POCKET GUIDES
FOR NURSING AND HEALTH CARE

CONSENT

MARC CORNOCK

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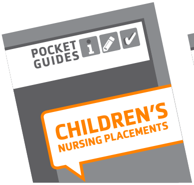

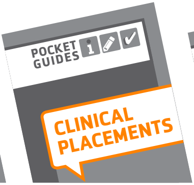

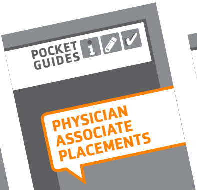

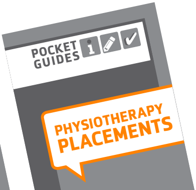

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Lantern

ISBN: 9781914962066
First published in 2023 by Lantern Publishing Ltd

Lantern Publishing Limited, The Old Hayloft, Vantage
Business Park, Bloxham Road, Banbury OX16 9UX, UK
www.lanternpublishing.com

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Typeset by Medlar Publishing Solutions Pvt Ltd, India
Printed and bound in the UK

Last digit is the print number: 10 9 8 7 6 5 4 3 2 1

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Dedication

To Lois and Simon, you will never know how much I appreciate all the support you have given to Sarah and me. Thank you seems so inadequate.

A valid consent licenses what would otherwise be unlawful[1]

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[1] McHale, V. (2017) ‘Consent to treatment: the competent patient’. Chapter 8 in Laing, J. and McHale, J. (eds) *Principles of Medical Law*, 4th edition. Oxford University Press, p. 422.

Preface

Many textbooks present information on consent in a way that seems academic and removed from clinical practice. This is not one of those books.

This book sees consent as being practice-focused and something that underpins your clinical practice, and therefore an essential part of your everyday practice. Although it can seem it at first glance, consent does not have to be complex or difficult to understand. Neither does it have to be an onerous part of your practice.

Rather, consent is a representation of the partnership that you make with your patients, to ensure that they are able to make their own treatment and care decisions that are appropriate for their needs, as well as being appropriate for their wishes and beliefs. This is the approach that this book takes in discussing consent.

This book is a handy pocket-sized guide to the consent process: the ways in which consent can be given, and by whom, when it can be given and how you can work with your patient through this process.

For your convenience, the book begins with a list of common terminology and key concepts, and brief summaries of the main legislation and legal cases to help guide your reading, and ends with a 'useful resources' section. Inside the covers of the book are a decision tree as to whether consent should be sought and, where appropriate, from whom, and a table of what patients at different ages can do and not do in the consent process.

Marc Cornock

About the author

Marc Cornock is a Senior Lecturer in Healthcare Law in the School of Health, Wellbeing and Social Care at The Open University.

Marc regularly lectures and writes for health care practitioners. His research focuses on the interplay between law and health care practice.

Acknowledgements

I would like to thank the many people who have helped me to think about consent and how it can be presented – in particular the students who I have been fortunate to teach and the fellow lecturers who I am pleased to be able to call colleagues.

In particular I would like to single out those students who attended the AMC classes and participated in the discussions around this aspect of professional practice.

My family and friends deserve a special thanks for encouraging me and giving me the space to develop and write this book. Sarah, you have gone above and beyond in your support, and I am eternally grateful. You are the best of the best.

Common terminology and key concepts

These are the common terms, abbreviations and key concepts that are used in this book which you may come across when reading about consent.

The word 'patient' has been used as shorthand to include patients and clients, and 'health care practitioner' has been used to include practitioners of all grades, including those in training, unless specifically stated.

Adult	Legally, this is a person 18 years of age and over.
Assent	Agreement that something can happen but not a formal legal process like consent. May be used when it is not possible for consent to be obtained from the person, but the nurse wants their agreement, as with a child who is not Gillick competent.
Battery	A criminal offence which involves someone applying unlawful physical force to another person; for example, hitting them.
Best Interests	The way of establishing what care or treatment an incompetent patient should receive, by considering what the patient would want to receive if they were able to make the decision themselves. Has to be something that provides a benefit to the actual patient.
Child	Legally, someone who is under 18 (section 105 of the Children Act 1989).

