

# Introduction

Consent to treatment lies at the heart of the relationship between the patient and the health care professional. The patient relies on the professional's expertise, knowledge and advice, but it is up to the patient to decide whether he/she will accept or reject treatment, or in some circumstances request that the professional make the decision. The focus on patient centred care and shared decision making highlights the importance of informed consent, and this is reinforced by professional guidelines and the law. However, the issue of consent to treatment is not quite as straightforward as it may seem on initial inspection. For consent to treatment to be meaningful a person must be able to understand the information he/she is given, which must be sufficient for him/her to evaluate the available choices, and he/she must feel free to make that choice. Determining the appropriate amount of information or a person's ability to understand and evaluate it can be difficult in a health care context, and the very nature of the health care relationship and health care setting can lead to implicit if not explicit coercion. Thus issues around consent can lead to ethical dilemmas that may be brought to a clinical ethics committee. In this section we provide a brief overview of the ethical and legal approaches that apply to consent and then look at some specific issues that may present to clinical ethics committees illustrated by hypothetical cases. The section concludes with some suggested further reading on the issues.

This section does not provide a comprehensive overview of the issues around consent and refusal, and does not make recommendations about what an ethics committee should do. It highlights issues that a committee may wish to consider and provides some ethical and legal frameworks for approaching the subject.

## Ethical Considerations

### Respect for Autonomy

The principle of respect for autonomy underpins the requirement for valid consent to treatment. This principle acknowledges the right of a person to determine how his or her life should be lived and to make choices that are consistent with his/her life's plan. While respect for autonomy is often associated with deontological theories, utilitarian philosophers such as John Stuart Mill also stress the importance of an individual's right to determine how he/she lives his/her life, free from coercion:

".....the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others to do so would be wise, or even right" (*Mill JS, On Liberty, 1982, Harmondsworth: Penguin, p 68*).

Autonomy is not all or nothing. Very few of us are able to make fully autonomous choices all the time. Some of us, in certain situations, will not have the ability to understand and evaluate the options in order to make a choice. The more complex the choice and the more impaired our ability to understand, the less we are likely to be able to make an autonomous decision. This has implications for respecting autonomy in the context of health care, specifically in consent to treatment. First, health professionals have an obligation to endeavour to enhance autonomy and facilitate the likelihood of a patient being able to make an autonomous decision. Second, where a patient is unable to make an autonomous decision, it is the duty of the health professional to act in the patient's best interests. However, even in these situations, an effort should be made to discover any previous preferences of the patient, or current wishes, in order to respect his/her

autonomy as far as possible.

## **Rationality, competence and autonomy**

Does an autonomous decision have to be rational?

"In the ideal of autonomy day - to -day decisions should be rational, i.e. consistent with the person's life plans" (Hope, Savulescu and Hendrick, *Medical Ethics and Law*, the core curriculum, Churchill Livingstone 2003 p 34).

However this internal rationality may not be viewed as rational by an external view. A health professional may judge the rationality of a patient's decision by its consistency with the professional's view of what would be in the best interests of the patient. A decision that is seen as contrary to the patient's best interests may be interpreted as irrational by the health professional and therefore the patient may be seen, erroneously, as not competent to make an autonomous choice. It is the internal rather than the external rationality that is important here. A patient is not necessarily incompetent simply because he/she doesn't agree with the health professional about the suggested treatment. A good example of this is the case of a Jehovah's Witness who refuses a life saving blood transfusion. The decision appears irrational to the health care professional but is internally consistent with the beliefs of the patient.

## **Beneficence and Best Interests**

The principle of beneficence highlights the moral importance of doing good to others. When a patient is unable to make an autonomous choice the health professional has a duty of beneficence. Beneficence is usually considered to rely on an objective view of what would be best for the patient whereas respect for autonomy identifies what the patient subjectively considers to be in his/her best interests.

The concept of 'best interests' is linked to well-being / beneficence but includes considerations wider than purely medical risks and benefits such as the religious and cultural interests of the patient. This implies a duty to discover if possible what the patient would have wanted or what is likely to be appropriate in the context of this patient's particular life. Thus respecting the patient as an individual person (or respecting his/her autonomy) is an intrinsic part of the process of determining best interests.

There is generally no conflict between beneficence and the principle of respect for autonomy - most patients would choose the course of treatment that is objectively considered to be in his/her best interests. However difficulties arise where the view of a competent adult patient as to what is in his/her best interests conflicts with medical opinion - for example where a Jehovah's Witness patient refuses treatment using blood products. The principle of respect for patient autonomy overrides the principle of beneficence. If the patient is unconscious then knowledge of what he/she would have wanted in the circumstances is part of the assessment of what is in his/her best interests.

