BJH Consent

Following this year's judgment in the case of *Montgomery v Lanarkshire Health Board [2015] UKSC 11*, legal and moral issues surrounding consent have been thrown into the spotlight. Elizabeth Larner, Solicitor, and Rachel Carter, Partner, of Wollen Michelmore LLP, look at the issues surrounding consent including when problems arise in the fields of clinical negligence and non-accidental injury and what health professionals can do to ensure that their advice to a patient about a procedure or treatment is sufficiently cogent and appropriately recorded so as to avoid later criticism, and possible legal action. Of course, breaches of duty of care can lead to action against the implicated health professional's registration, and possibly even civil or criminal liability.

Informed Consent

The consent process is of course only one small part of a patient's treatment journey. Criticisms as regards whether a patient was appropriately advised prior to consenting are ones which often arise when the worst happens and the outcome is not as expected. If the consent process is material to a potential legal claim, the solicitor or legal adviser will commonly look to the consent form to reflect what the patient was told. The most common pitfall here is failing to properly explain the risks to a patient, meaning that their decision to go ahead with the procedure was not properly informed. Another common pitfall is the health professional explaining the various risks of the procedure properly, but then failing to record this discussion fully within the medical notes. In the latter situation, it is then very difficult for whoever is looking at the notes afterwards (be that another medical professional, a solicitor, the GMC or a coroner) to understand what was actually said, and it can then be very difficult for the implicated professional to rebut the evidence that they did properly advise the patient. It must be remembered that a health professional sees many patients every day (and any criticism levied may well be weeks or months after the material event). This is in stark contrast to the patient or their family, who will have seen that one health professional prior to the procedure, and who will likely give evidence of recalling the consultation and what they were told very clearly.

The GMC guidance on recording and note keeping is very clear. As regards to what should be recorded, the GMC says –

- You must keep clear, accurate and legible records. You must record your concerns, including minor ones, in the records.
- You must make the records at the time that the events you are recording happen, or as soon as possible afterwards.
- If you share information, you must record this in the patient's records. You should also include whether consent was given and, if so, who gave it.
- If you share confidential information without consent, you must record the reasons for your decision. You should also record any steps you took to try to get consent or your reasons for not doing so, and details of any advice you received.

For a long time, the case of *Sidaway v Bethlem Royal Hospital Governors [1985] 1 All ER 643* was good law and established that a doctor had a duty to provide their patients with sufficient information to enable them to reach a balanced judgment as to the proposed course of treatment. The patient was to be informed of how necessary a procedure was, advised as to any alternatives to that course of treatment, and any common or serious consequences of it. Of course, the test as to what constituted 'common' or 'serious' was open to debate, and would depend upon what the health professional providing the advice interpreted as common or serious.

In the *Sidaway* case, Mrs Sidaway had a significant and relevant medical history, including an elbow injury at work and previous spinal surgery. She had been treated by the implicated surgeon for many years for her various complaints. She then developed pain in her neck, right shoulder and arms. The surgeon suggested that a cervical cord compression would assist in alleviating her symptoms, and she was consented by the doctor for the procedure to go ahead. Following the procedure, she was left paraplegic, and alleged that she was not adequately warned of this possible outcome.

In fact, Mrs Sidaway's case was dismissed on the basis that she had been adequately advised of the risks but, given that the risk of paraplegia in such surgeries was less than 1%, the treating surgeon had not been negligent to not specifically advise her of that risk. Most notably, the *Bolam* test of whether a reasonable body of doctors skilled in a particular field would have adopted the same practice, was applied to determine whether or not the failure to advise Mrs Sidaway of a 1% risk of paraplegia was negligent or not.