Competence/ Competent	Competence refers to the ability of a person to make decisions and the process by which this can be determined. A person is said to be competent when they are able to make their own decisions. Competence is also referred to as the capacity of a person to make a decision.
Consent	What this book is about! The legal process by which a person provides permission for another to touch them for a specific purpose, such as providing health care. Requires specific legal principles to be followed for it to be a legally valid consent.
Delegated consent-taking	Occurs when a practitioner other than the one who will be performing the care or treatment obtains the consent from the patient. Also known as delegated consent.
Fraser guidelines	Specific legal principles that should be applied when advising or treating a child under 16 in relation to contraception or other sexual matters.
Gillick competence/ competent	Only applies to a child under 16. It refers to a child who has been assessed as being able to provide their own consent for a specific procedure or treatment.
Implied/ Inferred consent	Although there are subtle differences between the two terms, they are often used interchangeably.

	Implied consent is usually used for situations where the patient's actions can be used to indicate their agreement with a proposed action. For example, if a patient rolls up their sleeve when told that a blood pressure reading is needed, they are said to be implying that they agree with the proposed treatment. Inferred consent is used when viewing the situation from the health care practitioner's perspective; for example, if the patient rolls up their sleeve in response to the health care practitioner saying that a blood pressure reading is needed. The health care practitioner sees the patient rolling up their sleeve and infers that as meaning the patient is agreeing to the taking of the blood pressure reading. In reality no consent has been obtained.
Incompetence/ Incompetent	Incompetence refers to the inability of someone to make their own decisions. When someone is not able to make their own decisions they are said to be incompetent. This can be temporary or permanent.
Informed consent	This is an ethical and American legal concept. It requires a person to receive all the information regarding a specific treatment so that they can make an 'informed' decision. Informed consent is not currently a legal requirement in the UK.
Lasting Power of Attorney (LPA)	These were introduced in the Mental Capacity Act 2005 and allow individuals to appoint another person to make decisions on their behalf if they become incompetent.

Legally valid consent	Consent that has been given voluntarily by a competent patient who has been adequately informed about a treatment.
Minor	A legal term for a child, someone under the age of 18.
Negligence	Refers to care that falls below the required standard, that causes harm to a patient.
Next of kin	Often abbreviated as NoK. Usually taken to mean someone the patient would want to be the point of contact for their care needs.
Parental responsibility	A child's parent or guardian who has the legal authority to make decisions in the best interests of the child.
Paternalism	Refers to situations where one person believes that they know what is better for another person and exerts influence over them. In health care, this would occur when a health care practitioner believes they know what is right for the patient, and what treatment the patient should receive, regardless of the patient's wishes.
Principle/ Doctrine of necessity	The legal principle that allows an incompetent patient to be treated without their consent.
Relative	Generally someone who has a relationship to another person through blood, by adoption, or as a result of marriage.
Self-determination	The right of someone to make their own decisions regarding what happens to their body.
Valid consent	A shortened form of legally valid consent (see above).

Main legislation and legal cases

This section provides a brief summary of the main legislative provisions and legal cases that have resulted in the current law on consent.

