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Title page

Title: Informed Consent in Care homes – Legal and Ethical Considerations.

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Angela Smith and Julia Parkhouse examine the principle of informed consent being given by residents in care homes in respect of their care and treatment and advise staff on how to comply with the rules.

This article will consider the basic legal and ethical principles in relation to the giving of informed consent by residents living within a care home environment. The four principles of biomedical ethics underpin the principle of informed consent and govern ethical issues in healthcare (Beauchamp & Childress, 2009). Equally, it is subject to the legal principle of gaining consent from an individual prior to performing any action. Importantly, the absence of valid consent may result in an action in a criminal court (a charge of battery as a minimum) and/or in a civil court (legal action for battery and/or negligence). It is therefore important that healthcare professionals caring for residents are aware of their responsibilities from both an ethical and legal perspective. The four ethical principles will be discussed, as will recent case law as to how the law has developed in recent years and the impact this has had on healthcare professionals who wish to obtain a valid consent.

What is consent and why is it important?

Consent simply means “agreement” or “permission” to do something. Within a healthcare setting it is vital that consent is obtained. Without such agreement, any touching of a person’s body, including small but regular instances (taking blood pressure, washing, moving/rolling a patient or resident, administering vaccinations and any type of clinical/surgical procedure), can amount to at least a charge of battery or grievous bodily harm (criminal offences). It is therefore essential that healthcare professionals are at all times aware of both their ethical and legal duties to residents in their care.

Ethical duties

Beauchamp & Childress (2009) have highlighted four moral principles that we can use to structure our thoughts about moral problems within the healthcare setting. These are *Autonomy* (right to self-govern); *Non-maleficence* (do no harm); *Beneficence* (contribute to welfare) and *Justice* (in healthcare this is taken as meaning the fair distribution of healthcare resources). The authors suggest that *autonomy* is the most relevant moral principle relating

to consent, although it doesn't override the other principles. Essentially, the word derives from the Greek *autos* (meaning 'self') and *nomos* (meaning 'rule') and therefore the general principle means that people should be allowed to 'hold views, to make choices, and to take actions based on their personal values and beliefs' (Beauchamp, Childress, 2009, p 103).

In a healthcare setting, this means that provided a person has capacity and is able to make their own decisions (discussed later in this article) they should be allowed to do so, even if this is considered to be an unwise decision (i.e. refusal to take medications, refusal to be washed). This principle is enshrined in law, as evidenced in the much publicised case of *Kings College Hospital Foundation Trust v C & V* [2015] EWCOP 80. Even though the prognosis for C, who had suffered kidney failure due to an unsuccessful suicide attempt, 'remained excellent with survival fully anticipated' (para 21), the court held that it was her choice as to whether or not she continued to receive dialysis based on the principle that 'this position reflects the value that society places on personal autonomy in matters of medical treatment and the very long established right of the patient to choose to accept or refuse medical treatment from his or her doctor' (para 2). Ultimately, C was allowed to refuse dialysis and died shortly afterwards.

Legal duties

While ethical principles should be considered when dealing with residents, there is no concrete sanction available if such a moral principle is breached (although the health professional may hold themselves morally accountable for their own actions). However, there are legal implications if proper consent is not obtained. The following discussion will therefore consider how consent should be obtained from residents for all interactions, in order to comply with the law.

Types of consent

There are four types of consent:

- Imputed – essentially, this could possibly mean that just by living and being cared for in the care home a resident is agreeing to anything that you wish to do to them. This is the weakest form of consent and is legally questionable;

