



Consent – the basics

Advice correct as of May 2015

Respect for patients' autonomy is expressed in consent law; to impose care or treatment on people without respecting their wishes and right to self-determination is not only unethical, but illegal.

Key principles

For consent to be valid:

- **The patient must be competent** – mental capacity is decision-specific. Assessment of a person's capacity should be based on his/her ability to understand, retain and weigh in the balance the information relevant to a particular decision. The person must also be able to communicate the decision. A patient who is unable to make a decision about a complex proposal is not necessarily incapable of making any decisions at all, and may be perfectly able to consent where the issues are simpler. The starting point in the case of adults is always to presume that the patient has capacity until it is shown otherwise.
- **The patient must have sufficient information to make a choice** – without adequate information, patients are unable to make decisions about their treatment. The information provided should, for example, include: an explanation of the investigation, diagnosis or treatment; an explanation of the probabilities of success, or the risk of failure; or harm associated with options for treatment. The patient should be given time to ask questions. The GMC and the courts expect patients to be given all information material to their decision, with the proviso that it would not cause the patient serious harm.
- **The patient must be able to give their consent freely** – pressuring patients into consenting to treatment invalidates the consent. To ensure that consent is freely given, patients should, where possible, be given time to consider their options before deciding to proceed with a proposed treatment. Be aware, too, that patients' friends and relatives may also try to exert their influence and that this can be subtle but nevertheless powerful.

Patients who lack capacity

Patients who lack capacity should not be denied necessary treatment simply because they are unable to consent to it. The principle of proxy decision making on behalf of children is well established. The Mental Capacity Act 2005 has provisions allowing for the appointment of proxy decision makers for incapacitated adults.

In the absence of a proxy decision maker, either because there isn't one or because the proxy cannot be reached before emergency treatment is required, the principle of necessity justifies treatment of an incompetent patient without consent. In all these circumstances any decision that is taken on behalf of an incompetent patient must be taken in his or her best interests.

The Mental Capacity Act Deprivation of Liberty Safeguards provide legal protection for those who lack capacity and who may be deprived of their liberty in hospitals or care homes to protect them from harm.

For more information see the MPS factsheet, *Mental Capacity Act 2005 Deprivation of Liberty Safeguards*.

Cases that should go to court

The Court of Protection's Practice Direction regarding "serious medical treatment" states that some matters should be brought to the court. In paragraph 5, which relates to the applications for patients without capacity, it says:

"Cases involving any of the following decisions should be regarded as serious medical treatment for the purpose of the Rules and this practice direction, and should be brought to the court:

- (a) Decisions about the proposed withholding or withdrawal of artificial nutrition and hydration from a person in a permanent vegetative state or a minimally conscious state

(b) Cases involving organ or bone marrow donation by a person who lacks capacity to consent

(c) Cases involving non-therapeutic sterilisation of a person who lacks capacity to consent.”

There are other procedures or treatments not contained in the list which can be regarded as serious medical treatment (see link to Practice Direction below). Whether or not a procedure is regarded as serious medical treatment will depend on the circumstances and the consequences for the patient.

Verbal or written consent?

There are very few occasions where the law specifically requires written consent – for example, in relation to the storage and use of gametes and embryos in fertility treatment. But in the main, a verbal consent is just as valid as written consent. Consent is a process – it results from open dialogue, not from getting a signature on a form.

Completed consent forms provide some evidence that consent was obtained, but mean little beyond that – it is important to realise that they do not constitute proof that the consent was valid. If there is any dispute over whether valid consent was obtained, the key issue will not be whether the patient signed a form or not, but whether they were given all the information they needed to make a considered decision. It is, therefore, crucial that the essential elements of discussions with the patient are documented in the medical record.

The notes do not need to be exhaustive, but should state the nature of the proposed procedure or treatment and itemise the risks, benefits and alternatives brought to the attention of the patient. Any particular fears or concerns raised by the patient should also be noted.

Failure to obtain valid consent

A significant proportion of clinical negligence claims are settled simply because valid consent was not obtained. In theory, where harm has befallen the patient and consent was not obtained, this could also give rise to claims for assault or battery and, in extreme cases, criminal charges, but fortunately this is exceptionally rare.

Disregarding the GMC's advice on consent can sometimes result in charges of professional misconduct and action by the GMC on the doctor's registration.

Further information

- MPS factsheet, *Consent – Children and Young People* – www.medicalprotection.org/uk/factsheets
- GMC, *Consent: Patients and Doctors Making Decisions Together* (2008) – www.gmc-uk.org/guidance
- BMA, *Consent Toolkit: 5th edition* (2009) – www.bma.org.uk
- DH, *Guidance on Consent to Treatment* – www.dh.gov.uk
- Mental Capacity Act (2005) – www.legislation.gov.uk/uk
- Mental Capacity Act Code of Practice – www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- Courts and Tribunals Judiciary, *Practice Direction E – Applications Relating to Serious Medical Treatment* – www.judiciary.gov.uk/publications/9e-applications-relating-to-serious-medical-treatment

For medicolegal advice please call us on:

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This factsheet provides only a general overview of the topic and should not be relied upon as definitive guidance. If you are an MPS member, and you are facing an ethical or legal dilemma, call and ask to speak to a medicolegal adviser, who will give you specific advice.

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