Nurses know they must have their patients’ informed consent before giving any form of care or treatment but they may not be fully aware of the legal basis behind this and the implications of not doing so.

What is informed consent? Why is it important? What does it mean for practice? This article – the first in a two-part series – explores the legal principles of informed consent in adults, considers why it is fundamental to the provision of person-centred care, and explains how the law relating to informed consent has recently changed.

Clinical decision making
Nurses make many clinical judgements and decisions throughout the course of their working day. They assess patients’ health status and plan care based on their observations, deciding which treatments and interventions best meet patients’ needs. The process of clinical decision making has been widely explored and can be explained in a number of ways, ranging from the intuitive to the analytical (Taylor, 2005; Thompson and Dowding, 2001; Hamm, 1988).

Regardless of the process used, the consensus is that decisions will be based on information of one kind or another, and will influence the outcomes for patients (Taylor, 2005). It follows, therefore, that the quality of the outcomes will depend on the quality of the information upon which decisions were based. As such, nurses must ensure their decisions are based on “the best evidence available” (Nursing and Midwifery Council, 2015).

Person-centred care
Evidence-based practice is considered fundamental to the delivery of good-quality person-centred care (Banner et al, 2016). The concept of “person-centred care” is widely cited in the literature and applied in nursing practice. Although the term may be used interchangeably with “patient-centred care” (Perez-Merino, 2014; McCrae, 2013), there is some variance in how it is defined in the literature. Sometimes person-centred care is not defined but, instead, is simply described in terms of...
patient autonomy, holistic care and primacy of patient need (Hayes, 2014).

For the purpose of this article, person-centred care is defined as the:
“approach to care that places the person at the centre of their own care. Individuals are supported, facilitated and enabled to contribute to their care through shared decision making, equality of communication and mutual respect” (Mitchell and Agnelli, 2015).

Person-centred care implies the centrality of the patient, who is seen as a key participant in care, rather than the passive recipient of it.

**Accountability and best evidence**

The NMC’s (2015) code of conduct sets out a mandatory framework of professional standards for practice. All registered nurses, registered midwives, student nurses and student midwives are accountable for their practice and must comply with the Code to ensure their practice meets the standards required not only by the NMC, but also by patients and the general public. Compliance with:
“the professional standards that registered nurses and midwives must uphold [is] not negotiable or discretionary” (NMC, 2015).

Some of the key legal principles of the NMC Code are highlighted in Box 1. Nurses will be accountable for any deviation from these principles and must be able to justify their actions (Cornock, 2011). If they base their decisions on the best available evidence, they will be able to inform, explain and account for these decisions (Aveyard and Sharp, 2017).

Arguably, as well as informing the clinical element of care (for example, selecting the most appropriate wound dressing), the best available evidence must also inform the wider framework for decision making (for example, determining the legality of providing treatment if the patient is unconscious and, as such, not able to give their consent).

**Understanding the legal basis**

There is a legal principle that ignorance is not a defence: if a law is not known or not understood, this does not remove any liability that comes with it. To recognise and uphold their patients’ rights, nurses must not only be aware of the standards set out in the Code, but also understand their legal basis. However, although nurses may be aware of broad legal concepts set out in the Code, they do not always understand the detail of the law and how it affects their practice (Taylor, 2016). This means that, beyond the potential negative impact on patient care, they may be in breach of the law without knowing it.

As well as understanding the legal framework that underpins care, nurses need to be aware that the law can change quickly, even after long periods without changes. This is the case of the law relating to consent to treatment.

**Autonomy**

It is useful to start by considering consent from an ethical perspective and how it relates to the principle of autonomy. Autonomy recognises an individual’s right to make choices on matters relating to themselves, unrestricted by factors – such as controls imposed by others or lack of information – that would limit the freedom of their choice (Beauchamp and Childress, 2012).