- Implied – where the resident does not specifically agree (verbally or in writing) to an action, but their actions suggest consent. This type of consent is often used in healthcare situations; examples within a care home setting may be where a health professional asks (or tells) the resident that they wish to take their blood pressure and the resident rolls up their sleeve so that this can be done. Similarly, they may tell the resident that they have their medications and the resident reaches out his/her hand to take them;
- Express – where a resident will explicitly agree either verbally or in writing to an examination/procedure. For example, a health professional asking ‘can I wash you now Mr Jones?’ and Mr Jones replying ‘yes, you may. Similarly, if a surgical procedure is being carried out, then written consent will be required. Any procedure that carries an element of material harm or risk will require express consent.
- Presumed (deemed) consent – Only applies in relation to organ donation and is currently only in use in Wales. This came into effect on 1 December 2015 and unless a person has registered their desire to ‘opt out’ of donation, then their consent is presumed/deemed. England and Scotland have announced their intentions to introduce similar legislation to move to a soft ‘opt out’ system of organ and tissue donation. Northern Ireland is the only part of the UK not to have made such a commitment; nonetheless, it is a priority with its Health (Miscellaneous Provisions) Act (Northern Ireland) 2016, including a duty to promote and increase awareness of transplantation and organ donation with provision for a yearly promotion campaign. Further, the British Medical Association (BMA) in Northern Ireland supports a change in legislation to soft ‘opt-out’ and has written to political parties for their support.

Assuming therefore that in care homes the majority of procedures will require either implied or express consent, there are a number of components to consider when deciding if valid consent has in fact been given. These include matters such as age, whether the resident has capacity to consent and does so freely and without coercion, and whether such consent is indeed ‘informed consent.’ We look at these issues separately:

Requirements for a valid consent:

Age

For the purpose of this article, and assuming that residents in care homes will all be adult patients, they must be aged 18 and over. The law in respect of consent for those aged under 18 is complicated and generally speaking will not be relevant for those not specifically working within that field.

Must be given freely and without coercion

The resident must agree to the procedure freely and without being persuaded by others who may use pressure or threats to secure agreement (regardless of reason). While this may initially seem non-problematic, health professionals should consider that residents may feel obliged to agree to certain actions even though they do not want to. They may feel an obligation to staff caring for them or feel inferior to medical, nursing and care staff for fear of them judging the resident or withdrawing care. They may feel the need to agree when their relatives say that something should be done. It is important to recognise that the decision should be made without any undue influence being placed upon them to agree.

The patient must have capacity to consent

If a patient has capacity, then the decision is theirs to make. With regards to patients who may not have capacity, the legal framework provided by the Mental Capacity Act (MCA) 2005 (Department for Constitutional Affairs, 2005) will apply and this is supported by a Code of Practice which informs and guides the health professionals in terms of applying the Act. While there is no legal obligation to conform to the Code, if the guidance is not followed then the reason(s) for such departure will be required and should be documented. Ultimately, when deciding whether or not a person has capacity, that person has to be able to understand the information relevant to the decision, retain that information, use or weigh that information as part of the process of making the decision, and be able to communicate his/her decision (whether by talking, using sign language or any other means).

If the healthcare professional considers that a person lacks capacity, they have to abide by the principles contained within the MCA 2005 and act in the patient's 'best interests.' While these provisions are subject to much greater discussion, this article is aiming to focus on the first principle contained within the Act, namely that 'A person must be assumed to have capacity unless it is established that he or she lacks capacity (MCA 2005: s1(2)).

This is an area that will be relevant within the care home setting, as many residents will have characteristics that may, at first glance, lead to the carer making the assumption that the resident lacks capacity. *Figure 1* deals with some characteristics that you may regularly come across in a care home setting and which may make carers assume that the resident lacks capacity.

| | |
|---------------------|---|
| Age | The fact that a person is elderly/old does not mean that they lack capacity. It may however be a factor if linked with other characteristics |
| Physical disability | If a resident is deaf or blind or is partially paralysed or has a urine infection, this does not mean that they lack capacity, although such persons may need extra assistance in being able to come to a decision, such as using sign language |
| Mental disability | If a resident has epilepsy or dementia or a learning disability or schizophrenia, this does not automatically mean that they lack capacity. It may be an indicator but mental illness alone does not equate to lack of capacity |
| Pain | If a resident is in pain, this does not mean that they lack capacity, although it may indicate this. If the pain can be dealt with through 'best interests' then when the person is no longer in pain they may well be able to make a decision |
| Unwilling | If a resident is unwilling to undertake the relevant act/treatment, it does not mean they lack capacity. Every person has the right to make his/her own decisions |
| Language | If a resident cannot understand what you are asking them, whether this is due to language issues or the choice of words used, this does |

| | |
|--|---|
| | not mean that they lack capacity. They may need assistance to help them understand. |
|--|---|

