Consent

The general legal and ethical principle is that valid consent must **'usually'** be obtained before starting treatment or physical investigation or providing personal care for a patient. This principle reflects the right of a patient to determine what happens to his or her own body and is a fundamental part of good medical practice. Case law has established that touching a patient without valid consent may constitute a civil or criminal offence. Poor handling of the consent process may lead to complaints from a patient.

My use of **'usually'** above means there are exceptions. These include grounds of necessity, where the patient is unconscious or cannot communicate, and others.

Consent – Asking for and giving consent

Before a doctor, nurse or health-care professional or health-care student (hereafter called '**medic**') can examine or treat a patient, they 'usually' need his or her **consent**, given **voluntarily**. Here **'voluntarily'** means given freely, without pressure or undue influence from anyone.

For consent, the patient must **understand** what is involved – including the nature and purpose of the procedures, the consequences / risks of having or not having the intervention, and including using and weighing this information in the decision-making process.

Seeking consent is usually a process, with appropriate information and explanations being given in discussion, not a one-off event. Acquiescence where the patient does not know what the intervention entails is not 'consent'. The patient must have the **capacity** to comprehend and retain the relevant information.

If the patient has some ability to understand and think things over, he or she should be encouraged to decide for himself or herself. It may not be a decision that a 'friend' agrees with, but that is not the key test. What the 'friend' and the 'medic' need to ask is: *can the patient understand and weigh up the information provided?*

Where the patient understands:

- if ***over 18***, only he or she can give consent or refusal. A husband, wife, partner, relative, carer or friend (here called '**friend**') cannot give that consent.
- if aged ***16-17***, he or she can give consent similarly. But their refusal can be over-ridden by a 'parent' on the grounds of 'welfare' – avoiding risk of grave irreversible mental or physical harm, or in a life-threatening emergency.
- if ***under 16***, and with sufficient intelligence and understanding of the issues, he or she can similarly give consent.

Consent need ***not*** be in writing: written consent is only useful as a record or evidence of it.

If a patient is ***unconscious***, or ***cannot communicate*** their wishes, or is too bewildered to make decisions – eg from stroke, panic, shock, fatigue, then he or she is not in a position to give consent. Then 'medics' are allowed to do what they believe is in the patient's **'best interests'** – meaning taking into account the patient's general well-being and what he or she is known to believe in.

Intervention is also legally justified on the grounds of **necessity**. In circumstances where a split-second decision needs to be made, eg at a car crash or where a patient becomes unconscious or unable to communicate consent, intervention would be justified legally on grounds of necessity. There is not time to do a 'best interests' evaluation, albeit one might conclude that the chance of saving the patient's life must be in their best interests.

'Friends' cannot make decisions on behalf of patients who cannot decide for themselves. However, they may be able to tell the 'medics' about the patient's opinions, views, and beliefs – eg whether the patient has ever accepted or refused certain kinds of treatments. This will help the medics make better decisions in the patient's 'best interests'.

Living wills

Sometimes a person may decide how he or she would want to be treated in the case of a future incapacity – if something happened to them in the future and they were no longer capable of refusing consent – called a **living will**.

A patient may ***refuse*** a particular treatment, and/or make a living will. Certain conditions apply. Medics, first aiders, and carers must then comply with the refusal.

'Friends' should tell 'medics' about such past decisions and preferably give the 'medics' a copy of the document.

Advance **refusals** are **normally** legally binding on medics, even if the 'friend' disagrees with it/them. It is only advance ***refusals*** (as opposed to other advance directives) that must be respected and are legally binding, where valid and applicable to the subsequent circumstances in which the patient lacks capacity. '**Normally'** here means there are some exceptions.

'Friends' should never be asked to sign a consent form on behalf of a patient. However, they may sign a form to say that they have been consulted.

Consent – for carers and first aiders

The legal position in the UK of **first aiders and carers** is *similar to* that for 'medics' as above. I have put 'similar to' not 'the same as' since first aiders and carers may not have all the relevant medical knowledge and skills. They must take care and be careful not to be negligent.

For a conscious communicating patient they should ask for consent before intervening, examining and/or treating. Where a patient is unconscious or there is not time to ask for consent, they should act as for medics as above. This includes doing what they believe is in the patient's 'best interests'. In a life-threatening emergency, doubt should be resolved in favour of preserving life.

Finally, these few paragraphs do not give the full legal position on consent. I have tried to summarize and explain the more common situations, but have not covered everything. Most of the currently available heart disease and first aid literature does not mention consent at all. It has become more of an issue in recent years. Most Department of Health (DH) literature on consent is dated 2001 or later.

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