# CONSENT IN HEALTH CARE PRACTICE

**Gareth R. Thomas © 1998**

This article provides a critical review of the law concerning consent to medical treatment. Particular regard is paid to the role of the health care professional who strongly recommends a course of action, to which an adult patient refuses consent. This article is not intended to be a discourse on the ethics of patient autonomy or paternalism.

**Introduction**

Any person making non-consensual contact with the body of another person may encounter civil and/or criminal liability for that act. There is little doubt that health care professionals are included here, though any liability will normally be civil rather than criminal, with compensation awarded to the wronged patient rather than punishment of the health care provider. Treatment provided in good faith and in a manner regarded as acceptable by a responsible body of practitioners does not attract criminal liability. It is the absence of *bona fide* treatment or the presence of *mala fides* that attracts criminal liability. An example of this would be the administration of a soporific drug to a patient in order to have sexual intercourse without the patient's consent.

Civil liability for non-consensual touching is based on the tort of trespass to the person and specifically, the tort of battery. Trespass to the person is a strict liability tort. The patient does not have to establish any fault on the part of the health care provider in order to make him liable for compensatory damages. Since motive has no role in strict liability, a health care worker who aims to relieve pain, but does so by proceeding with treatment which the patient has not consented to, whether expressly or impliedly, can be faced with a legal action in trespass to the person.

In English law, "an adult patient who is mentally and physically capable of exercising a choice ***must*** consent if medical treatment of him is to be lawful." per Lord Donaldson in ***Re T***.[1] This is the requirement for the patient to have the capacity to consent to medical treatment.

The un-coerced, voluntary consent of an autonomous patient will provide a health care worker with a complete defence to trespass to the person. It is immaterial whether the patient's consent is verbal or written or implied by non-verbal communication. In English law, it has been argued the 'true' or 'valid' consent of an autonomous patient is known as a **real** consent and not informed consent. In many respects the phrase, "informed decision and reasoned consent" conveys a more appropriate meaning than 'real' consent since it better describes the two stages involved in the decision making process.

**Consent to Treatment.**

Consent to treatment, is a controversial topic with divergent views on what amounts to patient consent. It has been stated that:

> *"For medical interventions it is widely accepted that consent means a voluntary, uncoerced decision, made by a sufficiently competent or autonomous person on the basis of adequate information and deliberation, to accept rather than reject some proposed course of action that will affect him or her."* Gillon[2].

Thus, any health care professional who wishes to avail himself of a defence to trespass to the person must :

(a). provide the patient with a minimum quantum of information. The information must be "understandably communicated" which means that the patient must be informed in broad terms of the nature of the treatment intended.

(b). satisfy himself that the patient is capable of receiving and giving information. The significance of this lies in the fact that the legal presumption of capacity which *prima facie* applies to all adults is a **rebuttable presumption**. A legal presumption is the starting point for the court which can in appropriate circumstances be persuaded by counsel to take the opposite view.

(c). ensure that the patient's decision is attributable solely to the patient, if that patient is an adult who is not recognised as suffering from any form of mental impairment. If the patient is a minor (particularly someone under the age of 16 years), then in addition to (a) and (b) having to be satisfied, the health care professional must satisfy himself that the patient is capable of understanding the information. This capability will depend on the age of the minor patient as well as the nature of the

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1 Re T [1992] 3 W.L.R. 782.

2 Philosophical Medical Ethics, Chichester: Wiley& Sons 1987.

proposed treatment. If the health care provider is satisfied that the minor has demonstrated this capability then he may operate on the basis that the minor has sufficient capacity to consent to treatment. The treatment itself may then be commenced without fear of litigation in respect of trespass to the person. The legal principles relating to consent to treatment are identical for all professional health care providers such as doctors, dentists and nurses and equally appropriate for all.

