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 must be provided about what is to be done and why, and what the foreseeable risks and consequences of treatment are. Competent patients understand, remember and use the information provided to them to either consent to, or refuse, treatment. Patients without capacity are protected by The Mental Capacity Act 2005, which obliges medical treatment decisions made by third parties (doctors, defined proxies or the courts) to be both necessary and made 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.

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The process of consent enables patients to indicate which treatments they are willing to accept from their anaesthetist. Morally, this gives the autonomous, but vulnerable, patient a measure of protection from any perceived paternalism on the part of the anaesthetist.[1] Society has continuously reinforced the importance of such protection through the development of common (judge-made) and statutory (government-made) laws relating to consent,[2] such that an anaesthetist may be liable in battery or assault if they administer a treatment to a patient without obtaining valid consent from the patient. Legal sanctions, including awards of damages and (in extreme cases) imprisonment, are used to ensure that patient autonomy is respected.

The text below is summarized in Table 1

Ethics

Patients and anaesthetists usually agree about proposed treatments. However, problems tend to occur when conflict arises, and patients reject anaesthetic advice about what is medically in their best interests (e.g. spinal anaesthesia for hip hemiarthroplasty in a patient with severe chest disease).

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In these instances, proponents of patient autonomy — and indeed society as a whole — stress the prime importance of letting the autonomous patient decide, by asserting that only patients can really decide what is in their best interests overall, as opposed to merely being in their medical best interests.

It has been argued that all patients are never more than partially autonomous in a medical setting, as a result of their illness, treatment or dependency on treatment, and because they rely on the opinions of others when deciding about treatment. Furthermore, otherwise autonomous patients may waive their autonomy by asking the anaesthetist to decide for them, or by refusing to listen to any information about their treatment. Some patients do not possess autonomy, because they do not have the capacity to think, decide and act on the basis of such thought, independently and without hindrance. Patients may be permanently or temporarily unconscious. Children, although capable of independent thought and deed, are not necessarily able to decide about treatment based on the information given to them. Patients with mental illness may transiently or permanently be unable to make a treatment decision. In these instances, a third party is called on to make a proxy decision about what treatment should be given (if any) in the patient's best interests.

This process is necessarily paternalistic, but achieves the best outcome for the patient provided the decision-maker acts beneficently (i.e. optimizes patient benefit), non-maleficently (i.e. minimizes patient harm) and justly (i.e. authorizes treatment that they themselves would be happy to accept in similar circumstances).[3]

Law

The law relating to consent allows an individual to define and protect their own interests and to control bodily privacy. If a procedure is undertaken without consent, a doctor may be liable as follows:

- for clinical negligence in depriving a patient the opportunity to decline to undergo a particular procedure at a particular time[4]
- for the civil wrong of battery, that is, touching without consent and not in circumstances otherwise permitted, and
- for the criminal offence of battery.

Obtaining a patient's consent is not the same as having the patient sign a consent form. A consent form does not prove that consent was obtained, although a written, countersigned document provides important evidence if consent is disputed in court.[5] However, verbal or implied consent (e.g. when the patient holds out their arm for cannulation) can be equally valid.

Consent may be withdrawn at any point. Withdrawal of consent renders subsequent treatment unlawful. Consent is valid if it is given **voluntarily** by an **appropriately informed** person, who has the requisite **capacity** to exercise an informed choice.

Consent must be voluntary

This may be affected by a wide range of perioperative influences, including family and religious considerations, the necessity and urgency of treatment, and the status of the patient with regards criminal or psychiatric detention.

