Helping patients to give informed consent

In this article...
- Learning about patients’ experience of consent
- Reflections on capacity and consent
- Power relationships between nurses and patients

Talking points
1. What is the purpose of consent?
2. Are you aware of the power and influence you have when seeking informed consent?
3. What can you do to equalise a power imbalance?
4. How can you check your patients’ understanding before they give consent?
5. What action should you take if you suspect a patient’s consent was invalid?

Patient experience

The validity of consent may be affected by the power imbalance between health professionals and patients. Nurses need to reflect on these power inequalities.

If nurses are to truly respect patients and embody patient-centred care in our practice, we need to recognise their narratives as an important voice in the illness journey.

Francis (2013) stated that failing to listen to patients was one of the issues at the heart of the serious neglect experienced by patients at Mid Staffordshire Foundation Trust.

Key agencies such as The King’s Fund (2013), professional regulatory bodies (Nursing and Midwifery Council, 2015), voluntary organisations (Mencap, 2007) and government reports (Department of Health, 2012) have also highlighted the importance of keeping patients at the centre of their care and working in a collaborative manner to ensure their voices are heard.

Snowden (1999) suggested that the use of patient narratives, which encourage patients to describe their direct experiences, can change health professionals’ understanding of those experiences, resonate with the professionals’ own experience and offer incentive for practice development and change.

Reflective patient narrative

Colin Emery*, who has a learning disability, recently moved into independent living accommodation, having previously lived with his father. In his new accommodation, he started to collect his urine and faeces in bottles and leave them around the house. When support staff visited him he

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thwarted them and prevented them from entering. He became angry and abusive. The support staff did not feel safe and the service referred him to the learning disabilities community team for treatment of his anger. The community nurse assessed that Mr Emery had capacity, and sought his consent, for a programme of anger-management counselling comprising six sessions. The nurse's manager had told him to “get Colin consented”. Somewhat reluctantly, Mr Emery signed the consent form and the programme started.

Read Mr Emery’s story in Box 1, reflect on his experiences and then consider the reflection points below.

**Reflection points**

In this story, Mr Emery has been assessed as having capacity to give consent. The nurse assumed that if Mr Emery demonstrated capacity, and that the plans were carefully explained, he would be in a position to make a decision based on informed consent. However, it appears the issue for Mr Emery was not capacity, but a sense of autonomy. He wanted to please the nurse (and hence his father), and so gave consent. Many people who receive a high level of care find it a good strategy to agree with staff, in order to keep out of trouble.

**Reflection point 1**

Think of a time when you have gained consent. Do you think the patient had the power to say no? Might the patient have been in awe of you as a professional? Was that consent valid and informed?

Typically there is a substantial power differential between nurses and their patients. Table 1 shows a breakdown of some factors influencing this.

In Mr Emery’s case, it can be argued that he has a position of less power compared with the nurse, in every respect other than the fact that he was in his own home. However, this may be “his home” in a different way to other members of the community. For example, who holds the keys? Do staff knock or let themselves in? Is there a staff office or sleeping room in the house? Who answers the phone?

**Reflection point 2**

Think of the last patient you discussed treatment and consent with. Draw up a similar power-factor table. Do you think the relative power was sufficiently equal for consent to be considered valid?

Mr Emery has faced a significant and worrying life-change. He is struggling to adjust to those changes and feels threatened by the staff. The service initially

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<tr>
<th>TABLE 1. POWER FACTORS BETWEEN THE NURSE AND MR EMERY</th>
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<td><strong>Context</strong></td>
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<td>Personal information on the other</td>
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<td>Relationship to service</td>
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**BOX 1. “GET COLIN CONSENTED”**

The following is Mr Emery's account of the events

“They moved me out of my dad’s house. I didn’t want to but my dad and the social worker said it was the best thing.

“My new flat is OK. I have my own TV and beer.

“I miss my dad, he looked after me. He told me what I needed to do. He reminded me when I was going to college or when I needed a clean shirt. The staff in my flat are bossy so I think I’ll lock the door. I want to keep them out because they make me clean up all the time and make me eat vegetables.

“I am not sure what I need to do but I started putting wee and poo in bottles. I can decide what to do with them when I’ve had time to think.

