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The word “consent” is used frequently in healthcare. Patients can either give or refuse consent. Consent is obtained, and consent forms are signed. Consent may be implied or explicit, and patients either have or do not have the capacity to give their consent to treatment. Consent is clearly an important issue in contemporary healthcare and one nurses need to be familiar with.

This article, the first in a two-part series, explores individuals’ right to choose, the legal meaning of the word “consent” and the importance of gaining consent before treatment. The second article will discuss what makes consent valid and individuals’ capacity to consent.

Most people value the right to choose and will make many decisions on a daily basis: what to wear, what to eat, who to socialise with, what to watch on television and whether or not to follow medical advice about diet or alcohol intake.

When making decisions, people will usually explore and evaluate the available options, choosing the course of action that suits them best. For example, it could be argued that most people are aware of the strong body of evidence suggesting that cigarette smoking is harmful to health. However, regardless of how much the government, health practitioners, family and friends might prefer someone to stop smoking, this decision can only be made by the person concerned. Smokers themselves will evaluate the financial, health and social consequences of continuing to smoke and will be responsible for the outcome of their decision.

The right to choose is protected by the ethical principle of autonomy (Burkhardt and Nathaniel, 2008), and is supported both in law and healthcare policy (for example Re C (Adult: Refusal of Treatment) (1994); Department of Health, 2012; General Medical Council, 2008; Mental Capacity Act, 2005). The principle of autonomy – the right to be self-governing – is regarded as so fundamental that there are circumstances where the “sanctity of human life must yield to the principles of self-determination”, as Lord Goff said (Airedale NHS Trust v Bland, 1993). This means, subject to some exclusions, people have the right to decide things such as:

» Who touches them and when;
» Which professional advice to accept, and which to ignore;
» What information to share, and with whom.

Although the principle of autonomy applies to all three of the rights listed above, this article focuses on the first two.

Patients’ right to choose

On 15 April 1989, Anthony Bland received catastrophic brain injuries in what became to be known as the Hillsborough disaster. After more than three years of care,
Mr B was considered to be in what was then called a persistent vegetative state (PVS), and it was generally agreed that he had no prospect of recovery. He had no cognitive awareness and, although he was able to breathe, he needed assistance with all other bodily needs, including hydration and nutrition. Both the hospital caring for him and his family were of the opinion that it would be in his best interests to continue all treatment so he could die with dignity, and they applied to the court for a declaration that withdrawing treatment would be lawful. There were appeals and the case was finally heard in the House of Lords.

Mr B had not made an advance decision about refusal of life-sustaining care, and was not able to understand either his condition or any treatment options available to him. The lords used this case as an opportunity to consider patients’ rights to choose in relation to life-saving treatment. It was their opinion that, even in the most extreme of circumstances, patients’ right to self-determination is paramount. Even if medical opinion advocates treatment that may be the patient’s only life-saving option, provided the patient fully understands the options available and the associated outcomes, their wishes must be respected if they choose not to have the treatment. It would be unlawful to force the patient to have that treatment, even if the ultimate outcome is death (Airedale NHS Trust v Bland, 1993; Re W (Adult: Refusal of Treatment), 2002). In Mr B’s case, the decision to stop life-sustaining treatment was made on the basis of his best interests.

**Capacity**

It is generally presumed in law that adult patients have the capacity to make decisions, unless there is evidence that they do not (Mental Capacity Act, 2005). A decision made by a patient with capacity must be respected, even if it appears unwise or irrational (this is discussed in more detail in part two of this series). Although hospitals and other healthcare providers have a legal obligation to provide adequate care for their patients (Cassidy v Ministry of Health, 1951), patients do not generally have to accept any offer of treatment.

Health professionals sometimes find it difficult to respect their patients’ rights to autonomy, and may feel frustrated by what they see as a foolish or reckless decision. They may also feel uncomfortable knowing that a failure to provide care may lead to liability in civil law (negligence) or a criminal charge of gross negligence manslaughter if the patient dies as a result (R v Adomako, 1994). This concern, combined with their awareness of their ethical and professional obligations (Nursing and Midwifery Council, 2008) to provide care, may cause professionals to worry about the implications of following a patient’s wishes, particularly if the patient has refused potentially life-saving treatment.

Where there is cause to question a patient’s decision-making capacity, it can be difficult to decide the best course of action if they refuse treatment. In these situations, cases can be referred for a court declaration on the lawfulness of a proposed course of action.

