Consent and Capacity in Medicine

Consent

Battery: Unlawful application of physical force to another
Assault: An attempt to commit battery or an act that may reasonably cause fear of imminent battery.
Many medical interventions are therefore battery/assault unless permission (consent) is given to perform them.

Implied consent: Patient makes an action to facilitate an intervention.
Explicit consent: Patient agrees to intervention, verbally or in writing. Legally the two are no different, but easier to prove substance of discussion if written consent.

Both of these require the patient to have capacity (see below)

Presumed consent: Assumption that a patient would agree to an intervention if they had capacity; generally applies if it is considered to be in their best interest and they had not previously indicated they would refuse it.

While a competent patient can refuse treatment, they cannot legally demand treatment that the treating team believe is inappropriate or futile. If there is debate over this, referral for a second opinion is considered best practice.

Capacity

Some issues of capacity were documented in the Mental Capacity Act 2005. The main principle is to permit and enable people to make their own decisions wherever possible.

Test for capacity:
1. Understand and believe the information give
2. Retain the information
3. Weigh it up to reach a balanced decision
4. Communicate that decision

The decision must be considered, but need not appear rational to those hearing it.

Capacity is dependant on the decision, not an absolute.

While a patient has capacity, they can appoint someone with **Power of Attorney** to act on their behalf in decisions on their healthcare; this person then has the authority the patient usually would. They may also write an **Advanced Directive**, consenting or refusing certain interventions in certain circumstances. These are legally binding, provided the patient had capacity when they were written, and the circumstances described apply. (NB Proof of validity in an emergency situation will not always be easy to verify).

In the absence of Power of Attorney or an advanced directive, treatment of a patient lacking capacity is based on their best interest. This should involve discussion with the patient where possible, and if not discussion with relatives, friends, or long term carers to determine what they believe the patient would wish (NB This should not reflect the beliefs if those spoken to; they are asked to represent the previous opinions of the patient). In the absence of anyone else, an **Independent Mental Capacity Advocate (IMCA)** should be asked to represent the views of the patient.

If there is a significant disagreement over what is in the best interests of the patient, the **Court of Protection** (established by the MCA 2005) can be asked for a ruling.

Notes:

Mental Health Act: Permits treatment against the patients will (in certain situations) for mental illness only. No section permits treatment of a physical illness.

Children:
Those over 16 are presumed to be competent to make their own decisions, provided they are competent to do so.
Those under 16 may consent on their own behalf if Gillick competent (understand the implications of the intervention), although parental assent is good practice.
A parent cannot overrule a valid consent of a child under 16, but can overrule a refusal of treatment – can consent on their behalf.

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