**Consent and Liability for Trespass to the Person**

The general rule relating to the tortious action of trespass to the person is that:

> *"...Everybody is ... protected ... against any form of physical molestation ... [though this rule is] subject to exceptions. For example ... people may be subjected to the lawful exercise of the power of arrest; and reasonable force may be used in self defence or for the prevention of crime ... [furthermore] a broader exception has been created to allow for the exigencies of everyday life. Generally speaking, consent is a defence to [the tort of] battery; and most of the physical contacts of everyday life ... are impliedly consented to by all who move in society and so expose themselves to the risk of bodily contact. So nobody can complain of the jostling which is inevitable on a busy street; nor can a person who attends a party complain if his hand is seized in friendship, or even if his back is, within reason, slapped ...*" per Goff L.J.[3]

The amount of information that should be imparted to a patient in order to displace tortious liability in English law has been specifically addressed by the courts.

> "*... once the patient is informed in broad terms of the nature of the procedure which is intended, and gives [his] consent, that consent is real ... Of course, if information is withheld in bad faith, the consent will be vitiated by fraud* " per Bristow J. in ***Chatterton v. Gerson***[4].

Consent to treatment is not necessarily consent to be subjected to unknown and unconsidered risks from a patient's point of view. This begs the question whether or not to be valid, consent must be based on a complete understanding of the risk entailed by the patient. Should practitioners explain fully to patients all possible likely outcomes and not just the beneficial hoped for outcomes of treatment, or are patients to be deemed to appreciate these risks without more input from the practitioner, from a description of the treatment?

In the English Legal System there is no doctrine of **informed consent** as in some States in the United States of America. The case that rejected the opportunity to import this "prudent patient" test otherwise known as the "informed consent" was ***Sidaway v. Bethlem Royal Hospital***[5]***. The significance of the case was summed up by Lord Scarman, who stated, that the issue was the principle of "informed consent":***

> " *... plainly of great importance. It raises a question which has never before been considered by your Lordships' House: has the patient a legal right to know, and is the [doctor] under a legal duty to disclose, the risk inherent in the treatment which the [doctor] recommends.*"

Some commentators have reached the conclusion that informed consent is part of English Law. This misconception may be attributed to an unduly generous reading of Lord Scarman's later opinion, where he stated in his judgement that:

> " *... the circumstance that this house is now called on to explore new ground is no reason why a rule of informed consent should not be recognised and developed by our courts. ...If, therefore, the failure to warn a patient of the risks inherent in the operation which is recommended does not constitute a failure to respect the patient's right to make his own decision, I can see no reason in principle why, if the risk materialises and injury or damage is caused, the law should not recognise and enforce a right in the patient to compensation by way of damages.*"[6]

Suffice it to say, however, this was not an opinion accepted by the other Law Lords and the doctrine of informed consent or the prudent patient test has not been adopted by the English Courts. The principle that "informed consent" is not part of English Law has since been reaffirmed by Lord Donaldson M.R. in ***Re T***[7].

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3 Goff L.J. in ***Collins v Wilcock*** [1984] 1 W.L.R. 1172.

4 ***Chatterton v Gerson*** [1981] 1 Q.B. 432.

5 ***Sidaway v Board of Governers of the Bethlem Royal Hospital and the Maudsley Hospital and Others*** [1985] 1 A.C. 871.

6 ibid p. QQQ

7 ***Re T*** [1992] 3W.L.R. 782.

It is submitted that it is not too late for such a principle to be introduced by the courts and the legal position could change in the future. None the less this is the position in English Law at present.

The decision of the Court in ***Sidaway*** whilst ultimately rejecting the concept of the "prudent patient" did, however, change the previous accepted parameters of what was acceptable communicated consent without adopting the doctrine of informed consent.

In essence, there are two principal differences between 'informed decision and reasoned consent', and informed consent as recognised in the minority of American States :

(i) for an informed decision and a reasoned consent to be obtained, the patient must be informed in "broad terms of the nature of the procedure which is intended", whereas for informed consent all material risks have to be disclosed. "The test for determining whether a particular peril must be divulged is its materiality to the patient's decision; all risks potentially affecting the decision must be unmasked."[8]

(ii) Whereas the standard in English law for determining the quantum of information to be disclosed is determined by a responsible body of medical opinion (the ***Bolam test***[9]***), the transatlantic standard:***

> "*demands a standard set by law for physicians rather than one physicians may or may not impose on themselves [because] any definition of scope in terms purely of a professional standard is at odds with the patients prerogative to decide on projected therapy himself*.".[10]

Accordingly, English law continues to recognise as acceptable and appropriate a health care professional's paternalistic attitude towards his patients: "a doctor knows best" approach may be the most realistic method of providing health care even in situations in which the patient's autonomy is clearly overridden. In such circumstances, as in the ***Sidaway*** case for example, doctors have successfully claimed "therapeutic privilege" and so negated liability.