Legislation

Family Law Reform Act 1969	The Family Law Reform Act 1969 made a number of substantial changes in relation to families and young people. For instance, it reduced the age of majority, i.e. when someone becomes an adult, from 21 to 18, and clarified the legal position of illegitimate children. The main effect regarding consent is that Section 8 allows a minor who has reached the age of 16 to consent on their own behalf.
Mental Capacity Act 2005 (MCA)	The Mental Capacity Act 2005 is currently the main legislative provision which covers the principles of consent and the processes that need to be undertaken when a person is unable to provide their own consent. Key provisions in the Mental Capacity Act 2005 relate to how competence is defined and assessed, and the introduction of the Lasting Power of Attorney.
Mental Health Act 1983 (MHA)	The official title is the Mental Health Act 1983, as amended by the Mental Health Act 2007. This is because the 2007 Act made significant amendments to the 1983 Act but did not replace it. However, the short title of Mental Health Act 1983 is generally used. The Act provides detail on how the law needs to be applied when patients are subject to compulsory treatment for a mental disorder without their consent, either because they can't or won't consent. The Mental Health Act 1983 is important in relation to the consent discussion because it allows someone to be treated without their consent, but only for the condition which is covered by the Act.

Legal cases

F* v. *West Berkshire	***F* v. *West Berkshire Health Authority* [1989] 2 ALL ER 545** This case concerned F, a 36-year-old woman who had a serious mental disability which meant she had the mental capacity of a 4-year-old. The court was asked to give consent for F to have a sterilisation as she was in a sexual relationship, and medical evidence stated that she would be psychiatrically harmed if she became pregnant. The court ruled that because F was over 18 they had no authority to provide consent but could state that, based on all the medical evidence, having a sterilisation would be in F's best interests.
Gillick case	***Gillick* v. *West Norfolk and Wisbech Area Health Authority and another* [1985] 3 ALL ER 402** In this legal case Mrs Gillick sought an assurance that her five daughters who were under 16 would not receive contraceptive advice and/or contraception from their GP without her knowledge and consent. The case ultimately considered whether a child could consent on their own behalf and resulted in two key legal principles of consent:

	Gillick competence and Fraser guidelines. Gillick competence is discussed further in *Sections 4.2.3*, *4.6*, *4.8* and *6.4*. **Brief aside on the term Gillick competence** It is a common misconception that the term Gillick competence is named after Mrs Gillick, and many individuals find this confusing as she lost the case. Legal principles are generally named after the name of the case where the principle originates or the Judge in the case who proposes the principle. Hence from the Gillick case we have the term Gillick competence as shorthand for the legal principle regarding the right of a minor under 16 to consent for medical care and treatment, as originated in *Gillick* v. *West Norfolk and Wisbech Area Health Authority and another*; and Fraser guidelines named after Lord Fraser, who first outlined the guidance.
Montgomery case	***Montgomery* v. *Lanarkshire Health Board* [2015] UKSC 11** This legal case concerned Mrs Montgomery who was not warned that because of her diabetes and the weight of her unborn child there was a risk associated with a vaginal delivery. Mrs Montgomery was not offered an elective caesarean delivery and the risk materialised, resulting in Mrs Montgomery's baby suffering severe disabilities.

	A key fact in the case was that Mrs Montgomery stated that had she been aware of the risk she would have requested an elective caesarean section. The case confirmed a change to information-giving when seeking consent from a patient.
Re C	***Re C (Adult: refusal of medical treatment)* [1994] 1 WLR 290** This legal case concerned a man with paranoid schizophrenia who had gangrene of his right foot and did not want a below-knee amputation as advised by a surgeon. Because of C's schizophrenia, he was an inpatient in a secure hospital, and it was felt by the hospital authorities that he did not have the competence to make his own treatment decisions. The court case was held to decide if C had the competence to make his own decisions or whether he should have his leg amputated against his wishes. *Re C* resulted in the three-stage test to determine competence, which was the main legal test of competence prior to the Mental Capacity Act 2005. It is discussed further in *Section 3.2*.
Re T	***Re T (Adult: refusal of medical treatment)* [1992] 4 All ER 649** T, a 20-year-old woman, had been brought up by just her mother since the age of 3 or 4. Her mother was a practising Jehovah's Witness

but T was not. When T was 34 weeks pregnant she was injured in a road traffic accident. A blood transfusion was suggested as a probable requirement, as a caesarean section was being considered. After speaking with her mother T refused a blood transfusion but not the caesarean section.