The doctor's duty to warn a patient about risk was further endorsed in the notable case of *Chester v Afshar [2004] UKHL 41*. Ms Chester had a long history of back problems, and consulted Mr Afshar, a neurosurgeon, as to a possible solution. He proposed micro-discectomy surgery which went ahead, but unfortunately Ms Chester was left with cauda equina syndrome. Ms Chester's case was that she was not warned of the 1 – 2% risk of neurological injury. It was found that Mr Afshar had been wrong not to warn Ms Chester of this risk. Lord Bingham at para 16 said –

> "*A surgeon owes a general duty to a patient to warn him or her in general terms of possible serious risks involved in the procedure. The only qualification is that there may be wholly exceptional cases where objectively in the best interests of the patient the surgeon may be excused from giving a warning…In modern law medical paternalism no longer rules and a patient has a prima facie right to be informed by a surgeon of a small, but well-established, risk of serious injury as a result of surgery".*

Ten years have now passed since *Chester v Afshar*, and judgment in *Montgomery v Lanarkshire Health Board [2015] UKSC 11* now provides us with a significant development in the way that health professionals should deal with issues of consent. Whilst the circumstances of the case surround the consequences of a shoulder dystocia to a baby at birth, thus in a maternity context, the principles arising are without doubt applicable to issues of consent in all areas of medical care.

In this case, Nadine Montgomery was delivered of a baby boy in October 1999. She was an insulin dependent diabetic, and of small stature. It was accepted that women with diabetes are more likely to have bigger babies, and because of her diabetes Mrs Montgomery's antenatal care was to be Consultant led at the hospital, as opposed to in the community.

Mrs Montgomery was told that her baby was larger than average size for gestation. She was not however told that the size of the baby might cause difficulties with the delivery, and particularly she was not told that the risks of shoulder dystocia (where the baby's shoulders are too wide to pass through the pelvis without medical intervention) in her case, being a diabetic mother, were 9 - 10%. Despite this, and despite the fact that the implicated clinician admitted that this was a high risk, the clinician did not as a matter of routine explain the risks of shoulder dystocia, as she felt that this would be likely to cause women to opt for a Caesarean section as opposed to a natural vaginal delivery.

Mrs Montgomery expressed concern as to the size of the baby at her 36 week appointment, and that she was worried the baby could not be delivered vaginally. She had expressed this concern before to her treating clinician.

Mrs Montgomery's labour was induced at 38 weeks and shoulder dystocia arose at the point when the baby's head was half emerged outside the perineum. This resulted in a fraught delivery, during which the umbilical cord became occluded, resulting in the baby being diagnosed with cerebral palsy, as well as a brachial plexus injury resulting in Erb's palsy. It was averred that, if the baby had have been delivered by Caesarean section, he would have been born uninjured.

It was held that a treating clinician had a duty to ensure that the patient was informed about any material risks and any alternative treatments that were available. The test of materiality was whether, in the circumstances of that particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it. The only limited exceptions to this are if the doctor considers that disclosure of such a risk would be seriously detrimental to the patient, or if the patient requires urgent treatment and is unable to give consent (such as being unconscious).

Most notably, the *Montgomery* case now means that the *Bolam* test is not applicable in relation to consent.

Refusal of Consent

The leading case in relation to the right to refuse treatment is *Re T [1992] EWCA Civ 18***.** This case involved Miss T who needed a blood transfusion but refused on religious grounds. Miss T was 34 weeks pregnant when she was involved in a road traffic accident. She spent several days in hospital complaining of pain in her chest and later when x-rayed she was found to have pneumonia. She was prescribed antibiotics and analgesics including Pethidine. Miss T's mother was a strict Jehovah's Witness. Her father was not and was in fact wholly against the religion. The evidence was that Miss T herself held some of the beliefs but did not practice the religion.