**It may be helpful to consider how judges in legal cases have used the concept of best interests.**

#### **Re F [1990] 2 AC 1**

The House of Lords considered whether it was in the best interests of an incompetent adult female patient to be sterilized to prevent her becoming pregnant. The court took the view that treatment would be in the best interests of a patient if it is carried out to:

- save the life of the patient
- ensure improvement / prevent deterioration in the patient's physical or mental health.

This would cover mundane treatment such as dental care and washing and dressing the patient.

**The concept of best interests is wider than a consideration of purely medical issues:**

#### **Re Y [1996] 35 BMLR 111**

The patient (Y) was 25 years old, severely mentally and physically handicapped. She lived in a nursing home but had a close relationship with her family. One of her three sisters suffered from leukemia and needed a bone marrow transplant. The patient was the only suitable donor. The court considered that it was in Y's best interests to donate bone marrow to her sister even though there was no therapeutic medical benefit to Y (and a minimal risk to Y from the procedure). The court considered that it was in Y's emotional, social and psychological interests, since, if Y's sister died, Y's mother would have to look after the sister's daughter and therefore be unable to spend as much time visiting Y in the nursing home.

There is much discussion in ethics literature about the interpretation of best interests. If a wide interpretation is given to "best interests" then the interests of those other than the patient may be taken into account in determining the interests of the patient and there is a danger of moving away from the patient as a focus for legal / ethical decision-making.

## **Professional Guidelines**

Seeking patients' consent: the ethical considerations, , November 1998

'Best Interests' principle

2.5 In deciding what options may be reasonably considered as being in the best interests of a patient who lacks capacity to decide, you should take into account:

- options for treatment or investigation which are clinically indicated;
- any evidence of the patient's previously expressed preferences, including an advance

- statement;
- your own and the health care team's knowledge of the patient's background, such as cultural, religious or employment considerations;
- views about the patient's preferences given by a third party who may have other knowledge of the patient, for example the patient's partner, family, care, tutor-dative (Scotland) or a person with parental responsibility;
- which option least restricts the patient's future choices, where more than one option (including non-treatment) seems reasonable in the patient's best interest.

Consent toolkit, 2nd Edition, BMA, February 2003

The Tool Kit consists of a series of cards relating to specific areas of consent such as providing treatment to children, consent and research, obtaining consent for teaching purposes, assessing competence and determining best interests.

[DoH](#), Reference guide to consent for examination or treatment

[DoH](#), [Good practice in consent implementation guide](#)

## Legal Considerations

There are no statutory provisions in England regarding consent of adults to medical treatment, other than adults who are subject to the Mental Health Act. Even then, the Mental Health Act only permits compulsory treatment in relation to the psychiatric condition for which the patient has been "sectioned". The position in relation to children is different. Section 9 of the Family Law Reform Act 1969 provides that the consent to medical treatment of a child of 16 or 17 is as valid as that of an adult. The section has no application to refusal of treatment by a 16 or 17 year old. The law in Scotland is different and is addressed below.

The Law Commission (Mental Incapacity 1995; Report No. 231) made recommendations to change the law on the area of mental incapacity. A draft Bill the "Mental Incapacity Bill" is likely to be introduced soon to Parliament.

1997 consultation paper 'Who Decides' [www.open.gov.uk](http://www.open.gov.uk)  
The Lord Chancellor's Department: Mental Incapacity, May 2003

### Form of Consent (Express / Implied)

Consent provides lawful justification for treatment. If valid consent is not given, any treatment which involves touching e.g. physical examination, surgery, dressing a wound, would amount to a **battery**.

There is no legal requirement that consent should be written, or be in a particular form - oral consent is valid (or it may be implied from circumstances, where for example a patient undresses prior to examination). However a written consent form provides evidence of consent and is recommended for major interventions such as surgical procedures. The Department of Health has produced standardized [consent forms](#).

Consent may be withdrawn at any time, even after signing of a consent form, and to proceed with treatment where consent has effectively been withdrawn would constitute a battery.

In order for consent to be valid it must be:

- given by someone who is competent (has legal capacity)
- sufficiently informed
- freely given

## Battery

Battery is any non-consensual touching - it does not have to harm the patient. A doctor can commit a battery even though the doctor considers he is acting in the best interests of his patient by treating him/her. To avoid liability in battery the patient should be informed in broad terms of the nature of the procedure that is intended to be carried out and give consent to it.