The court decided that T had been unduly influenced by her mother and as such, her refusal of the blood transfusion was not legally valid.

Notes

3

The three principles of consent

This chapter considers the various principles that are an essential part of consent and the consent process. It also discusses when consent can be considered legally valid.

3.1 The consent principles

As you will have seen from the chapter title, there are three main principles of consent. These principles are related to:

- the competence of the person being asked to give their consent,
- the amount of information that should be provided to that person, and
- the voluntariness of the consent that is given.

> It is only when all three principles are satisfied that consent can be considered legally valid.

These three principles will be discussed in turn below.

3.2 Competence

A patient who is asked to consider a therapeutic procedure needs to be competent at the time they give or refuse to give their consent.

Being competent means *"the ability to make decisions or take actions affecting daily life: when to get up, what to wear, what to eat, whether to go to the doctor when feeling ill etc. In a legal context, it refers to a person's ability to do* *something, including making a decision, which may have legal consequences for the person themselves or for other people”* (Cornock, 2021, p. 69).

Determining if a patient is competent is not always an easy task and because of this the question of whether a particular patient is competent to make their own decision has resulted in the courts being asked to give a declaration on whether specific patients are competent or not.

The general principle of whether a patient is competent to make their own decision was based on the *Re C* case (see p. xix). In that case, it was decided that although C’s paranoid schizophrenia affected his decision-making, he remained able to understand the information he had been given and was able to use that information to reach a decision.

As a result of the *Re C* case, a three-stage test of competence was used to determine if a patient was competent to make their own decisions. This three-stage test asked if the patient:

- was able to comprehend and retain the relevant information
- believed the information they were given
- was able to use the information they had been given, considering risks and benefits and their own needs, to reach a decision.

If all three questions were answered positively, the patient would be considered competent. If one or more was not answered positively, the patient would be seen as being incompetent to make their own decision.

However, as legislation has precedence over case law, since the introduction of the Mental Capacity Act 2005 (MCA) in October 2007, the principles in the MCA have been used to determine a patient’s competence.

Section 1 of the MCA states the following principles:

- It is assumed that someone is competent unless and until it can be proved otherwise.
- Before someone can be deemed to be incompetent all reasonable steps need to be taken to help the person.
- Making an unwise decision does not on its own make someone incompetent.

The assumption that a patient is competent applies to all patients aged 18 and over. For those patients under 18 see *Section 4.2*.

Although appearing to have similar principles, there is a major difference between using case law (such as *Re C*) and the MCA when determining competence. Under case law, a patient would have to prove that they were competent to make a decision. Under the MCA, the starting point is the assumption that the patient is competent, and it is up to others to disprove this. This is a big step forward for the recognition of patient self-determination.

3.3 Adequate information

There is no principle of informed consent in English law. Thus, there is no requirement that patients are presented with every piece of information on a specific treatment before they are asked whether they wish to consent to it or not. On the other hand, patients need to receive adequate information so that they can decide whether to have the specific treatment or not.

The key is to know how much information to give to a patient so that they are adequately informed without the risk of them being overloaded with information.

Over the years a number of legal cases have been decided in the courts on how much information has to be given to a patient. At various times different approaches have been used as the legal requirement for providing information to patients:

- In the 1980s, it was based around what other health care practitioners would give to comparable patients. Patients would receive similar information that health care practitioners thought was appropriate.
- In the late 1990s, there was a change to give information that a reasonable patient in similar circumstances would want to know. Information was based on the general patient rather than modified for each specific patient.
- In the 2000s, this included ensuring that patients were informed of serious risks of the treatment.
- In 2015, the Montgomery case (see p. xviii) made the information requirement patient-specific. Health care practitioners are now required to provide information that the specific patient considers to be relevant.

Currently, as a result of the Montgomery case, health care practitioners have 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"* (paragraph 87). As to what is a material risk, the health care practitioner has to consider what *"a reasonable person in the patient's position would be likely to attach significance to…* [or]… *the particular patient would be likely to attach significance to"* (paragraph 87).