“They sent me to see a nurse. He smiles a lot but is a bit bossy. He showed me a form to sign. He said it was to agree for my treatment but that was a fib. He just wanted talk to me about getting cross with the staff. I hope he talks to them about being bossy.

“I can write my name. I showed him I can on the form. He was pleased with me. I didn’t want him to get cross with me, I think I did well. Dad always told me to do what people tell me and be a good lad.”
BOX 2. REFLECTIONS ON CONSENT

Mental health

A client detained under the Mental Health Act told her nurse that she believed the staff were injecting bugs into her skin when she had a depot injection. Despite this, she did not refuse the injection, as she said “the nurses will just give me it anyway”.

Within the mental health field, clients may present with psychosis and altered beliefs about their diagnosis, which may differ from those of mental health services. As a result, not only is their ability to consent impaired, but they might not agree that they need treatment. Services can often pathologise clients’ thoughts or behaviours and try to eradicate or treat them when the client may be happy to live with them. Are we right to seek consent on these occasions?

Adult nursing

Adult patients are frequently required to give consent for invasive diagnostic tests or surgery. The validity of their consent could be questioned if it subsequently comes to light that the patient had little or poor knowledge of the potential material risks and benefits of the procedure.

A landmark decision in Montgomery v Lanarkshire Health Board, given by the Supreme Court in March 2015, requires doctors to take reasonable care to ensure patients are informed of material risks and alternative treatment options. The judgment stated that “the doctor’s duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form”.

The terminology, language and manner in which information is disclosed clearly influences patients’ understanding. Nurses are familiar with medical terminology – this is our unique language and yet, all too often, we forget what is “heard” and understood by patients.

Think about the occasions when a patient has provided what is deemed to be informed consent; the consent form has been signed and dated yet, before the procedure, the patient has asked questions about the procedure itself or the recovery period. On such occasions, questions could be asked about whether the consent is fully informed or whether the patient has simply “been consented”.

Response by dealing with Mr Emery’s aggression; in other words, the service was responding to the problems it faced rather than the problems Mr Emery faced. This would suggest that the service was not patient-centred.

It was later discovered that collecting urine and faeces was Mr Emery’s attempt to impose order on his environment.

Reflection point 3

Has a patient’s problem ever resulted in challenges for your service or staff? Whose problem did your service focus on? (We could class bereavement, being in pain, grief for loss of bodily function and control, fear, confusion or body change as being a significant problem.)

We need to question whether Mr Emery gave informed consent to the anger-management therapy. He signed the form but thought the nurse was just going to talk to him. In other words, he did not have sufficient information to make a decision and the nurse did not check his understanding. Did Mr Emery really know what he was consenting to?

The NMC (2015) states “you must respect and support people’s rights to accept or decline treatment and care”.

Support is an active process that gives patients every opportunity to refuse. Sometimes the consent form is seen as a cover for the organisation rather than a patient-centred part of the care process.

Reflection point 4

Have you recently sought consent from a patient? Do you think they fully understood what they were agreeing to? How would the care team respond if the patient changed their mind halfway through the treatment? Do you believe that the form was part of a patient-centred process or something to “cover your back”?

The manager in the story asked for Mr Emery to “be consented”. This is an interesting use of language. Consent is a noun; it is an object. “Consenting” is a verb; it is doing something. In fact, in this narrative it is the nurse “doing something” to the patient. The principle of informed consent is that it involves a discussion between nurse and patient, but what actually happened to Mr Emery does not seem to be in the spirit of the NMC Code (2015).

Reflection point 5

Do nurses in your organisation talk about “consenting” people?

Does this say anything about the spirit in which consent is obtained?

The themes around consent identified above apply to all fields of nursing.

Box 2 provides examples from other fields of nursing.

Conclusion

As nurses, we are all required to provide information to clients to enable them to make valid choices in their lives. These decisions might be difficult for the client. Our power and role may exert influence on a client’s decision.

On the other hand, as nurses we may experience the power of the organisational culture influencing our behaviour.

The NMC code of conduct states that nurses must “make sure that those receiving care are treated with respect, that their rights are upheld” (NMC, 2015). If we are to adhere to this aim when discussing consent with clients, we must become conscious of these influences on the behaviour and perception of clients and ourselves.

* The patient’s name has been changed.

References

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