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This principle is upheld in the law, which recognises that all adults generally have a presumed right to decide what happens to their body. The law not only protects a person from any unwanted touch, but also from the fear of being touched. It is unlawful to touch another person unless they have agreed to it; their consent makes lawful an act that would otherwise be unlawful (Taylor, 2013), as highlighted in Collins v Wilcock [1984] 3 All ER 374.

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Clinical Practice

Discussion

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**Right to decide**

This applies to all areas of life, including healthcare (Re F (Mental Patient: Sterilisation) [1990] 2 AC 1) and means patients generally have the right to make decisions about their care – for example, whether to accept a treatment or intervention – even if their “refusal may risk permanent injury to [their] health or even lead to premature death”. The patient’s decision must be respected even if it is considered foolish, unfounded or irrational (Re T (Adult: Refusal of Medical Treatment) [1992] 4 All ER 649).

In Airedale NHS Trust v Bland [1993] AC 789, Lord Keith of Kinkel stated that: “it is unlawful, so as to constitute both a tort and the crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent”.

The NMC Code expands on this by stating that nurses must ensure that they “get properly informed consent and document it before carrying out any action” (NMC, 2015).

Consent must be voluntary. It may not provide a valid legal defence if, for example, the patient felt obliged or was persuaded by others to accept treatment. Some patients may be particularly vulnerable to pressure from others so nurses need to be alert to the possibility of coercion and make every effort to ensure patients are supported to reach their own decision (General Medical Council, 2008).

**Informing patients:**

**Chester v Afshar**

What does informed consent mean? The concept is not explained in the NMC Code, but the doctrine of informed consent as a principle in English law was clearly established in Chester v Afshar [2004] UKHL 41. In that case, the House of Lords made clear that a practitioner would be negligent – and in breach of their duty of care to the patient – if they failed to advise them of the risks associated with a proposed treatment. Although the case refers specifically to surgical interventions, more recent cases such as Gallardo v Imperial College Healthcare NHS Trust [2017] EWHC 3417 (QB) show that the principle applies to treatment more generally.

Chester v Afshar [2004] does not specify the extent of the information doctors must provide, other than saying there is a “legal duty to a patient to warn him or her in general terms of possible serious risks involved in the procedure”. If there is doubt as to whether consent was sufficiently informed, a decision will be made by the court (Montgomery v Lanarkshire Health Board [2015] UKSC 11; Chester v Afshar [2004]). The health professional would be found negligent if they have not given the patient enough information to make an informed decision.

**Paternalistic approach**

Health professionals need to give patients sufficient information to make an informed decision, but what does this mean in practice? In the past, there was a paternalistic approach to healthcare: doctors decided not only what treatment would best fit their patients’ needs, but also what information to give to them. Patients would be spared information which their doctor thought they might find upsetting or otherwise did not need to know – for example, a diagnosis of cancer or terminal illness (McCrae, 2013).

Box 2. **The Montgomery case**

Mrs Montgomery, who had type 1 diabetes, was expecting her first baby; a pre-natal assessment indicated that the baby would be large. During the later stages of her pregnancy, she told her obstetrician about her concerns that the baby’s size would make delivery difficult. The obstetrician recognised there was a 9-10% risk of shoulder dystocia that would complicate the delivery, but decided not to share that information with Mrs Montgomery. The obstetrician felt the risk to Mrs Montgomery and her baby was relatively small, and did not warrant the elective Caesarean section that she would be likely to request if told of the risk. She would have been given this information only if she had asked “specifically about exact risks” (Montgomery v Lanarkshire Health Board [2015] UKSC 11).

Mrs Montgomery went into labour. Shoulder dystocia occurred and made vaginal delivery impossible, so an emergency Caesarean section had to be performed. Oxygen deprivation during birth resulted in severe and permanent disability for Mrs Montgomery’s son. She sued the NHS trust, arguing that she should have been advised of the risks of vaginal delivery and that, if she had been aware of those risks, she would have opted for an elective Caesarean section.