**Capacity of the Patient to Consent to Treatment**

An adult person in full charge of his or her mental capacity is deemed to be capable of making decisions in respect of medical treatment. From the legal point of view **capacity** is used to describe any situation which deprives the patient of the mental capacity to make such decisions. A number of tests have been proposed by which a patient's capacity may be determined. An acceptable approach having to determine whether:

1. any individual can consent to the proposed treatment; and
2. the individual in question can consent to it.

The first stage can immediately be answered in the affirmative, provided it is a recognised treatment. An individual even has the capacity to consent to "non-therapeutic" "treatment" which has no medical benefit to him/her personally, an example of this being an organ transplant from the individual in question to a related or an unrelated recipient.

Therefore, the central question revolves around the second stage as to whether the individual in question, who is the subject matter of the discussion, has the capacity to consent to the proposed treatment. In this context, Kennedy & Grubb, in their first edition[11] have listed three factors that are important in relation to capacity:

> " (1). Determination of what is meant by the capacity of a particular individual;
> (2). Selection of the most appropriate method for establishing his or her capacity;
> (3). Potential legal liability for incorrect assessments of his or her capacity."

**(1).** ***Meaning of Capacity.***

If a patient is to be judged as being autonomous; that is, he has the right to self determination, or, in legal terms, he is accorded the capacity to make a decision regarding his proposed treatment then he must possess:

(i) **the ability to receive and give information;**
(ii) the ability to compare the results of accepting and refusing treatment;
(iii) the ability to make reasonable consistent choices.

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8 per Robinson J. in ***Canterbury v Spence*** (1972) 46 F. 2nd 772.

9 "A doctor is not ... negligent if he act[s] in accordance with a practice accepted as proper by a responsible body of men skilled in that particular art ..." per McNair J. in ***Bolam v Friern Hospital Management Committee*** [1957] 1 W.L.R. 582.

10 op.cit. fn 8

11 Kennedy & Grubb, Medical Law Text & Materials, London: Butterworths 1989, p 180-214.

A distinction must be drawn between the patient's capacity to make a decision by applying these criteria, to the capacity of any person to make a decision on the basis of the actual information supplied by the practitioner.

**(2).** ***Establishing Capacity.***

The four accepted principal methods of establishing patient capacity used by practitioners are:

(i) evidencing a choice;
(ii) the outcome approach;
(iii) status; and
(iv) understanding.

**Use of tests.**

**(i) Evidencing a choice.**

The basic requirement for this test is that the patient is capable of making a decision for or against the proposed treatment that is evidenced either verbally or by way of his actions. Not making a decision can lead to the conclusion that the patient is not competent. This test is clearly very crude in that it required of the patient only the ability to verbalise yes or no to the proposed medical treatment. It is supposed to have the merit of securing a non-paternalistic decision, but provides no evidence of a reasoned choice in respect of a patient who cannot make up his or her mind as to an alternative. This is an *ex facto* test. Did the patient make a choice? If so he was capable of doing so.

**(ii) The Outcome Test.**

For a patient to have capacity within the meaning of this test, he must make a decision that is in accordance with conventional medical practice. It is valid as a test since it is the basis of judicial tests an example being Jehovah's Witnesses where practitioners' challenge the patient's capacity in Court. If the patient fails to make such a decision, then under this test of capacity, treatment could be imposed on him by way of necessity. A patient who chooses one of several "medically" approved treatments would be deemed to have reached a valid outcome. It is a test that is not acceptable, as it does not show any regard for patient autonomy.

A practitioner could avoid using this test in respect of a patient who cannot make up his or her mind or move on to an alternative test in order to reach an outcome.