Thus, to be adequately informed a patient has to receive information that has been tailored to their specific needs, their concerns about their condition and proposed treatment, and their desire to receive information.

It is also a requirement that health care practitioners check that the patient understands the information they are being given and answer the patient's questions and queries.

3.4 Voluntariness

For something to be done or given voluntarily, it has to be done without any duress or undue influence. The person who volunteers for something has to believe that they have the right not to do it. If they only volunteer because they do not believe they have any other option, then they have not volunteered but have been coerced or pressurised into it.

Pressure and influence upon a patient to accept a specific treatment could come from the patient's relatives or from health care practitioners. All of them may believe that they are acting for the patient's benefit by telling the patient what they see as being the right thing to do.

Although as a health care practitioner you will have expertise and knowledge the patient does not, and can use that to advise a patient regarding a specific course of treatment, you cannot tell the patient what they have to do. As to when advising becomes telling, this is something that you will have to judge.

If the patient feels pressurised by your 'advice' you have overstepped into telling the patient what to do, and any consent they provide may not be legally valid consent.

Because most patients do not give reasons why they are giving their consent to a specific treatment, it is not always possible to know if a patient's consent is truly voluntary or not.

However, there are times when you will be able to determine that a patient is being subject to duress or undue influence by a relative in reaching a decision. If this is the case then the decision made by the patient may not be legally valid.

For instance, in the legal case of *Re T* (see p. xix) the court decided that someone who is unduly influenced by the wishes or beliefs of someone else when they make a treatment decision has not made that decision voluntarily and any decision made is not legally valid.

Undue influence could be used by someone to 'encourage' a patient to consent to a treatment they do not want or to refuse a treatment that is beneficial to them: for instance, a relative who says, 'Gran, you have to have this operation because if you don't, you know you won't be able to come home' or 'you can't have this operation because you won't be accepted by our religion if you do'.

If you suspect that a patient is being subject to duress or coercion or similar, you need to take appropriate action to protect the patient and allow them to make the decision that they want to make. However, you need to be confident that you are right and the first course of action may be to discuss your suspicions with another health care practitioner and, if they agree, to escalate your concern according to local policy.

3.4.1 Involuntary treatment

Although *Section 3.4* has just stated that consent needs to be given voluntarily for it to be legally valid, there are some very specific instances, detailed in the Mental Health Act 1983, where a patient can receive involuntary treatment. This involuntary treatment must be for a *"disorder or disability of the mind"* (section 1(2) Mental Health Act 1983) and the Act allows someone to be detained to be assessed or to receive treatment (being detained under the provisions in the Mental Health Act is generally known as being 'sectioned').

It is worth noting that mental health legislation only allows a person to be involuntarily treated for the mental disorder or disability which has resulted in their detention.

ℹ A person cannot be involuntarily treated for a physical condition unrelated to their mental disorder or disability.

This is why C (see p. xix) could not be treated for the gangrene in his leg without his consent, and why his competence to consent needed to be assessed.

3.5 In summary: legally valid consent

For consent to be considered legally valid – that is, it meets the legal requirements – it has to comply with the three principles which have been discussed in this chapter. In short, it has to be consent that is:

- given voluntarily,
- by a patient who is competent to make their own decision,
- after being adequately informed about the proposed procedure, any known risks and any other relevant information for that particular patient.

Consent that is legally valid will also meet the regulatory body requirements for consent (see *Section 2.5*). The NMC's code requires nurses to *"make sure that you get properly informed consent and document it before carrying out any action"* (Nursing and Midwifery Council, 2018, paragraph 4.2) whilst the Health and Care Professions Council's code requires practitioners to *"make sure that you have consent from service users or other appropriate authority before you provide care, treatment or other services"* (Health and Care Professions Council, 2016, paragraph 1.4).

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