What does consent mean in clinical practice?

In this article...
- How failure to gain consent can lead to liability
- When consent can or cannot be used as a defence
- How mental capacity affects ability to consent

**5 key points**

1. Every adult must be assumed to have capacity to make decisions unless it is proved otherwise
2. Practitioners must obtain consent to treatment even in an emergency
3. If health professionals carry out a procedure without valid consent, they may be liable
4. Patients must understand the consequences of planned procedures to give valid consent
5. Medical treatment is not generally subject to criminal liability because their ultimate aim is to benefit the patient

Regardless of their own views, health professionals must respect patients’ decisions to consent to or decline interventions and ensure they are informed of the consequences.

**Keywords:** Consent/Capacity/Liability

This article has been double-blind peer reviewed.
cases where there is the need for a number of stitches (but not the superficial application of Steri-strips) or a hospital procedure under anaesthetic” (Crown Prosecution Service, 2013).

This threshold is generally imposed in the public interest, and was considered at length in the case of R v Brown (and Other Appeals) (1993). During this case, appeals against conviction made by a group of sadomasochistic homosexual men were dismissed. The group had engaged in parties involving sexually motivated, mutually inflicted acts of violence, often resulting in injury contrary to the OAPA (1861). The appellants argued that there was no criminal liability because they had all consented to the acts and outcomes, but it was held that consent would not provide a defence to a criminal act.

In general, consent cannot be used as a defence for an assault intended to cause anything more than a minor injury. In healthcare, it could be argued that some surgical interventions, such as amputations, invasive brain surgery or even appendectomy result in injuries that could be classed as ABH or even grievous bodily harm.

The fact that surgeons do not generally incur criminal liability in the course of their work was considered by Lord Mustill in R v Brown (and Other Appeals) (1993): “Many of the acts done by surgeons would be very serious crimes if done by anyone else, and yet the surgeons incur no liability. Actual consent, or the substitute for consent deemed by the law to exist where an emergency creates a need for action, is an essential element in this immunity; but it cannot be a direct explanation for it, since much of the bodily invasion involved in surgery lies well above any point at which consent could even arguably be regarded as furnishing a defence. Why is this so? The answer must in my opinion be that proper medical treatment, for which actual or deemed consent is a prerequisite, is in a category of its own.”

The legal basis for the validity of consent as a defence in medical treatment is generally considered to stem from the absence of intention to cause harm, and from lawful reasons for the surgery. Medical treatment does not, therefore, meet the criteria under OAPA (1861) and is not subject to criminal liability (as considered by Lawson J in R v Hogan (1974)). This means consent is likely to be a valid defence for healthcare interventions, provided that they are carried out with the ultimate aim of benefiting the patient.

The nature, purpose and possible consequences of investigations or treatment – as well as – the consequences of not having them? ... They are only competent if they are able to understand, retain, use and weight this information and communicate their decision to others.”

If a child lacks capacity, consent may be given by a parent or an adult with parental responsibility, providing that person has capacity. If a child with capacity refuses consent for treatment that doctors consider to be in the child’s best interests, the treatment may go ahead if a parent or the court gives consent (Re W (a minor) (Medical Treatment: Court’s Jurisdiction), 1992).

If both child and parents refuse consent for treatment that doctors consider to be in the child’s best interests, an application can be made for the High Court to override this refusal (as per Re B (a Minor) (Wardship: Medical Treatment), 1981). However, doctors do not always have time to appeal to the courts for a declaration that a proposed treatment is lawful. For example, if a patient’s life is in danger and doctors risk being prosecuted for manslaughter if the patient dies as a result of their failure to act, they may need to act without consent (R v Senior, 1899). In those circumstances, the patient must be treated according to their best interests.

**Young people**

Unlike children, young people (aged 16 or 17 years) are presumed to be capable of making decisions to others.” (British Medical Association, 2009).

**Children aged under 16 years**

In Gillick v West Norfolk and Wisbech AHA (1985), it was held that if children are able to fully understand what is involved in an intervention, they are likely to have the capacity to consent to it. Capacity should be assessed for each separate decision because children may have the capacity to consent to some procedures but not others.