When this case was first heard, the Scottish Court of Session followed the approach taken in Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871 and concluded there was insufficient risk of significant harm to Mrs Montgomery to warrant a warning. The Supreme Court disagreed and upheld Mrs Montgomery’s appeal, recognising that there had been a shift in the relationship between patients and health professionals. Patients are “now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. They are also widely treated as consumers exercising choices: a viewpoint which has underpinned some of the developments in the provision of healthcare services” (Montgomery [2015]).

**“All adults generally have a presumed right to decide what happens to their body”**

Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871 reflects the view that patients cannot be expected to have the same level of knowledge as the doctors treating them, might not be able to objectively balance the risks and benefits of a particular intervention, and might place “undue significance” on certain elements of the information they are given. It was thought that giving the patient too much information might “prejudice the attainment of the objective of restoring the patient’s health” and, therefore, conflict with the doctor’s duty to act in the patient’s best interests (Sidaway [1985]).

The courts considered that patients needed to be protected from making irrational decisions so the House of Lords extended the Bolam test – used to assess negligence – to the information doctors were required to give or disclose to patients. This meant doctors were able to withhold information from their patients and would not be deemed negligent provided they had: “acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art” (Bolam v Friern Management Committee [1957] 2 All ER 118).
As such, although patients had the right to access the information they needed to make a balanced decision (including any “general dangers and [...] any special dangers [...] without exaggeration or concealment”), doctors had the right to “decide what information should be given to the patient” and how that information should be presented (Sidway [1985]).

A turning point: Montgomery

This remained the law until 2015, when a landmark judgement was made by the Supreme Court in the Montgomery [2015] case, which is described in Box 2.

Patients no longer have unquestioning faith in their doctors and nurses. In recent years, their confidence in health professionals and the healthcare system has been eroded by a succession of scandals (McCrae, 2013). Patients are now more aware of their treatment options, more aware of their rights as consumers of healthcare, and prepared not only to complain about care they consider substandard but also to take legal action (McCrae, 2013).

Although not all patients want, or are able to, participate in decision making, there has been a shift towards the active involvement of patients in this area. Generally, patients are no longer passive recipients but, rather, active partners in their care. With this comes the duty for practitioners: “to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments”.

The test to be applied 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” (Montgomery [2015]).

Implications of the case

The Montgomery case has a number of implications for nursing practice, which are outlined in Box 3. Nurses should be aware that they will be accountable for the decisions they make about disclosure, and should ensure that they carefully record the decision-making process and the information shared. If they are uncertain about any of this, they should seek advice.

Practitioners will be deemed negligent if they fail to give patients the information that they need to decide whether they want to accept the risks that a particular treatment may present (Montgomery [2015]). However, this comes with three caveats:

- Practitioners may withhold any information that they reasonably consider would “be seriously detrimental to the patient’s health” (Montgomery [2015]);
- Practitioners may withhold information in circumstances where the patient needs urgent treatment but is either unconscious or has a condition that means that they are not able to give valid consent (Montgomery [2015]);
- Practitioners are not required to share information if the patient, after having been given the opportunity to receive it, makes clear their wish to remain uninformed.

It must be noted that, although much of the existing case law refers to doctors, the legal principles on informed consent apply in just the same way to nurses and all other health professionals (Young, 2009). It must also be noted that the law relating to consent in children is different to that for adults, and is not covered by this article.

Conclusion

Other than in exceptional circumstances, nurses have both a legal and a professional obligation to ensure:

- Their patients are informed about the proposed treatment;
- They have their patients’ consent before starting treatment.

Consent will only be valid if that information has been given. Nurses will be acting unlawfully, and contrary to the principles of person-centred care if they administer care without a patient’s consent.

The second article in this series will consider what makes consent valid and explains that this may depend on the circumstances in which care is planned. It will also discuss situations in which treatments and interventions may be given lawfully in the absence of consent.

References