Miss T's mother visited and after some time alone together a staff nurse joined Miss T and her mother and Miss T told the staff nurse that she did not want a blood transfusion, that she used to be a Jehovah's Witness and that she still maintained some beliefs. Later that night, Miss T went into labour and was transferred to the Maternity Unit. During this time Miss T was again alone with her mother. A decision was made that the delivery should be by caesarean section and Miss T expressly told the midwife that she did not want a blood transfusion. Immediately afterwards a doctor saw Miss T and asked "Do you object to blood transfusions?" She replied "Yes". The doctor then asked "Does that mean that you do not want a blood transfusion?" Miss T answered "No".

Afterwards Miss T said "You can use other things though, cannot you, like sugar solutions?" Although the doctor could not remember the whole conversation that followed he essentially explained that other solutions could be used to expand the blood but that it would not be as effective. Miss T then signed a refusal to consent form. The form stated "that it may be necessary to give a blood transfusion so as to prevent injury to my health, or even to preserve my life" but this was not explained to Miss T or read out to her.

The baby was unfortunately still born and Miss T's condition deteriorated further to the extend that ordinarily the anaesthetist would have administered a blood transfusion. Given Miss T's previously expressed wishes against this, he felt unable to do so.

Miss T's father and boyfriend then applied to the court for assistance. Ward J dealt with the matter at first instance and concluded that Miss T was competent to make the decision she did in refusing the blood transfusion. Although it was suspected that she had been influenced by her mother, this was not to a sufficient extent to overrule her decision. However, Ward J then considered whether the refusal given by Miss T covered the emergency situation they were now in. He concluded that the situation Miss T was now in was not in her contemplation at the time she expressed her wish to refuse a blood transfusion. It was felt that Miss T had been lulled into a sense of false security and that she had been misinformed about the effectiveness of alternative procedures. Subsequently, the refusal she had given did not take into account a change in her circumstances (i.e. a significant deterioration in health). The refusal was not a continuing one. It was therefore declared that it would be lawful for the hospital, in these circumstances, to administer blood to her as this was in her best interests

This decision was appealed but the Court of Appeal upheld the decision of Ward J and dismissed the appeal.

If faced with a situation where a patient refuses to consent to treatment, a doctor will have to give careful consideration to the patient's capacity at the time. The doctor should consider whether the patient has sufficient capacity commensurate with the gravity of the decision being made.

If the patient has capacity, then the doctor must uphold the refusal to consent, no matter how irrational the refusal may seem. However, the scope of the refusal must be carefully examined – was the refusal only intended to apply to certain scenarios or was it based upon an assumption that has not been realised?

If the patient does not have capacity to make the decision in hand, the doctor can treat without consent on the basis that it would be in the patient's best interests. In practice sometimes a doctor will ask the next of kin but legally the next of kin has no legal right to consent or refuse treatment on behalf of the patient.

Issues of Capacity

The above cases look at the issue of consent from a conscious adult patient of sound mind entitled to decide for themselves whether they will submit to course of treatment. There are, however, situations where there may be doubt as to whether the patient is capable of giving consent, either due to their age or mental capacity.

'Gillick Competence' is a well-known phrase when discussing whether a child or young person has capacity to make their own decisions including in respect of the medical care they receive. The phrase comes from the case of *Gillick v West Norfolk and Wisbech Area Health Authority & Another [1985] 3 All ER 402.* Although over 30 years old, it remains the leading authority on this issue.

In December 1980 the Department of Health and Social Security (DHSS) issued guidance on family planning services for young people. It had circulated a memo giving advice about issuing

contraception to girls under the age of 16. Essentially, the advice given was that the doctor would not be acting unlawfully if he prescribed contraceptives to a girl under 16 as long as he was acting in good faith to protect that girl against the harmful effects of sexual intercourse. It went on to advise that the doctor should try to persuade the girl to inform her parents to enable parental consent to be gained but that the principle of confidentially by way of the doctor patient relationship still applied to the girl and therefore in exceptional circumstances the doctor could prescribe contraceptives without consulting the parents or obtaining parental consent if in his clinical judgment it was desirable to do so.

