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Review

Common-law principles in consent for patients in oral and maxillofacial surgery who lack mental capacity: do we know them all?

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Abstract

Over the last 5 years, the medical profession has relied on the Bolam test for their defence in cases of clinical negligence. While still a matter of controversy between health professionals and legal experts, the Bolam test has been tried and criticised not only by the English courts but also in the United States, Canada, and Australia. In the medical profession the concept of the law of consent has moved away from a doctrine of professional paternalism towards patient-focused paternalism, and has increased the emphasis on human rights and the autonomy and choice of the patient. These changes present a challenge to health professionals, and a lack of effective recognition and interpretation can result in non-compliance. We review the developments in the law of consent since Bolam and discuss how they affect patients with incapacity, and highlight the importance of being familiar with them.

Keywords: Consent; Mental Capacity Act; Changes in law; Review

Introduction

In the past, patients did not have autonomy-based rights, and under the Hippocratic Oath it was assumed that doctors would decide on the best treatment. However, during the 20th century, the Hippocratic principle was replaced by the approach that patients themselves should decide on their treatment, placing an emphasis on autonomy, which was further reinforced by the Human Rights Act 1998.

The concept of consent is controversial and can be interpreted in various ways depending on context. Consent transforms a morally or legally impermissible act into a permissible one, and the courts have drawn a distinction between the informational requirements of consent in battery law and the additional obligations for disclosure in negligence law. Consent is therefore required to avoid liability in battery, but is not sufficient to avoid liability in negligence.[1]

Development of the Law of Consent beyond Bolam

Beauchamp and Childress analysed the concept of informed consent and suggested two distinct outlooks.[2] The first indicated an individual's authorisation of a medical intervention, and the second was concerned with institutionally or legally effective consent in terms of the social rules of consent.[2] The patient's right to consent was first discussed in 1767 in *Slater v Baker and Stapleton*, and the court reasoned that the patient had a right to information that was relevant to the proposed procedure.[3] The *Bolam* case in 1957 formulated the Bolam test, which has been applied by the courts over the decades as a common negligence standard despite being

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the object of sustained criticism. Some argue that it allows doctors to decide on the accepted standard of care, and reason that it is for the courts to decide whether their conduct is negligent.[4] Others argue that it has been used by the courts to abdicate responsibility for defining and enforcing patients' rights, and has become no more than a requirement to find some other expert who will declare that they would have done what the defendant did.[5] Later in 1972, there was a radical development in consent law, as the *Canterbury v Spence case* introduced the prudent patient standard, and added the rules of disclosure to the legal doctrine of the law of consent.[6]

In the case of *Sidaway* in 1985,[7] the House of Lords supported and applied the Bolam test, and stated that the standard was to judge the adequacy of disclosure by reference to professional custom and practice. However, it failed to conclude the debate on the role of the law in deciding how much information must be provided to enable patients to give considered consent to medical treatment.

The *Bolitho* case in 1998 looked beyond Bolam and became important in the history of consent as it declined to favour the medical profession over the issue of causation in cases of clinical negligence.[8] The particular importance of this case lies in the fact that the House of Lords supported the Court of Appeal in its departure from the certainties of Bolam. It was held that the courts must also be satisfied that the body of opinion in question has a logical basis, but at the same time expected that it would be the case in limited circumstances only.

In 1997 the case of *Pearce*[9] supported the views from Bolitho,[8] and introduced consideration of a standard of risk disclosure in the form of a prudent patient test, which required a reasonable doctor to inform the patient of risks that a reasonable patient would wish to know. The definition of the "reasonable patient" is obviously subjective.

In 2002, Maclean[10] researched the database for cases of clinical negligence and reported that there had been 64 cases since Bolitho in which at least one of the issues was the standard of care. Forty-six cases were in the High Court or County Court, and 18 of them were in the Court of Appeal.

Among the 46 cases heard in the High Court or county courts, the defendant was held liable for negligence in 16 cases. The Bolam test was explicitly referred to in 10 cases, and in 2 of them the defendant was held liable. In 25 cases, explicit reference was made to the Bolitho judgement and the defendant was held liable in 9. In 10 cases, the courts did not refer to Bolam or Bolitho, but found the defendant liable in 4. Similar outcomes occurred in cases heard in the Court of Appeal.

This research has shown that liability seems to be more likely when the judgement is made beyond the Bolam test. However, while these figures are interesting, they are of limited significance without a deeper analysis of the judgements themselves.

While the doctrine of consent developed for patients with capacity, the common law applied to the medical treatment of those in whom it was lacking. These patients were largely treated under the Mental Health Law 1983. However, because of the complex nature of the legality of treating those who lack capacity, further reforms were introduced in the form of the Mental Capacity Act 2005. We will now review these developments in depth.

Development of law of consent for patients who lack mental capacity

Before the Mental Health Law 1983, De Prerogativa Regis, an act passed in 1324, and the first statutory law on guardianship for the mentally disordered, gave the King jurisdiction over the freedom and property of mentally disordered people.[11] Since then, 35 Acts of Parliament have added to services specific to such patients, and these statutes were precursors of the Mental Health Act 1983, which subjected patients to a statutory jurisdiction.

Among them, the Lunacy Act 1890 has been perceived as a watershed, as it merged all the legislation relating to the laws of insanity into one statute. The Mental Deficiency Act 1913 provided the basis for current provisions on guardianship in the Mental Health Act 1983 along with a legislative framework for early care in the community. The Mental Treatment Act 1930 introduced informal admissions to, and confinement in, a psychiatric facility, without a formal and binding order of admission. Until 1959, the legal control of the property, affairs, and personal decisions made for people who lack mental capacity was with the monarch as parens patriae - the father of the people. The Mental Health Act 1959, which followed the main recommendations of the Percy Commission, made parens patriae power statutory. It subjected guardianship to a statutory regime by placing the "mentally disordered" and "developmentally disordered" in the same statute.

The Mental Health Act 1983 retained the basic provisions of the 1957 Act but patients' rights were treated more seriously, and they had the same rights regarding treatment as those provided by the common law for people outside the facility. The powers of guardians were considerably reduced and they could decide only where the person might live and attend for treatment. While they could ensure that social services or medical professionals could have access to the individual during their treatment, they lost the authority to consent on the patient's behalf. This triggered a project by the Law Commission to reform the mental health legislature, and it eventually resulted in The Mental Capacity Act 2005 that came into force in 2007.[12] During this process the courts explored the common law and implemented changes in the form of policies, guidance, and directives from the Department of Health to bridge the gaps in the legislation while focusing on the legality of the treatment of people who lack capacity.[13]

The Act enshrines best practice and common law principles for people who lack capacity and those who make decisions on their behalf. For personal decisions it entered a