As explained in the first article in this two-part series, nurses need to obtain their patient’s consent before giving any care or administering any treatment. Valid and informed patient consent is not only a professional obligation but also an ethical and legal one, and its principles and parameters have been redefined by recent case law (Taylor, 2018).

Having established the need for patient consent, it is now important to consider how patients may give consent, how nurses may provide evidence of consent, and how to manage situations in which a patient is not able to give consent. This second article in the series discusses what makes consent valid, how to assess a patient’s ability to give consent, and in which situations treatment may be given lawfully in the absence of consent.

Validity of consent

The way in which consent may be given will depend on the type of treatment or other intervention that is planned. Patients may signal their consent in a variety of ways: verbally or non-verbally, orally or in writing, in an implied or an explicit way. An example of implicit consent would be when a patient voluntarily offers their wrist to have their pulse checked. The validity of consent does not depend on the form in which it is given, but on the circumstances in which it is given.

The Mental Capacity Act 2005 provides a legal framework for decision making when a patient is unable to make a decision (Taylor, 2018).

It may be lawful to treat a patient without their consent – for example, in an emergency situation or if the patient lacks decision-making capacity.

Informed consent 2: assessing validity, capacity and necessity

Key points

- Consent may be explicit or implied and patients may communicate their consent verbally, non-verbally or in writing
- The validity of consent depends on the circumstances in which it is given, not on its form
- It is good practice to record evidence that the patient has consented to treatment
- The Mental Capacity Act 2005 provides a legal framework for decision making when a patient is unable to make a decision
- It may be lawful to treat a patient without their consent – for example, in an emergency situation or if the patient lacks decision-making capacity

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Abstract Nurses need to obtain their patient’s consent before giving any treatment. This is the general rule, but the issue of consent is much more complex than that. How is consent given? How can you prove that it has been given? How do you decide whether or not to administer treatment to someone who is unable to give consent? The first article in this two-part series explored the legal principles behind informed consent and discussed why valid consent is not only required by law, but also fundamental to the provision of good-quality, person-centred care. This second article goes on to explore what makes consent valid, how it can be obtained, and in what circumstances treatment may proceed lawfully without the patient’s consent – which has been clarified by the Mental Capacity Act 2005.

Clinical Practice

Discussion

In some circumstances, written consent must be obtained before treatment can commence.

- There may be significant consequences for the patient’s employment, or social or personal life;
- Providing clinical care is not the primary purpose of the investigation or treatment;
- The treatment is part of a research programme or is an innovative treatment designed specifically for the patient’s benefit.

Furthermore, the Human Fertilisation and Embryology Act 1990 stipulates the legal requirement that written consent is to be obtained for certain treatments, such as fertility treatments.

Evidence of consent

Written consent is not, on its own, sufficient evidence that the consent was informed and given freely. As highlighted by the Department of Health (DH) (2009), “written consent merely serves as evidence of consent: if the elements of voluntariness, appropriate information and capacity have not been satisfied, a signature on a form will not make the consent valid”.

Should a situation arise in which, for example, a patient alleges that treatment has been given without their consent, it would be the patient’s responsibility as the claimant (Abrath v The North Eastern Railway Company [1883] 11 Q.B.D 440) – or, in a criminal case, the prosecution’s responsibility (R v Donovan [1934] 2 KB 498) – to prove that they had not given consent. The court will consider the issue as a question of fact – was valid consent given? An example is Connelly v Croydon Health Services NHS Trust [2015] EWHC 1339 (Q.B.) (Bit.ly/ConnellyCase).

A game changer – the 2005 Mental Capacity Act

Before the 2005 Mental Capacity Act (MCA) (Bit.ly/MCA2005) came into force in 2007, the law was not entirely clear on how to lawfully administer treatment to a patient who was not able to provide consent. There was no scope for consent to be given on a patient’s behalf. There were no criteria or procedures for taking a patient’s wishes and preferences into account. In these circumstances, care often proceeded on an uncertain legal basis.