There are very few cases where a doctor has been successfully sued for battery.

### **Devi v West Midlands RHA [1980] C.L.Y. 687**

A woman underwent a hysterectomy to which she did not consent (she had given consent to repair her uterus). The Court found the surgeon liable in battery as there was total lack of consent to the nature of the operation.

## Negligence

If the patient claims that he has not been sufficiently informed about the risks inherent in the treatment and alternatives to the treatment then liability does not lie in battery but rather in negligence. In deciding whether non-disclosure is negligent it is necessary to determine whether there is a responsible body of clinicians in the relevant field who would warn of the relevant risks (the Bolam test). In the area of disclosure of risk, however, the judges are more ready than in other areas of clinical negligence to go against expert medical evidence in deciding what amounts to "responsible" practice.

Recent judgments in legal cases have shown that a patient should be informed of risks if:

- the incidence of the risk is sufficiently high - for example a 10% risk of stroke
- if the risk materialised it would have serious consequences for the patient
- the patient specifically asks about a risk

### **Chatterton v Gerson [1981] 1 ALL ER 257**

Mrs Chatterton suffered intractable pain as a result of a trapped nerve following a hernia operation. Dr Gerson, a pain specialist, performed an operation to relieve the pain, but this resulted in permanent immobility of her right leg. Mrs. Chatterton said that she should have been informed of this risk and claimed in battery.

It was held that she had been informed in broad terms of the nature of the procedure ie. she had been informed and consented to an operation to her right leg. The fact that she may not have been informed of the risks of paralysis to her leg could not amount to battery but any claim would have to be made in negligence.

## Capacity to consent to treatment

Capacity is treatment specific - it depends on the treatment to be performed. If the treatment is risky / has potential serious side effects / is complicated, then a higher level of capacity is required than for treatment that is straightforward or less invasive. Thus a patient can have capacity to consent to one procedure, but not to another. Capacity can fluctuate.

### Tests of capacity

There are different tests to assess capacity for adults and children.

#### Adults

An adult is a person 18 years and over. An adult is presumed to have capacity although this presumption may be rebutted if the patient fails a 3-part test. This was set out in the case of **Re C**.

A patient has capacity to consent / refuse medical treatment if he/she can:

- comprehend and retain treatment information
- believe it **AND**
- weigh it up to arrive at a choice

#### **Re C [1994] 1 WLR 290**

The patient was an adult detained in Broadmoor mental hospital. He had gangrene in his left leg and the doctors considered that amputation was necessary to save his life. He refused such treatment. Although he was a paranoid schizophrenic **his mental illness did not render him automatically incapable of making a decision about his medical treatment.**

Although C believed that he was a world-renown doctor, the experts considered that he passed the 3-stage test therefore he had capacity to decide about his medical treatment.

Adults who fail the Re C test do not have capacity to consent/ refuse treatment.

**The Mental Capacity Act (2005) will provide statutory legislation governing the treatment of adult patients who lack capacity. The Act will come into force in October 2007. See section on the Mental Capacity Act on this website.**

#### Children

In law, children are those who are under 18 years of age.

For the purposes of giving consent to treatment, children are treated differently in law according to their age.

The Family Reform Act 1969 provides that the consent to treatment of a 16 or 17 year old is to be treated like the consent of an adult. This has no application to a refusal of medical treatment or to non-therapeutic procedures like organ or blood donation. For those children under 16 there is precedent in case law governing consent to treatment. The law was set out in the case of Gillick (Gillick v West Norfolk and Wisbech AHA [1986] AC 112).

This states that if a minor has sufficient intelligence and understanding to enable him / her to understand the treatment and implications of treatment then he / she is 'Gillick competent' and can consent to treatment. (However a refusal of treatment may be treated differently - see below).

For babies, young children and teenagers who are not competent in law someone else must consent on their behalf. This can be a proxy or the Court. A proxy is usually a parent or another person with parental responsibility. In making a decision about medical treatment the proxy must act in the child's best interests and if this is not the case then the decision can be overridden by the court. Usually consent need be obtained only from one parent (although if treatment involves an operation that is irreversible and not medically necessary e.g. male circumcision if the two parents disagree it is advisable to seek advice from the court). If there is a difference of opinion between the parent (s) and the clinician regarding best interests the matter can be referred to the Official Solicitor who is likely to make an application to the court. In an emergency situation, where a parent cannot be contacted, the child can be treated without consent, but only where treatment is immediately necessary.