It is important to recognise that capacity is person -, time - and decision - specific. Generally speaking, it will be the health professional delivering the procedure who assesses and decides whether the patient has capacity to consent. This is because the MCA empowers those working in healthcare to undertake capacity assessments themselves, as opposed to relying on expert testing, and good knowledge and training around the requirements of the Act is essential in this respect. It should be noted that complex and major decisions cases may require the services of an expert opinion, whether that is a GP or consultant psychiatrist or psychologist. On this basis, when considering whether a resident has capacity, consider that a resident may need assistance in the decision-making process. This could include drawing diagrams, having relatives interpret, using simple words, acknowledging that we are entitled to make unwise decisions (as per the case discussed above), and waiting for a decision until the resident is more lucid. For example, a resident may be unable to make a decision about taking their medications early on in the day (and it may therefore be necessary to administer them in his/her best interests) but later on in the day, when they may be more aware and no longer affected by any night sedation, they may be perfectly capable to make a decision on whether they want to be hoisted into their wheelchair or remain in bed.

Consent should be informed

This area has developed over many years, with numerous court cases debating the issue of how informed a patient should be in order to make a decision. Historically, the paternalistic approach of medical professionals was preferred over patient autonomy. In *Beatty v Cullingworth* 1896), even though a patient specifically told her doctor that if both of her ovaries were diseased neither should be removed, when he found this to be the case he removed both ovaries. Despite the lack of consent, the jury in the case found his actions to be acceptable on the basis that 'it is a humane act for a medical man to do everything in his power to remove the mischief' (in this case, the diseased ovaries) (*Beatty v Cullingworth*,

1896). While this may appear to be noble, it completely goes against the ethical principle of autonomy.

The notion of patient autonomy has advanced since then, albeit slowly. The cases of *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583, and *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 have discussed the issue of informed consent and the extent to which health professionals should explain the risks of any treatment prior to gaining consent. In the now leading case of *Montgomery*, Mrs Montgomery was a small woman with diabetes who was carrying a large baby. Despite her asking her consultant about the risks of a vaginal birth, her questions were not addressed, as the consultant felt that if she informed the mother of the risks of shoulder dystocia, the mother would opt for a Caesarean section, which in her opinion is 'not in the maternal interests for women' (UK Supreme Court (UKSC), 2015). Unfortunately, the risk materialised and as a consequence the child suffered harm. The legal principle now established as a result of the *Montgomery* case is that consent may only be seen as being valid if informed i.e. a patient is aware of the material risks and benefits to treatment. Patients should be made aware of any reasonable alternative or variant treatments. As far as the test for materiality is concerned, this is 'whether, in the circumstances of the 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' (UKSC, 2015). It is therefore evident that patient autonomy is now considered vital and that their decision must be informed.

So what can you do to improve?

Consider something that you have done for a resident in your care over the past few days. Think about:

- What type of consent did you seek (implied/ express)
- Did your resident give valid consent – was (s)he pressurised into agreeing
- Did (s)he know what they were agreeing to (i.e. did they have capacity to give their consent)
- Was (s)he aware of any possible risks of the treatment (e.g. medications, manipulation)?

Conclusion

In respect of consent, staff working within the care home setting should be aware of the necessity to obtain valid consent from their residents before touching them. Provided a patient has capacity, it is their choice, both ethically and legally, to decide whether or not to agree to the suggested action. Attention therefore needs to be made to whether or not the resident is agreeing because they are being pressurised into doing so, whether they have capacity to make a decision and whether they have been given sufficient information to enable them come to a decision.

Key points

- **Valid consent from a patient satisfies ethical and legal requirements of a health professional**
- **Implied and express consent may be considered to be valid types of consent in a health-care setting**
- **Consent should be given without any pressure being put upon a resident**
- **If a patient has capacity the decision is theirs to make, regardless of the wishes of the care home staff or relatives**
- **Consent needs to be informed**

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