The Plaintiff was Ms Gillick, a mother of 5 girls under the age of 16, who approached her local area health authority for assurance that none of her children would be given advice or treatment regarding contraception without her knowledge and consent. The health authority were unable to give such a reassurance and therefore Ms Gillick brought an action against the authority and the Department of Health and Social Security on the following basis:

> i) Against the department and authority seeking a declaration that the advice contained in the memo was unlawful as it encouraged underage sexual intercourse contrary to s.28(2) of the Sexual Offences Act 1956 or the offence of being an accessory to unlawful sexual intercourse with a girl under s.6(1) of the Act.
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> ii) Against the area health authority seeking a declaration that a doctor or anyone within the family planning service could not give advice or treatment relating to contraception to any child of the Ms Gillick under the age of 16 without her consent as to do so would be unlawful and inconsistent with her parental rights.

The Judge at first instance held that giving advice or treatment relating to contraception to a girl under 16 years old, in accordance with the advice given within the department's memo, was not unlawful and was not committing an offence or encouraging unlawful sexual intercourse with a girl under the age of 16. Further, doing so without parental consent was not an unlawful interference of parental rights. Ms Gillick's action was therefore dismissed.

She appealed to the Court of Appeal who allowed the appeal and granted the declarations on the basis that a child under the age of 16 could not validly consent to contraceptive treatment without parental consent and subsequently the memo circulated by the department was unlawful.

The Department appealed to the House of Lords (as it then was) against the first declaration (there was no appeal against the second declaration). The main issues for the House of Lords were:

(i) Whether a girl under 16 has the legal capacity to give valid consent;
(ii) Whether providing advice or treatment relating to contraception without parental consent infringes the parent's rights, and
(iii) Whether a doctor who gives such advice or treatment commits a criminal act.

The decision of the Court of Appeal was reversed. It was held that a girl under the age of 16 did not, simply by reason of her age, lack legal capacity. The issue for the doctor was whether the girl has a sufficient understanding and intelligence to enable her to properly and fully understand what was proposed. It therefore followed that there was no impingement on parental rights and no criminal act committed.

A patient may be over 16 and conscious but there may still be concerns as to their capacity to consent to a course of treatment.

To assist with making a decision as to a patient's capacity, a doctor should refer to the *Mental Capacity Act 2005*. It is important to assess a patient's capacity at the particular time a decision is made. Capacity can vary depending on the circumstances and where a patient lacks capacity at one point in time, they may well have regained capacity next time a decision needs making. A decision regarding capacity can be simple in obvious cases but where capacity is borderline, a doctor will need to show that is it more likely than not that the patient lacked capacity at that time. Advice may be taken from those who know the patient and other professionals involved in that patient's care. Where there remains doubt, legal advice should be sought, as the Court of Protection may need to determine capacity. Again, it is vital that a proper record is kept in relation to the decision-making process and steps taking to determine capacity.

Conclusion

The theme from the above cases is clear that every adult has an absolute right to make decisions about their treatment. Adults are also deemed to have prima facie capacity to consent to medical treatment or to refuse treatment even where this may lead to death.

Previously, providing a doctor was acting in the patient's best interests there was not too much concern over what a patient was or was not told about the risks. However, this has changed and what is vital now is that a patient is fully and properly informed to enable them to make a decision about their treatment. If *Montgomery* remains good law, the onus will be on the doctor to point out all material risks and document those discussions fully. The health professional will have to have regard not only to what s/he appreciates to be a material risk, but also to those risks which that particular patient might appreciate as being material (even if the doctor appreciates it not to be so). Following the practical steps set out within case law and GMC guidance will assist in avoiding common pitfalls and provide a level of protection.

Where there are concerns about capacity, this should be carefully assessed and documented fully. Where capacity is lacking, it is the duty of the doctor to treat the patient in accordance with his best interests. If there is doubt about capacity when decisions are being made that may threaten a patient's life, legal advice should be sought.