In practice, this is rarely an issue in legal determinations of consent. The leading English case remains that of *Re T*,[6] in which the Court of Appeal upheld the lower court's decision to allow the transfusion of blood to *T*, a critically ill Jehovah's Witness on

Practical summary of the law relating to consent

- Consent should be obtained for any procedure which involves touching a patient or which carries a risk that might be significant to the patient
- Obtaining consent from a patient is not the same as having the patient sign a consent form
- Documentary evidence of consent provides important legal evidence, but not affirmation of valid consent
- The clinician providing treatment is responsible for obtaining consent from the patient
- Consent is legally valid if it is given **voluntarily** by an **appropriately informed** person, who has the requisite **capacity** to exercise an informed choice
- Competent patients understand and remember information given to them about the treatment, and use the information to decide whether or not to consent to treatment
- Information should be given about what treatment involves and why it is being given, and about the risks and consequences of treatment
- A competent adult (over 18 years old) may refuse any and all treatment, even if it is life-saving
- Medical decision-making involving adults without capacity is now subject to regulation under the Mental Capacity Act 2005 (MCA)
- According to the MCA: adults (over the age of **16** years) are assumed to be competent, unless it is shown that they cannot understand, remember or use the information given to them; patients must be given a reasonable chance to demonstrate that they have capacity; the treatment of adults without capacity must be both necessary and in the patient's best interests
- According to the MCA: Lasting Powers of Attorney and court-appointed deputies can make treatment decisions in the best interests of an adult without capacity, but only Lasting Powers of Attorney can refuse life-saving treatment (if specifically authorized to do so by the patient
- The MCA reaffirms the legal validity of advance decisions, provided they are made voluntarily by an appropriately informed adult, who specifies the circumstances under which the refusal of treatment should apply
- Under-16s may consent to treatment if they are deemed *Gillick/Fraser* competent. Refusals of treatment by anyone under 18 years old may be challenged in court
- Patients detained under certain sections of the Mental Health Act 1983 are not necessarily excluded from making medical treatment decisions

Table 1

the basis that the patient had been unduly persuaded by her mother to refuse transfusion on religious grounds.

The patient must be appropriately informed

The few studies that have assessed what information about their treatment patients would like to be given have been inconclusive, with some patients preferring simple descriptions of procedures and explanation about the main risks and benefits, and others requesting fuller or exhaustive information.

A doctor who wishes to provide treatment to a patient has to be able to prove that the patient has been supplied with adequate information about both the **nature** and the **purpose** of the treatment given (i.e. what the treatment involves and why it is being recommended).

For a patient to prove that they have not been appropriately informed they must show that the anaesthetist failed to supply adequate information about the **risks** and **consequences** of the treatment, and that the patient made the treatment decision based on that information.

Anaesthetists cannot withhold information about risk from patients for fear of scaring them into not having treatment, except in the very rare circumstances where a court agrees that non-disclosure is appropriate, but it would be unreasonable to suggest that every single risk should be mentioned.

A way to look at how much information should be given to the patient is to consider and discuss with the patient the significant risks of that procedure. The definition of 'significant risk' remains vague and can lead to considerable difficulties in quantifying risk, and consequently communicating risk to patients.[7]

Although a useful approach to assessing significance is to attach it to risks which occur with a prevalence in excess of 1%, the legally correct approach is to consider which risks will be significant to the patient. A very rare (e.g. 0.5%) risk of death would be significant. Minor but frequent risks (such as vomiting after general anaesthesia) would be significant. Risks that might have particular relevance to the patient (e.g. vocal cord damage when intubating an opera singer) would be significant.

Recently the Courts have found that in some rare cases it will be necessary to advise the patient of the comparative risks of different procedures. The one case in which this duty was found to arise[8] concerned a patient who required either an MRI scan or catheter angiography to exclude a posterior communicating artery aneurysm or cavernous sinus pathology. The patient was consented for angiography (which had a very small risk of harm) but not informed of the possibility of an MRI scan (which carried virtually no risk), and the consent-taking was found to be inadequate. The Court went to great lengths to make it clear that the decision did not create a general duty to advise of comparative risks, and so far the Courts have not seen a substantial number of similar claims being brought.

The importance of capacity

The patient must have capacity to consent or refuse treatment. Since 1 October 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'[9] by clarifying the law concerning decision-making by others on behalf of mentally incapacitated adults.

In practice, the MCA is simply a statutory codification of the pre-existing common law, with a few notable exceptions relating to proxy decision-makers, advance decisions ('living wills') and the conduct of research on adults without capacity.

The MCA is founded on five basic principles, which imply three broad concepts:[10]