Consent and Capacity

Further information can be found be clicking the embedded hyperlinks

Underlying Law/Advice

2000 NHS plan and advisory group on consent led to "HSC 2001/023: Good practice in consent: achieving the NHS Plan commitment to patient-centred pactice" go to HSC 2001/023

Human Right Act 1998 HRA 1998

Human consent case law go to English Consent Law FAQ's

GMC "Seeking Patients Consent: The Ethical Considerations"

Childrens Act 1989

Bolam vs Friern Hospital Management Committee 1957

Sidaway vs Board of Governers of the Bethlem Royal Hospital 1985

Gillick vs West Norfolk & Wisbech AHA 1985

Validity

Consent is only valid is patient has all the necessary information to make a decision (depending on age, maturity, intellect etc), has capacity, is legally competent, is voluntary and is not under duress (from clinician or eg relative).

When?

Most practice is 'implied', lying down for examination, holding out arm for venepuncture, BUT good practice to first mention what you are about to do and ask if it is OK. Failure to get permission or proceeding against patients wishes constitutes assault.

Any sedation, GA or procedure which carries significant risk (eg thrombolysis) must have specific consent obtained. Ideally consent obtained 'pre-op' to allow cooling off period. Impractical for most EM practice, but could be used for eg Colles under Biers the next day-get consent the day before. Oral consent is JUST as valid as written but written easier to justify actions and provide what was discussed at a later date.

If patient unconscious, then in best interest if:

- It saves life
- and/or prevents deterioration
- and/or improves health
- is in accordance with established medical practice
- patient was competent and did not refuse treatment before losing consciousness

Who obtains consent?

The person doing the procedure or who has the necessary knowledge (not delegated to junior)

What information?

'Bolam test' for most cases, ie body of expert opinion. However in the Sidaway case the House of Lords ruled that although the information given should be that of a responsible body of medical opinion (ie Bolam test) as for negligence, it was up to the COURT to decide if a particular risk was so obviously necessary that it would be negligent not to provide it, even if a 'responsible body' of medical opinion would not have done so-case law still evolving (also see Bolitho vs City & Hackney Health Authority 1997).

Must include if; material (doctor/patient attaches significance to them), high incidence, serious consequences, patient asks. Not if doctor thinks it would be detrimental to patients health ('therapeutic privilege').

In practice need to include details of intended procedure, benefits and common or serious risks for patient and possible alternatives (risks without procedure) to make a balanced decision. Need to try and tailor it to an *individuals* needs according to GMC. Patient can change his/her mind.

Who gives/witholds consent?

Consent and Capacity

Only an adult with capacity can give consent for themselves. No-one can currently give/withhold consent for another adult in England & Wales*. Children <16 years can *consent* to treatment even if parents don't if they are 'Gillick' competent [Fraser guidelines-relates specifically to contraceptive advice] though does not cover *refusal* (Re R 1992) depending on age and complexity of proposed treatment (if upheld by health professional and parent. If child refuses a parent can override and consent. In an emergency, clinician can override both parental and child refusal of consent in the best interests of the child (eg blood transfusion in a Jehovah's' Witness child). If not urgent, the local/health authority can issue a 'specific issue order' under the Children Act 1989 specifically for the treatment.

If in doubt in non-emergency apply to High Court.

Capacity

A patient, to have capacity, must be shown to:

1.*comprehend* and

2.*retain* information that has been presented to him in a way that he can understand

3.*believe* that information

4.be able to *weigh up* that information and use it to make an informed decision

Refusal to consent requires a higher level of capacity than agreement. May need psychiatry input if refusing life saving treatment (+'spread the risk'!). In law alcohol intoxication does NOT make a person incapable of making a decision

Assessment may be compromised by drugs, alcohol, pain , coexisting illness eg head injury and LOC.

Does not hold true if woman pregnant-law protects potentially viable foetus.

Can treat patients who lack capacity under the 'doctrine of necessity'. Unclear how Human Rights Act may influence detention under common law.

If a patient leaves against advice there is no LEGAL basis to have him brought back by police unless sectioned under the mental health act.

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*Mental Capacity Act 2005

Carers of patient lacking capacity cannot be held accountable for acting in the patients best interest (eg injections etc).

Detaining a patient without capacity against their will is now covered in this act (ie no longer 'common law'). Human Rights Act Sec 5(1) does not cover these patients

Patients can have 'Lasting powers of attorney' (LPAs)to make health decisions for them if lose capacity

Independent Mental Capacity Advocate (IMCA) to make decisions on patients behalf who lack capacity