**(iii) Status**

The basis of this approach for use by practitioners is that capacity is conferred on someone belonging to a particular group and lack of capacity is associated with those outside the group. The age of majority is a *prima facie* example of capacity being conferred on someone by their status. **The Family Law Reform Act 1969** (FLRA 1969) lowered the age of majority from 21 to 18. However, in the case of medical or dental treatment s.8(1) of the 1969 Act provides that:

"The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has ... given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian."

If s.8(1) is read in isolation, it could be taken to indicate that the age of sixteen has replaced the age of eighteen as the age of majority for "surgical, medical or dental treatment", but this is too simplistic. This concept of a fixed age limit was criticised in ***Gillick v. West Norfolk and Wisbech Area Health Authority***[12] by Lord Scarman[13].

> " *... A fixed age limit of sixteen ... brings with it an inflexibility and a rigidity which in some branches of the law can obstruct justice, impede the law's development and stamp on the law the mark of obsolescence where what is needed is the capacity for development*."

In fact, **s.8(3) FLRA 1969**, confirms that in certain circumstances, the possibility of minors under the age of sixteen, can also give a legally valid consent. It provides that:

> "*Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted*."

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12 ***Gillick v West Norfolk and Wisbech Area Health Autthority*** [1986] A.C. 112

13 ibid p.

Thus, this sub-section of the **FLRA 1969**, permits a minor to consent to treatment on the basis of his common law capacity to understand the nature of the proposed treatment. Persons of sixteen years and over are presumed to have this legally required degree of understanding, though, as noted, this is a rebuttable presumption.

**(iv). Understanding.**

There are two problems that are recognised with this test:

(a). The level of understanding which a patient must demonstrate if he is to be deemed as having the capacity to consent.

(b). The application of this test depends on the patient's mental processes that are unobservable and inferential rather than observable, objective elements of behaviour.

(a). The Level of Understanding Required.

Three different tests have been postulated to test a patient's understanding and therefore the capacity to consent.

(1) The patient understands what is involved.

(2) The patient in general is capable of understanding though it may emerge in the future that he did not understand.

(3) The reasonable patient is capable of understanding the procedure involved.

Options (1) and (3) have been rejected. Option 3 does not relate to the individual patient, but to the reasonable patient. It is wholly inappropriate to suggest that it is the patient in question who must be capable of understanding the issues involved, but then approving a test which does not require that individual patient to understand, only a notional reasonable patient who must understand the proposed treatment. Option 1, has been rejected because it places an onerous burden on the health care worker in that he would have to demonstrate that the patient has understood the information imparted to the patient by the health care worker. The only viable option is option 2 where the patient must be *capable* of understanding what is involved before he can be deemed as having the capacity to consent.

An unwise decision in the eyes of a doctor or dentist does not mean that the patient lacks understanding neither does it mean that the health care professional is liable for according that patient capacity. In difficult and/or controversial situations it is permissible, indeed it is recommended, that the health care provider questions the patient over the choices and decisions that he has made. This is in order to determine that the patient has understood the nature of the situation and the decision that he has made on the information given by the health care provider. The general rule is that "the patient's right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent." per Lord Donaldson in ***Re T***[14]**.** ***"The patient has a right to be wrong," per Prowse in Hopp v. Lepp***[15].

It would not be acceptable to create a situation where a person who is dissatisfied with the results of treatment could disclaim consent simply by alleging that they did not understand the implications at the time, leaving the health care practitioner to disprove the "actual state of mind".

The court indulges in a fiction when it makes a finding of fact as to actual understanding which it bases on objective tests - viz.- in the absence of proof would a person of the patient's capacity have been capable of understanding?, if so understanding is **implied**, since it is impossible to establish actual understanding as **a fact**.

The test, therefore, is could a reasonable health care practitioner in all the circumstances of the case have reached the conclusion that the patient had the capacity to understand the proposition and/or issues put before them. If so the patient had capacity.

**Minors and Understanding**

The accepted situation following ***Gillick***[16] was that a minor who demonstrated the maturity and understanding appropriate to the nature of the intended treatment could consent to that medical or dental treatment. Therefore, *at the time*, the minor's right to self determination was noted in respect of that *particular treatment*, the minor was said to be "Gillick competent". It cannot be over emphasised that

14 ***Re T*** [1992] 3 W.L.R. 782

15 ***Hopp v Lepp*** 112 D.L.R. (3d) 67 per Prowse J.

