ensure that patient autonomy is respected and that treatment is in the patient's best interest. The recent Montgomery ruling represents the most significant legal change to medical consent in recent decades, and has significant implications for the anaesthetist.

Ethics

Patients and anaesthetists usually agree about the best course of medical treatment. However, problems can occur when there is disagreement, for example when a patient rejects advice about what is medically in their best interests (for example when a patient with severe chest disease refuses spinal anaesthesia for fixation of a hip fracture).

In these instances, proponents of patient autonomy emphasize the importance of letting the autonomous patient decide, by asserting that while the clinician can judge what is medically in the patient's best interests, only the patient can decide what is in their overall best interest. This will be explored further later in the article.

It has been argued that the patient can never be more than partially autonomous in a medical setting, as a result of their disease or illness, treatment or dependency on treatment, or their reliance on others for information. Furthermore, patients who are otherwise autonomous may waive their autonomy by asking their anaesthetist to decide for them, or by refusing to listen to information given during the consent process. Some patients do not possess autonomy, because they do not have the capacity to understand, retain or act on information given to them. Patients may be temporarily or permanently unconscious. Children are generally considered unable to decide on whether to consent to medical treatment, unless it can be proved otherwise. Patients with mental illness may transiently or permanently be incapable of making decisions relating to medical treatment. In these cases, responsibility for deciding what treatment (if any) is in the patient's best interests is devolved to a third party.

This process is necessarily paternalistic, but achieves the best outcome for the patient provided that the decision-maker acts beneficently (i.e. optimizes patient benefit), non-maleficently (i.e. avoids patient harm) and justly (i.e. authorizes treatment that they themselves would be happy to accept under similar circumstances).

Law

The law relating to consent allows an individual to define and protect their own interests and to control bodily privacy. If consent is not obtained prior to carrying out a medical procedure, the doctor can be liable in various ways:

- for clinical negligence in depriving the patient an opportunity to decline to undergo a particular procedure at a particular time
- for the civil wrong of battery

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- for the criminal offence of battery.

For consent to be valid, it needs to meet three main requirements. Firstly, consent must be given **voluntarily.** Secondly, it must be given by a patient who is **appropriately informed.** Thirdly, it must be given by a patient with the requisite **capacity** to exercise an informed choice. It is important to note that obtaining a patient's consent is not the same as having a patient sign a consent form, although a written, countersigned consent form provides important evidence if consent is disputed in court.

Consent must be voluntary

This can be affected by a wide range of influences perioperatively, including family or religious considerations, the necessity and urgency of treatment, or the status of patients detained on psychiatric grounds.

In practice, this is rarely an issue in legal determinations of consent. The leading English case remains that of Re T,[2] in which a Court of Appeal upheld the lower court's decision to allow the transfusion of blood to a critically ill Jehovah's Witness, on the grounds that she had been unduly persuaded by her mother to refuse transfusion on religious grounds.

The patient must be appropriately informed

A doctor who wishes to provide treatment to a patient must ensure that the patient has been given sufficient information regarding the nature and purpose of the treatment. For a patient to prove that they have not been appropriately informed, they must be able to prove that the doctor failed to provide them with information regarding the risks and consequences of the treatment, and that this led to the patient making a treatment decision that they would have otherwise avoided.

The recent Montgomery ruling by the Supreme Court,[3] in which it was judged that information about the risk of shoulder dystocia during labour and subsequent risk of cerebral palsy had been inappropriately withheld from the patient, thereby depriving the patient of the opportunity to decide to deliver by Caesarean section, represents a significant change to the way in which court cases involving consent for medical treatment will be determined.

Prior to this ruling, in deciding if the nature and extent of discussion of risk with a patient had been sufficient, the courts followed the approach of Sidaway[4] in applying the Bolam test, namely, if the doctor had acted in accordance with a practice accepted as proper by a body of responsible and skilled medical opinion.

The Supreme Court ruling represents a departure from this principle, and makes clear that responsibility for determining the nature and extent of a patient's rights – specifically, the right of a patient to be informed of risks and alternative treatment options – lies with the courts. In reaching this decision, whilst it was acknowledged that effective explanation of risk to patients is a matter requiring medical skill, the question of whether a particular risk or alternative treatment ought to be discussed with a patient was not deemed to be a matter of purely professional judgement.

It is important to note that this ruling enshrines in law principles already advocated by the General Medical Council in published guidance on consent.[5] It is reflective of the broader change in medical practice, where patients have transitioned from being passive recipients of care to shared decision-makers.

Practically speaking, it is the anaesthetist's responsibility to ensure that patients are informed of any 'material' risk prior to accepting treatment. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.

Risks that are common but relatively trivial (such as postoperative nausea and vomiting) should always be communicated to the patient. Risks that are rare, but with more profound consequence (such as paraplegia after central neuraxial blockade) should also be discussed. In the above examples, it is assumed that all patients would attach significance to the risk on account of their frequency or gravity respectively.

The significance of a given risk may vary between patients, and so it is important to establish a dialogue with the patient in order to gain an impression of the significance that they would be likely to attach to a given risk. For example, an opera singer would be likely to find the risk of vocal cord damage following endotracheal intubation significant, and so this should be discussed preoperatively.

In handing down the decision in the Montgomery case, the Court noted that the patient had expressed concerns over her ability to deliver the baby vaginally, but despite this, had not been given information regarding the risks of a vaginal delivery. It is important for the anaesthetist to be sensitive to patient concerns, and if anxieties of any nature are expressed, exploration of these concerns is mandated.

The 'therapeutic exception' allows the anaesthetist to withhold information from the patient when it is deemed that disclosure would be seriously detrimental to a patient's health. The Court was careful to point out that this should not be used to subvert the entire process (for example by withholding information which may make merely make the patient upset) and should only be used sparingly.

Importance of capacity

For consent to be valid, the patient must have capacity to consent or refuse treatment. Since October 1st 2007, the relevant legal provisions are contained in the Mental Capacity Act 2005 (the MCA).

The MCA aims to 'empower and protect people who cannot make decisions for themselves' by clarifying the law concerning decision-making by others on behalf of mentally incapacitated adults.

The MCA is founded on five basic principles, which imply three broad concepts.[6]

- First, adults (anyone over the age of 16 years) should be assumed to be competent to make decisions about their treatment unless they are obviously unable to make a decision when they are required to do so, such that they lack the ability to understand, retain or use the information given to them.
- Second, patients should always be given a reasonable chance to demonstrate that they have capacity. This can

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