### **Where consent cannot be obtained from an adult patient**

In Scotland the Adults with Incapacity (Scotland) Act 2000 provides that competent individuals over 16 can appoint someone to make decisions about medical treatment on their behalf if they become unable to do so. However in English law no-one can consent to medical treatment on behalf of an incompetent adult patient (and relatives cannot demand treatment they consider is in the best interests of the patient). **However see the section on the Mental Capacity Act (2005) which will come into force in October 2007. This will provide statutory legislation governing the treatment of adult patients who lack capacity.**

There are two categories of situation where decisions about medical treatment need to be taken for incompetent patients:

- When a patient is temporarily incompetent, e.g. if he/she is unconscious following an accident or acute medical event.
- When a patient is unlikely ever to be able to make a competent decision about treatment, e.g. severe dementia or learning disability or persistent vegetative state.

In the first situation the healthcare professional should do no more than is necessary in the circumstances. This does NOT justify treatment that is against the known wishes of the patient.

### **When Consent may not be needed - s63 Mental Health Act 1983**

A patient who has been sectioned under the Mental Health Act may be treated without the requirement for consent. This is only applicable for treatment for the mental illness.

<http://www.doh.gov.uk/mentalhealth/>

## Refusal Of Treatment

### Adults

A competent adult (passes the Re C test) may refuse treatment even if his/her life depends on it. The right to refuse treatment also applies to a **pregnant woman** (who is competent under the Re C test) even though the exercise of the right to refuse treatment may result in the death of her unborn child.

The English courts protect strenuously the right to be self-endangeringly eccentric, as these extracts from judgements illustrate:

"The patient is entitled to reject [the] advice for reasons which are rational, or irrational, or for no reason." Per Lord Templeman in *Sidaway v Board of Governors of Bethlem Royal Hospital* [1985] 1 AC 171

"It is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that, if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even....though they do not consider it to be in his best interests to do so...." Per Lord Goff in *Airedale NHS Trust v Bland* [1993] AC 789.

### Children

A child who is competent can **consent** to treatment. However, a refusal of treatment may be overridden by a parent or the Court where such a refusal would be likely to result in the death or permanent disability of the child. Then the wishes of the child may be overridden to preserve his or her long-term interests.

#### **Re M [1999] 2 FLR 1097**

M was a competent 15 ½ year old who sustained acute heart failure and required a heart transplant. She stated that she did not want someone else's heart and refused to give consent. It was considered to be in her best interests to have the transplant and (although she ultimately consented to the operation) it is clear that treatment would have been declared lawful despite a refusal.

### Advance Statements

Advance statements about future medical treatment can be made by those who understand the implications of their choices in order to anticipate situations where they may lose mental capacity.

See End of Life section and Mental Capacity Act section.

# Issues that may present to a clinical ethics committee

- A competent patient refuses treatment
- An incompetent patient refuses treatment

The following worked examples of hypothetical case studies show how ethical principles would apply to practical problems.

## A competent patient refuses treatment

**Mrs X** is 35 and is in need of dialysis. She is refusing treatment because she is scared of the treatment which she believes is invasive. She has been counselled about the nature of the treatment - there are no alternatives that would be of practical benefit. She is competent to make treatment decisions. She understands that if she refuses dialysis she will die. She has a daughter of 15 years who lives at home. The clinician feels very strongly that she should receive dialysis but despite numerous attempts to persuade her she refuses.

**Can the clinician treat her?**

### Issues that a clinical ethics committee / group may consider:

**Mrs X** is competent and so has autonomy to make treatment decisions. If the principle of respect for autonomy is given the highest value then her refusal should be respected despite the resulting harm. It is clear that she considers invasive long term treatment not to be in her best interests.

It is important however that Mrs X is making an informed decision - a decision made in ignorance could not be said to be an autonomous one (although arguably a patient makes an autonomous choice if he delegates his decision to the clinician/ healthcare professional). Mrs X has received dialysis counselling but she still believes it to be invasive. Could more be done to inform her - perhaps she could be taken around a dialysis ward? If she has been sufficiently informed then does she need to make an objectively 'rational' decision? This seems unduly paternalistic and not respectful of autonomy which is the expression of individual wishes.

The clinician may feel that he is not acting beneficently towards his patient if he allows her to die for lack of dialysis. In addition, to what extent are the interests of Mrs X's daughter to be considered? Her exercise of autonomy has enormous repercussions for her daughter - has she been involved in discussions / expressed a view?

Mrs X has been assessed to have capacity. Therefore her refusal must be respected - otherwise a battery may be committed. If through lack of treatment her condition deteriorates and she becomes incompetent through illness, then her previously expressed wishes, made when competent, should be respected.