16 ***Gillick*** [1986] A.C. 112

capacity of a minor refers to the particular treatment consented to on that particular occasion. However, once the minor is accorded the capacity to consent, **s.8(1) FLRA 1969**, as noted above, provides that; " ... it shall not be necessary to obtain any consent ... from his parent or guardian." This point, was made by Lord Scarman, in ***Gillick***[17] where he stated:

> "*As a matter of law the parental right to determine whether or not their minor child below the age of sixteen will have medical treatment terminates if and when that child achieves sufficient understanding and intelligence to enable him or her to understand fully what is proposed*."

However, following the Court of Appeal decision in ***Re R***[18], it was held that the Court could decide what was in the minor's best interests even if that did not accord with the wishes of the Gillick competent child or the child's parents. The reasoning behind this was given in the later case of ***Re J***[19] that affirmed the comments made in ***Re R***[20]. Lord Donaldson said that:

> "*Good parenting involved giving minors as much rope as they could handle without an unacceptable risk that they would hang themselves. It was self-evident that that involved giving them the maximum degree of decision-making which was prudent. Prudence did not involve the avoidance of all risk but of risks which if they did eventuate might have irreparable consequences or were disproportionate to the benefits accruing from taking*."

In taking this approach, Lord Donaldson was following the philosophy and reasoning behind the **Children Act 1989**, where emphasis was placed on the welfare of the child as opposed to the mere wishes expressed by the child. The child in this case was over the age of sixteen years, but the Court of Appeal held that **s.8 FLRA 1969**, did not confer complete autonomy on minors over the age of sixteen years with regard to their medical treatment. The Court in its exercise of wardship jurisdiction would decide what was best for the patient.

**Recent Developments**

There have been recent cases on consent and capacity that have led to disquiet with the Courts judgements concerning patient autonomy as opposed to the paternalistic approach of the medical profession. These cases are ***Re R***[21]**,** ***Re S***[22] and ***Re T***[23]. The latter two cases being the more important as they are adult cases decided on the points of capacity and consent.

In many ways ***Re T*** is a classic example of medical law in operation. The facts of the case were that T was a woman who was 34 weeks pregnant and had been involved in a road traffic accident. She had been raised by her mother a fervent Jehovah's Witness, though T herself was not. T's paternal family was opposed to the Jehovah's Witness sect.

T went into labour subsequent to the accident and following a visit from her mother stated that she did not want blood transfusions. Indeed, T had enquired about substitute treatments for blood and had been informed, incorrectly as it transpired that substitutes were available. T went into labour and the decision was made to deliver the baby by Caesarean section. T signed a "consent/refusal" form to blood transfusions, but it was not explained that it might be necessary for her to have a blood transfusion to prevent injury to her health or to save her life. In fact, the contents of the form were not read to her and the implications were not explained.

T underwent Caesarean section. The baby was still born. T's condition deteriorated. She was taken to intensive care after an abscess developed on her lungs. Her condition was critical. On July 8 1992 Ward J. granted a declaration which stated, that it would not be unlawful for T to be given a blood transfusion despite the absence of consent. On July 10 Ward J held that:

(1) Miss T had the capacity to make a valid refusal of blood on July 5 and, although she was undoubtedly under the influence of her mother, she did reach a decision as to her own treatment;

(2) Miss T was lulled into a sense of false security and was misinformed as to the availability and effectiveness of alternative procedures;

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17 ibid

18 ***Re R*** [1991] 4 All E.R. 177

19 ***Re J*** [1992] 3 W.L.R. 758 (Reported as ***Re W***)

20 [1991] 4 All E.R. 177

21 ***Re R*** (a Minor) [1992] 3 Med L.R.

22 ***Re S*** [1993] 1 FLR

23 ***Re T*** [1992] 3 Med L.R.

(3) Miss T's refusal of treatment by blood transfusion did not extend to the question of whether or not she should receive transfusions in the extreme situation which had arisen;

(4) as Miss T was no longer able to express any view, it was an "emergency" situation in which it was lawful for the doctors to treat her in whatever way they considered, in the exercise of their clinical judgment, to be in her best interests.