Further guidance is provided by the General Medical Council (2007): “If the young person able to understand
Discussion

assessing capacity as for adults, including the provisions of the Mental Capacity Act (2005). Parental consent is not needed if valid consent has been given by a young person, but it is considered good practice to involve parents in the decision-making process, provided that the young person agrees to this (DH, 2009). However, as with children, if young people refuse to consent to treatment that doctors consider to be in their best interests, this can be overridden by a person with parental responsibility or by the court.

Physical touching
It is not enough for patients to have agreed to the physical act of touching; they must understand both the nature and the quality of the act. For example, in R v Tabassum (2000) the defendant had gained consent from a number of women to examine their breasts by misinforming them that he held a suitable medical qualification and was conducting research into breast cancer. He did not have this qualification, and the purpose of the examination differed from what he told the women. It was therefore held that the acts were non-consensual and the defendant was convicted of indecent assault.

Any form of confusion or deception, even if well-intentioned, may invalidate consent, for example:
- A patient declines a course of intravenous (IV) antibiotics but agrees to an IV infusion of normal saline. The nurse conceals a dose of antibiotics within the infusion fluids;
- A patient admitted to the emergency department is well-served by using illicit substances intravenously and a nurse has a needlestick injury while administering treatment. The patient has always refused HIV testing, but the nurse is worried about possible exposure to HIV. The nurse gains the patient’s consent to take a blood sample to test for anemia but also sends a sample for HIV testing without informing the patient.

In both of these situations, although the fundamental mechanics of the act had been agreed with the patient, the purpose was different from the one agreed and the patients’ rights to autonomy had been compromised, making the acts non-consensual.

Patients also need to be fully informed of the actual and potential risks associated with a procedure. Practitioners should avoid withholding information that could influence a patient’s decision regardless of why they may choose to do this. If a patient is not appropriately informed, liability in negligence may arise, and there would be no obligation for the patient to prove that any harm came from not being fully informed (Chester v Afshar, 2004).

For consent to be valid, the decision must not be influenced by information that is not true, biased or incomplete as this would compromise the patient’s right to self-determination.

Has consent been given?
The final factor to consider is whether the patient voluntarily gave consent to the intervention performed. The courts usually decide this as a matter of fact, which means that either the claimant (in civil cases), or the prosecution (in criminal cases) must satisfy the court that valid consent was not given.

Communication of consent can take a number of forms:
- Implied – such as a patient raising an arm for the nurse to apply a sphygmomanometer cuff;
- Explicit – such as a patient telling the nurse “you may check my blood pressure” before raising an arm.

While a signed consent form may provide useful evidence that consent was given, the existence of a “signature on a form does not make the consent valid” (DH, 2009). Further information may be needed, for example:
- What information about possible risks and adverse outcomes was given to the patient?
- Did the patient understand the information given?
- Was the consent voluntary and free from any undue influence?

The form of consent should be appropriate for the particular circumstance. For example, while implied consent might be enough when checking a patient’s pulse, it may not be sufficient for a patient about to undergo coronary bypass surgery. Voluntarily climbing onto a theatre bed does not prove that the patient fully understands the planned procedure, including the associated risks and benefits. In this situation, detailed preoperative discussions between the patient and relevant practitioners would be a necessary part of the consent process, and would need to be documented as evidence of this (Chester v Afshar, 2004).

Conclusion
Patients have a right, supported in law, to make informed decisions about their care and treatment. Nurses and other health professionals are required to obtain valid consent before starting any form of treatment or intervention. Even when they give consent, patients may withdraw it at any point, and professionals must generally respect patients’ wishes, regardless of their own personal views. NT

References
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General Medical Council (2007) 0-18 Years: Guidance for All Doctors. London: GMC. tinyurl.com/GMC-O-18years
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Mental Capacity Act (2005) (c.9) tinyurl.com/MCA2005
Offences Against the Person Act (1861) (c.00) www.legislation.gov.uk/ukpga/Vict-24-25-100/contents
R v Brown (and Other Appeals) [1993] 2 All ER 75.
R v Donovan [1934] 2 KB 498.
R v Hogan [1974] 2 All ER.
R v Senior [1899] 1 QB 283.
R v Tabassum [2000] All ER (D) 649.
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RESOURCES ON CONSENT
- Nursing and Midwifery Council: tinyurl.com/NMC-consent
- Mental Capacity Act 2005: tinyurl.com/govern-legislation-capacity
- Mind: tinyurl.com/consent-to-treatment
- NHS Choices: tinyurl.com/consent-to-treatment-intro