The MCA has given us a statutory framework for decision making when a person’s mental capacity to make a decision – including consenting to treatment – is questioned. Box 1 lists the five underpinning principles of the MCA. As well as a basis for patients to make valid advance decisions to refuse treatment (ADRTs), the MCA provides a framework for making decisions on behalf of a patient who has been deemed to lack decision-making capacity, including lasting power of attorney and court-appointed deputies.

Box 1. Mental Capacity Act: underpinning principles

- A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under this act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

Source: Mental Capacity Act 2005

Inability to make decisions

According to the 2005 MCA, “a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain”. Box 2 sets out how it defines inability to make decisions.

The assessment of mental capacity is decision specific. Simply because a person lacks capacity to make one decision (for example, whether to take antibiotic treatment for a chest infection), it should not be assumed that they lack capacity to make other decisions (for example, whether to take a bath).

Also, capacity may fluctuate, so the assessment of mental capacity is time limited. Even if a person lacks capacity to make a certain decision at a particular time, it does not follow that they will never again have capacity to make that decision in the future.

Who should assess mental capacity?

Who is responsible for assessing a patient’s mental capacity depends on the type of decision being made (Taylor, 2014). The general rule is that it will be whoever will be making the decision on the patient’s behalf. For routine personal and nursing interventions, this would usually be the

“Nurses must be able to justify their actions”
Giving treatment without consent

The MCA works on the presumption that a person has mental capacity to make decisions regarding their care, but it also sets out how to manage situations in which a person has been deemed to lack that capacity. It introduces a number of ways in which treatment can be authorised in those patients who lack capacity. It also establishes a statutory obligation to take into account the person’s wishes and preferences when making decisions on their behalf.

The circumstances in which treatment – as long as “it is in the patient’s best interests and is immediately necessary to save life or avoid significant deterioration in the patient’s health” (British Medical Association [BMA], 2016) – may lawfully go ahead without the patient’s consent are as follows:

- If the patient lacks the mental capacity to consent to treatment and is not able to engage with the consent process;
- If the patient has given no authority to consent under a lasting power of attorney;
- If the patient has not previously given any indication that they would refuse consent for the treatment (for example, verbally or in a valid ADRT).

Emergency situations

Except in the circumstances outlined above, the patient’s consent is required before any treatment can go ahead, even in emergency situations. However, in such situations, it may not always be possible to get their written consent – for example, in a life-threatening emergency or if immediate treatment is necessary to relieve acute pain. In these circumstances, oral consent may be relied upon.

In some emergency situations there may not be time to obtain the patient’s consent or otherwise determine the patient’s wishes, or the patient may lack capacity to consent. In these circumstances reasonable steps must be taken to check that:

- A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means);
- The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision;
- The information relevant to a decision includes information about the reasonably foreseeable consequences of:
  - Deciding one way or another or
  - Failing to make the decision

Source: Mental Capacity Act 2005

Box 2. Mental Capacity Act: inability to make decisions

- The patient has not made a lasting power of attorney giving authority to someone (an attorney) to make personal welfare decisions on their behalf;
- The patient has not previously given any indication that they would refuse that treatment if they were able to (either verbally or in a valid ADRT).

Once these checks have been made, medical treatment may go ahead lawfully, provided that only “medical treatment that is in the patient’s best interests and is immediately necessary to save life or avoid significant deterioration in the patient’s health” is administered (BMA, 2016).

Conclusion

The matter of consent can be complex. The GMC’s (2008) guidance on consent in clinical practice is a useful tool and now has a basis in law, as it has been endorsed by recent case law such as Gallardo v Imperial College Healthcare NHS Trust [2017] EWHC 3147 (QB) (Bit.ly/GallardoCase) and Montgomery v Lanarkshire Health Board [2015] UKSC 11 (Bit.ly/MontgomeryCase).

The first article in this series established that nurses must obtain valid consent from the patient before proceeding with treatment or any other intervention. This second article further explored the issue by considering what makes consent valid and in which circumstances treatment may proceed lawfully without it. However, health professionals should be aware that, in most cases, consent will be needed and responsibility for getting it will rest with whoever plans to deliver the treatment – that individual will be liable in law if they give treatment without having obtained consent. **NT**

**References**