The decision reached by Ward was appealed against before Lord Donaldson MR, Butler-Sloss and Staughton LJJ in the Court of Appeal, who dismissed the appeal.

Whilst Ward J.'s decision regarding the legality of the treatment was upheld, but Donaldson MR discussed whether or not T was originally in a position to give a reasoned consent to the proposed blood transfusion. It was clearly reaffirmed by Lord Donaldson[24] that:

> "*An adult patient who, ..., suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered*"

This clearly echoes Justice Cardozo's famous words in ***Schloendoff v. Society of New York Hospital***[25]

> "*Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages*."

Indeed, Lord Donaldson followed up his statement by stating that:

> "*This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent*." [26]

For my part I think that there is abundant evidence which would have justified this court in substituting findings that Miss T was not in a physical or mental condition which enabled her to reach a decision binding on the medical authorities and that even if, contrary to that view, she would otherwise have been in a position to reach such a decision, the influence of her mother was such as to vitiate the decision which she expressed.

I say this in the light of a number of considerations, the effect of which is cumulative:

(a) Miss T had been involved in a road traffic accident four days' earlier with effects which were not fully known.

(b) She was 34 weeks' pregnant and must have been anxious as to the health of her baby.

(c) She had developed a severe pneumonia and, whether as a result of the accident or the pneumonia or both, was in severe pain.

(d) She had for the previous 24 hours been receiving narcotic drugs and antibiotics and was in a state in which it was necessary to give her oxygen.

(e) She appeared to her father to be disorientated and, according to the original evidence of Dr F, to be "drowsy, detached and not fully *compos mentis*".

(f) The matrimonial history of father and mother suggests that Miss T's mother is a deeply committed Jehovah's Witness, who would regard her daughter's eternal salvation as far more important, and more in her daughter's best interests, than lengthening her terrestrial life span.

(g) We do not know what the mother said to Miss T, because she has not chosen to tell the court, but it appears to be fact that on the two occasions when Miss T raised the issue of blood transfusions, she did so suddenly and "out of the blue" without any inquiry from hospital staff and immediately following occasions when she had been alone with her mother.[27]

Thus, Donaldson faced the fundamental aspect of the case in questioning whether T did make a free and reasoned choice and if not whether her refusal to blood transfusions was a valid refusal or otherwise. Donaldson also addressed himself to the wider problems of consent and capacity in medical cases.

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24 ***Re T*** p307 [1992] 3 Med L.R.

25 Per Cardozo J. 211 N.Y. 125 1914.

26 ibid p.307

27 ibid. p311

Doctors faced with a refusal of consent have to give very careful and detailed consideration to the patient's capacity to decide at the time when the decision was made. It may not be the simple case of the patient having no capacity because, for example, at that time he had hallucinations. It may be the more difficult case of a temporarily reduced capacity at the time when his decision was made. What matters is that the doctors should consider whether at that time he had a capacity which was commensurate with the gravity of the decision which he purported to make. The more serious the decision, the greater the capacity required. If the patient had the requisite capacity, they are bound by his decision. If not, they are free to treat him in what they believe to be his best interests. [28]

In ***Re T***, it is possible to argue on the given facts that the influence of other people, in particular the mother, was of paramount importance. The importance of external influences did not escape the attention of Lord Donaldson in his judgement.

A special problem may arise if at the time the decision is made the patient has been subjected to the influence of some third party. This is by no means to say that the patient is not entitled to receive and indeed invite advice and assistance from others in reaching a decision, particularly from members of the family. But the doctors have to consider whether the decision is really that of the patient. It is wholly acceptable that the patient should have been persuaded by others of the merits of such a decision and have decided accordingly. It matters not how strong the persuasion was, so long as it did not overbear the independence of the patient's decision. The real question in each case is "does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?". In other words "is it a decision expressed in form only, not in reality?". [29]

Lord Donaldson, summed up this dilemma perfectly as; "*In other words the patient may not mean what he says*" [30]

However, Lord Donaldson may have done the greatest service to conflicts regarding consent and capacity with his statement of "the role of the courts", where it is made clear that it is the court's duty to decide what are the best interests of the individual patient and not the medical staff, family, friends etc.. The court has to make its decision based on the individual case before it rather than deciding on a class precedent of all patients in certain categories e.g. PVS being treated in the same manner. This is a distinction of great importance.

