Consent and medical negligence

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Treatment without consent (1)

- Health professional who intentionally or recklessly touches a patient without consent is committing a crime (battery) and a tort (battery and/or negligence)

Treatment without consent (2)

- 3 legal “flak jackets”

1) The consent of the patient
2) Consent of another person who is authorised to consent on behalf of patient
3) The defence of necessity

Autonomy rules

- Without one of the three legal flak jackets touching a patient is unlawful
- Even if treatment in patient's best interests

  St George's Healthcare Trust v S [1998]

Consequences of treating without consent

- Technically, could be charged with criminal offence of battery
- Very unlikely unless malicious
- Tort more likely (battery or negligence)
- Negligence preferred legally

1) Strong overtones of criminality in battery

2) Judge greater control of scope of liability

Battery v negligence

- Negligence focuses on question of whether behaved in accordance with Bolam, battery on whether patient consented
- Negligence claims need to evidence harm
- Defence to negligence claim if fully informed patient would consent
- Punitive damages in battery
- Battery requires physical contact

Providing consent: competent adult

- Only that person can consent (i.e. no consent by proxy)
- Presumably someone else can make a decision if given consent by patient to do so (consent via a third agent)
- Treatment can be permitted in certain circumstances under Mental Health Act. Treatment of mental disorder (broad interpretation)

Providing consent: incompetent adult

- MCA 2005 “best interests”
- Court decision
- NOT SUBSTITUTED JUDGEMENT
- Enduring power of attorney
- Advance Directive
- Deputy
- Defence of necessity permitted if legal action attempted and intervention urgent

Advance Decision

- 18+
- Has capacity
- At a later time, when no longer has capacity if specific circumstance arises the specific treatment is not to be carried out/continued

Invalid advance decisions (1)

- As per section 25 MCA

1) Patient with capacity withdraws it
2) Patient created LPA after advance decision
3) Patient acted in a way inconsistent with advance directive
   - HE v A Hospital NHS Trust [2003]

Invalid advance decisions (2)

- Advance decision only relevant if it specifies treatment in question or “reasonable grounds for believing circumstances exist which the patient did not anticipate at the time of advance decision which would have affected decision if he had anticipated them”
- If rejecting life-saving treatment must state that advance decision is to be respected even if results in his/her life being at risk

LPA

- Allows someone to make decisions related to someone's welfare, including medical decisions
- Can be more than one. If so, act jointly i.e. must agree
- LPA must make a decision based on patient's best interest, even if it is not "what he would have wanted"
- LPA no power to authorise the giving or refusal of life giving treatment unless LPA specifically states this

Providing consent: competent children

- A competent child can consent
- A parent can provide consent for an objecting child with capacity

Gillick competence

- As per *Gillick v W Norfolk AHA* [1985], child can consent provided “sufficiently mature”

a) Understand medical issues (proposed treatment, consequences of not having, effect of treatment)

b) Understand the “moral and family issues involved”

c) Mature enough for specific issue in question

d) If fluctuating, deem incompetent

e) Own decision, “not repeating views of parents” *Re S*

f) Not incompetent because decision “wrong”

Providing consent: incompetent children

- Those that have parental responsibility
- All mothers, fathers married to mother or on birth certificate, parental responsibility order. Non parent via a residence order
- MCA does not apply to children, so if parents don't consent court order or, if emergency, doctrine of necessity

More than a “yes”

- Competent individual
  - MCA section 1(2) presumed competence
- Sufficiently informed
- The person is not subject to coercion/undue influence

Lacking capacity: MCA (1)

- MCA 2(1) “impairment of, or a disturbance in the functioning of, the brain or mind”
- Decision specific
- Code of Practice suggests mental illness, delirium, significant learning disability, brain damage, dementia, concussion and symptoms of alcohol/drug use all potential causes of above

Lacking capacity: MCA (2)

- Section 3(1). Unable to make a decision if unable to

a) understand

b) retain

c) weigh

d) communicate decision

- Person should not be deemed as lacking capacity "unless practical steps to help him have been taken without success"

Lacking capacity: MCA (3)

- MCA 1(4) “person not to be treated as unable to make a decision merely because he makes an unwise decision”

- *Re B* [2002]-irrationality

“Doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient cloud their judgement in answering..whether patient has mental capacity”

Sufficiently informed (1)

- *Chatterson v Gerson* [1981]
  - All that is required is that the patient must understand "in broad terms the nature of the procedure that is intended"

Sufficiently informed (2)

- Two potential claims in relation to amount of info provided:

a) Consented only on basis of false or inadequate information

b) They consented, but medical professional negligent in not informing them of all risks

Case a) claims legally extremely rare!

Case a) claim

- Personal gain
  - *Appleton v Garrett* [1995]
  - *R v Tabaussum* [2000]
- Paternalistic deception
  - *Potts v NWRHA* [1983]

Free from coercion

- Consent needs to be given freely in order to be legally valid
- *Re T* [1992]

How precise should consent be?

- Legal grey area
- Is HIV test appropriate when a patient has consented for “blood tests” to be carried out?
- DoH suggest that specific consent should be sought for HIV testing

Negligence-how much information must be provided? (1)

- *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582
- A two part test, in order to establish and define a doctor's legal duty…
- *Part 1:* The defendant needed not to attain the 'highest expert skill' but must achieve the ordinary level of competence expected of a person in his profession and practising in a particular specialty of that profession
- *Part 2:* where "proper practice" was in dispute, McNair J stated that "a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular act . . . a doctor is not [guilty of negligence] if he is acting in accordance with such a practice, merely because there is a body of opinion taking a contrary view"

Negligence-how much information must be provided? (2)

- *Sidaway v Bethlem RHG* [1985]
- *Smith v Tunbridge Wells Health Authority* [1994]
- *Pearce v United Hospitals Bristol NHS Trust* [1998]
- Chester v Afshar [2004]

Montgomery: does it change everything?

- *Montgomery v Lanarkshire Health Board* [2015]
- Suggests law now requires a doctor to take reasonable care to ensure that the patient is aware of *any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments*
- The ‘Montgomery’ case has shifted towards a ‘prudent patient test’, focusing on what the patient would want to know