## An incompetent patient refuses treatment

**Mrs Y** is 56 years old. She has a learning disability and lives in a care home. She is admitted to hospital with an ovarian cyst. The cyst is blocking her ureter and if left untreated will result in renal failure. Mrs Y would need an operation to remove the cyst. Mrs Y has indicated quite clearly that she does not want a needle inserted for the anaesthetic for the operation to remove the cyst - she is uncomfortable in a hospital setting and is frightened of needles.

The clinician is concerned that if the cyst is not removed Mrs Y will develop renal failure and require dialysis which would involve the regular use of needles and be very difficult to carry out given her fear of needles and discomfort with hospitals. The anaesthetist is concerned that if Mrs Y does not comply with the procedure then she would need to be physically restrained. Mrs Y's niece visits her in the care home every other month. The niece is adamant that her aunt should receive treatment.

**Should the surgeon perform the operation despite Mrs Y's objections?**

### **Issues that the clinical ethics committee may consider:**

An initial step may be to clarify all the facts in the case, for example does Mrs Y have any understanding of the risks of not having this treatment? Her learning disability means that she is unlikely to be competent to consent or refuse the operation, but an attempt should be made to explain to her, in terms that she could understand, what the treatment would involve and what the outcome would be without treatment. Have alternative forms of anaesthetic and ameliorating strategies such as local anaesthetic cream or a sedative drink prior to injection been discussed? Has her autonomy been enhanced as much as is possible? If the conclusion is that she is unable to understand the consequences of non treatment, or that her fear of needles is stopping her evaluating the risks, then she will not be competent to make a decision. However, this does not mean that her fears and concerns should not be acknowledged.

The consequences of the various courses of action need to be considered. If she is not treated then she is likely to develop renal failure. Dialysis would cause her repeated distress as it is an ongoing treatment. If dialysis cannot be maintained she will die. Treatment will involve some degree of force or deception, which could cause increased distress, possible physical harm, and have long term effects on her future cooperation with health care professionals. A balancing of the harms and benefits of the various options is required to determine what would be in Mrs Y's best interests. In this case, in view of the serious and prolonged harm of not treating her, and the circumscribed nature of the harm of treatment, it would seem to be in her best interests to be treated. If dialysis is the proposed treatment the balance of harms and benefits may be such that treatment would not be in her best interests if it causes severe distress on a regular basis such that her life is intolerable. If the decision is to perform the operation on Mrs Y, then once again respect for her wishes and concerns should influence the approach to treatment so that her fears are mitigated as much as possible.

This approach reflects that it would not be ethical simply to assess Mrs Y as incompetent and then proceed to treatment in the most convenient manner for the health professionals without regard for Mrs Y as a person.

The views of Mrs Y's niece should be acknowledged but they can only be given weight in the decision if they contribute to the assessment of what would be in her best interests. Legally, no person can give consent or refuse treatment on behalf of another adult.

## **Useful Links For Patients**

The [Department of Health](#) has produced the following guidance for patients surrounding consent.

- [A guide for adults](#)
- [A guide for children and young people](#)
- [A guide for people with learning disabilities](#)

- [A guide for parents](#)
- [A guide for relatives and carers](#)

## Reading

Hope, Savulescu and Hendrick, Medical Ethics and Law, the core curriculum, Churchill Livingstone 2003, Chapters 3 and 6

Mason and McCall Smith. Law and Medical Ethics, J.K. Mason, R.A. McCall Smith, G.T. Laurie, (Butterworths) 2002.

The courts' role in decisions about medical treatment, Laurence Oates, Official Solicitor, BMJ 2000;321:1282-1284

Better to hesitate at the threshold of compulsion: PKU testing and the concept of family autonomy in Eire, G Laurie, J Med Ethics; 2002; 28:136-138

Depression and competence to refuse psychiatric treatment, A Rudnick, J Med Ethics; 2002; 28:151-155

Consent, sectionalisation and the concept of a medical procedure, A R Maclean, J Med Ethics; 2002; 28: 249-254

Clinical issues on consent: some philosophical concerns, R Worthington, J Med Ethics; 2002; 28: 377-380

Some limits of informed consent, O O'Neill, J Med Ethics 2003; 29: 4-7

Incapacity to give informed consent owing to mental disorder, C W Van Staden, C Kruger, J Med Ethics;2003; 29: 41-43

Paternalism and partial autonomy, Onora O'Neill, J Med Ethics;1984; 10: 173-8.

## University of Oxford - Medical Ethics Teaching Materials:

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