If in a potentially life-threatening situation or one in which irreparable damage to the patient's health is to be anticipated, doctors or hospital authorities are faced with a refusal by an adult patient to accept essential treatment and they have real doubts as to the validity of that refusal, they should in the public interest, not to mention that of their patient, at once seek a declaration from the courts as to whether the proposed treatment would or would not be lawful. This step should not be left to the patient's family, who will probably not know of the facility and may be inhibited by questions of expense. Such cases will be rare, but when they do arise, as was the case with Miss T, the courts can and will provide immediate assistance.[31]

Ward J provided a legal basis for clinical choice in emergencies. The status of this is however uncertain given the complexities of the individual cases.

A second adult consent and capacity case is ***Re S*** [32]**.** This again concerned a pregnant woman. Here the woman refused treatment deemed to be in the best interests of the mother and child. In this case an emergency Caesarean section was performed without the consent of the mother who was supported in her decision by her husband. The decision reached in this case were paternalistic in nature in that the health care practitioners decided what was in the best interest of the patient rather than the patient being allowed to display autonomy.

The potential difficulty with both ***Re T*** and ***Re S*** arguably is they are not straightforward consent cases, but are "religious cases" where different criteria apply. The proposed treatments being refused on religious grounds; that is, doctrinaire reasons rather than any reasoned decision by the patients in question. The difficulty with these two cases is that they have established the precedent of legalised medical intervention

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28 ibid p 312
29 Ibid p 312
30 ibid. p 313
31 ibid p 313
32 [1993] 1 FLR.

when the patient's decision is not in accord with conventional legal wisdom. Indeed, it is possible to argue that conventional medical wisdom and agreement with it, is the basis of patient competence or lack of competence. These are extreme examples of the doctor knows best doctrine or paternalistic approach, but they have established the precedents which other cases have to follow.

They can however, also be regarded as examples of "duress and undue influence" where no valid consent to or refusal of a valid treatment exists. It is submitted that the courts should limit the effect of these cases to the latter, where "emotional competence and rationality" are in question.

**Discussion**

To enable a patient to be accorded the capacity to consent, he must be capable of understanding in broad terms the nature of the proposed treatment. It is assumed that all adults have this capacity, though the presumption is rebuttable by the particular adult failing to demonstrate the necessary understanding. The presumption of capacity does not apply to minors. Minors must demonstrate an understanding of the broad nature of the proposed treatment if the health care provider is to accord them the capacity to consent to treatment. Capacity is not an "all embracing" concept, it applies only to the occasion on which a particular treatment was commenced.

Until the summer of 1992, the above resume was generally accepted as being an accurate statement of the law; that is, an adult who was not shown to lack understanding of the issue in question was not incompetent. He could make a choice with regard to proposed medical treatment whether it agreed with conventional medical practice or not.

However, since 1991 and the decision in ***Re R***[33], the major cases which have been decided on consent to treatment have gone against the conventional wisdom of the Gillick concept for minors to have the capability to understand and to give a valid consent or refusal to proposed health care treatment. Adult patients have also in recent cases had their capacity to consent called into question even when they can demonstrate a capability and capacity to understand. The decisions by the Court of Appeal have demonstrated that they will act in the manner in which they regard to be in the "best interests" of the patient, even if the patient does not want to be treated as the Court directs.

Unfortunately, as the law stands at the present time, it is possible to state that the individual has the capacity to consent if the decision he makes is in accord with conventional health care wisdom. If the patient, however, reaches a decision which is not in agreement with conventional health care wisdom then he may not have the capacity to consent to that unconventional treatment. Thus, the problem can exist that the patient is denied the opportunity to make the definitive decision about his proposed treatment if he is not in agreement with conventional medical thinking. It is the doctor's opinion which is ultimately the most important in the decision making process when consent is withheld by a patient. The doctor can hold the opinion that the patient does not have the capacity to consent and therefore the health care professional can attempt to have the patient's decision overturned by the courts. The court in reaching a decision in such a case has to rely on the opinion of the doctor to determine whether the patient has the capacity to consent.