One example of this is in the case of Re C (Adult: Refusal of Treatment) (1994). The applicant was a 68-year-old man who had paranoid schizophrenia and, at the time of the application, was serving a prison sentence for armed robbery. While in prison, he developed an ulcer on his lower leg, which became gangrenous. He accepted antibiotic treatment for this, but was advised that unless he had his lower leg amputated, his chances of survival were probably less than 15%. Mr C refused to consent to the amputation, but the treating hospital argued that because of his schizophrenia he did not have the capacity to fully understand the implications of his decision. Mr C argued that he did, and the court agreed, granting him an injunction that prevented the hospital from amputating his leg without his consent. The court supported Mr C’s right to self-determination, even though his decision was not considered to be wise.

Ms B v An NHS Hospital Trust (2002) considered the case of Ms B, who experienced a series of haemorrhages in her spine between 1999 and 2001 that resulted in her becoming tetraplegic and needing artificial ventilation. While she was receiving treatment, Ms B had made living wills and other requests to have her artificial ventilation discontinued as she did not wish to continue living with such a severe disability. Doctors argued that she did not have the capacity to make this decision, and continued to treat her. The court ruled that Ms B did in fact have decision-making capacity, and that her wishes should have been respected. Although the quality of care was not criticised, the court stated that continuing treatment without her consent was unlawful and a nominal award for damages was made.

Where a patient lacks decision-making capacity, courts may make a declaration that treatment can be given lawfully, even without the patient’s consent. An example of this is Miss MB, who was pregnant with her second child (Re MB (An Adult: Medical Treatment), 1997). Antenatal tests showed the foetus was in the breech position and Miss MB was advised that delivery by Caesarean section would be in her best interests. However, Miss MB had a severe needle phobia and, despite consenting to the surgery several times, the sight of the anaesthetic equipment caused her acute fear and anxiety and she withdrew her consent.

The hospital made an application to the court, arguing that her fear was so great she could not fully understand the implications of her actions, meaning that while she was experiencing anxiety she lacked decision-making capacity. The court agreed that her phobia had rendered her temporarily incompetent, and made an order that any treatment necessary for the safe and dignified delivery of the baby could go ahead even without consent.

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**BOX 1: PRINCIPLES OF THE MENTAL CAPACITY ACT**

The Mental Capacity Act (2005) was drawn up to: make provision relating to persons who lack capacity; to establish a superior court of record called the Court of Protection in place of the office of the Supreme Court; to make provision in connection with the Convention on the International Protection of Adults signed at the Hague on 13 January 2000; and for connected purposes.

**Under the act:**

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.

- A person is not to be treated as unable to make a decision merely because they make an unwise decision.

- An act done, or decision made, under this act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.

- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.
Miss MB appealed, but the court of appeal agreed with the original ruling. These cases show the weight placed by the courts on patients’ right to self-determination, and the need to respect the decisions of patients with capacity, even if they might seem unwise or their decision may result in their death. However, while patients have a right to choose between available options, they generally have no right to demand treatment that has not been offered to them on the basis of professional opinion.

**What is consent?**
In the cases above, people’s right to choose whether and how their bodies are touched was considered. Lord Goff made the position clear in the case of Collins v Wilcock (1984) when he said:

“The fundamental principle, plain and incontestable, is that every person’s body is inviolate.”

This means that any unwanted touching, or putting someone in fear of unwanted touch, is usually unlawful. The giving of consent simply means that a person has communicated their agreement to something.

In the examples given, this refers to being touched as part of medical treatment or other therapeutic process, but could also apply to other areas where the right to autonomy applies, such as sharing confidential information. Non-consensual touching, or being put in fear of being touched, may amount to a breach of both civil law (“battery”) and criminal law (“assault”) (Mackay, 2010).

Consent can act in one of two ways:
» Make an act that would otherwise be unlawful, lawful (subject to limitations in criminal law);
» Provide a defence in law to a charge of unlawful touching – a legal “safety blanket” (R v Brown (and Other Appeals), 1993).

**Conclusion**
No person should be subjected to any unwanted touching or intervention or put in fear of being treated against their will. Nurses should be aware that they will be committing an offence unless they obtain valid consent from their patients before touching them. NT

**References**
- Cassidy v Ministry of Health [1951] 1 All ER 574.
- Collins v Wilcock [1984] 3 All ER 374.
- Mental Capacity Act (2005) tinyurl.com/MCA2005
- R v Adomako [1994] 3 All ER 79.
- R v Brown (and other appeals) [1993] 2 All ER 75.
- Re C (Adult: Refusal of Treatment) [1994] 1 All ER 819.
- Re W (Adult: Refusal of Treatment) [2002] All ER (D) 223 (April).