Indeed, it should not be acceptable to declare that the only decision a person can make as a patient is one that is in accord with accepted medical practice. This would remove the right of patient autonomy. Whilst this may be unethical it is clearly not unlawful at present. The perceived ethics of the situation are however, outside the scope of this article.

It is most fortunate that in the vast majority of treatments, unlike the recent cases referred to, there is no life or death issue for any of the parties involved. Thus if a patient exercises his or her right to refuse the proposed treatment the consequences may not be fatal.

In the absence of a life or death decision or of the possibility of long term health problems consequent upon the non-administration of therapy, it is submitted that a health care professional is unlikely to have a court decision made in favour of non-consensual treatment. In the recent cases referred to, the Courts, acted in a manner which they (the Courts) determined to be in the best long term interests of the patients though these may have been against the religious principles or supposed principles of the women involved. It is possible that the long-term psychological damage to the patients could outweigh the benefits of the treatments administered.

33 ***Re R*** op. cit. fin. 19 and 21

**Conclusions**

Consent and the need for understanding are not the same in every situation. Consent to or refusal of treatment depends on the circumstances of the proposed treatments and/or investigations to be undertaken as well as the individual who is required to consent or refuse to consent. These requirements are further compounded by the question of whether the patient is an adult or a minor. A minor, who demonstrated ***Gillick*** competence, may give a valid consent to any treatment. However, if the child's decision goes against current medical wisdom then the purported ***Gillick*** competence may be called into question. If the courts are asked to exercise their power, the court could take into account parental responsibility though the recent trend is for the court to take medical opinion as being sacrosanct rather than respecting the patients/parents wishes

Similarly for adult patients, if the adult makes a decision that is in accord with conventional medical wisdom then the patient has made a "correct" decision. However, if the decision is not in agreement with conventional medical opinion and the life of the patient is threatened then the decision may be interpreted as being "incorrect" and the health care professional may go to Court to have the patient's statement of autonomy overturned. Whilst this may be legally acceptable, ethically the removal of the patient's right to self-autonomy at the altar of medical paternalism is not acceptable. It would be imperative for any health care professional, before taking such a step, to have thought through the consequences of such a decision including that of the long term prognosis of the patient if patient autonomy was to be overridden.

The recent precedents that the recent cases represent may lead to great confusion for all health care professionals. The circumstances of these cases were extreme and are unlikely to be encountered on a regular basis by health care professionals. The unknown factor that exists in medical consent cases following them, is the degree of intrusion that the Courts are prepared to sanction. Health care workers wishing to overrule patient autonomy in non-life threatening cases where the patient's decision is not in agreement with conventional health care wisdom will have to give greater consideration to the wishes of the patient.

Therefore, following the recent case law the situation at present would appear to be that a patient is competent to make a decision to consent to treatment as long as the decision' of the patient agrees with that of the health care provider. However, if the patient's decision is at variance with the opinion of the health care professional then, the patient may not be regarded as competent to make a decision to refuse the proposed treatment.

or most health care providers in virtually all cases, the need to obtain the patient's reasoned consent is still a legal requirement. No practitioner should rely on an uncertain trend in the case law suggesting that a patient's wishes can be discounted if they do not coincide with the treatment proposed by the health care professional. Indeed, routine, non-urgent treatment "requires that an adult patient who is mentally and physically capable of exercising a choice must consent if medical treatment of him is to be lawful."[34].

This is something that health care professionals should constantly bear in mind before they undertake treatment in a paternalistic manner. This is true, if as health care professionals, they are not going to find their professional career interrupted by the spectre of a Court case on the controversial aspect of a patient's consent to the treatment that they have undertaken.

It is possible to argue with some justification that the courts would act differently, if required to decide in non-urgent routine cases compared with the manner they reacted in the recent "life or death" cases. This is a valid consideration, if they are faced with a health care professional, who cannot obtain the patient's valid consent for the proposed treatment.

34 per Lord Donaldson M.R. in ***Re T*** [1992] 3. W.L.R. 782.