

Consent

Tips for health care professionals

By Hyder Gulam

The issue of consent in nursing practice

The issue of consent is of vital importance to health care professionals because whenever a patient is touched, technically an assault is committed.

Consent represents an intersection of the basic principles of health care: patient autonomy and the patient's right to self-determination.

Obtaining consent from a patient prior to treatment or a procedure is integral to good nursing practice, and should be a matter of course.

Therefore, this article attempts to clarify the legal concept of consent for nurses and other health care professionals.

Consent and trespass

For consent to be binding, patients must be provided with sufficient information to make a reasoned decision about whether to undergo the proposed intervention.

The patient should be legally competent and able to understand and comprehend the impact of the treatment being considered.

Competence is satisfied when the patient has the mental capacity to be responsible for their health and is able to communicate their wishes with respect to treatment.

Consent is not valid when a patient is unduly coerced or misled to provide it.

Trespass is a broad concept

which includes assault and battery. Both assault and battery can be either a crime or a civil 'wrongdoing'.

Assault is defined as 'intentionally creating in another person an apprehension of harmful or offensive conduct.'

Battery is the actual application of force or harm to a person's body without their consent.

Generally, the action of assault is normally included in battery as the threat of harm usually occurs before the actual harm occurs.

The elements of a battery are:

- A direct act by the defendant (the health care professional);
- Causing bodily contact with the plaintiff (the patient); and
- Doing so without the patient's consent, that is, unlawfully.

The patient need not be aware of the actual battery for battery to have taken place. For example, battery can take place when a patient is asleep, sedated or under anaesthesia.

In the landmark case of *Rogers v Whitaker (1992)*, the High Court of Australia stated that 'consent is relevant to actions framed in trespass, not in negligence'.

Australian law has taken the view that failure to disclose the risks inherent in a medical procedure to a patient can only be found to be an action in negligence, and not in trespass.

Thus, a lack of full information is a matter of negligence rather

than a lack of consent, as long as the patient knew about the broad nature of the proposed treatment.

Where the proposed treatment is to be undertaken by a medical practitioner, as opposed to other health care professionals, the responsibility for obtaining consent rests with the attending medical practitioner.

It is a duty that cannot be delegated except to another medical practitioner, and it may not be delegated to a nurse.

Elements of consent

The basic elements of consent are:

- It must be voluntary, without coercion, duress, misrepresentation or fraud;
- It must be specific, it must cover the act performed; and
- The patient must have the capacity to consent – the patient must be able to understand the implications of having the treatment.

Consent for the purpose of a battery action need only be consent in broad general terms to the nature of the proceedings.

If a patient agrees to undergo an operation or procedure then that consent is sufficient to defend against a charge of battery, even where there has been a failure to inform the patient. However, the consent must be valid; otherwise a trespass action can be taken.

The law does not generally require that the consent or

the provision of information (including warnings about material risk) be documented in writing.

Indeed, a patient can consent expressly, either orally or in writing, or it can be implied, from the patient's conduct, eg. holding out their arm to receive an injection. However, the mere fact that a patient presents at a health care facility does not in itself provide a valid consent for a health care professional to initiate diagnostic procedures or treatments.

Consent obtained in writing will assist health care practitioners in any subsequent legal proceedings, as it will support their view that the treatment was discussed with the patient and that consent was obtained.

The absence of a consent form may give rise to an implication that the procedure was not discussed, and consent was not obtained.

A signed consent form is not mandatory for minor procedures under local anaesthesia (eg. insertion of an IV cannulae; urethral catheterisation; or suture of minor lacerations), even though the criteria for obtaining a valid consent must be met.

However, consent obtained after a premedication has been administered may not be voluntary, and thus invalid.

If a patient wishes to discuss any element of the consent after premedication, the health care professional should address those concerns and form a view of the person's competence. ▶

If the patient is deemed competent, any wishes relating to consent should be acted on by the health care professional.

Misconceptions about consent

Two popular misconceptions about consent are that a person's relatives can provide sufficient consent and that consent is not necessary if the motive prompting a health care professional's conduct is to save a life or alleviate suffering.

Although there are certain exceptions, the main principle upheld by the courts is that of patient autonomy.

This principle protects patients from all medical treatment and interference with their body unless they have personally given a prior valid consent to the actual treatment involved.

The onus is on the health care professional to determine that the patient consents, and not upon the patient to express their refusal.

Consent in accidents and emergencies

It has been recognised by the courts that in an emergency situation, a person's consent is implied to undergo a medical treatment which is necessary.

Under *implied consent*, it is assumed that a patient would have consented to such treatment as was necessary for them to be saved.

In the case of *Murray v McMurchy [1940]*, a Canadian court distinguished between necessity and convenience. In this case, a surgeon found fibroid tumours during a Caesarean section and tied the patient's fallopian tubes so she could be 'spared the danger' of further pregnancy.

However, the court found the surgeon liable as there was 'no evidence that these tumours were at the time of the operation dangerous to her life or health'.

In another Canadian case, *Malette v Shulman [1990]*, a card found in the personal belongings of a woman who had been seriously injured indicated her religious beliefs and requested no blood transfusions.

Despite being aware of these beliefs, the emergency physician decided to administer a transfusion when the woman's condition deteriorated.

Following her recovery, the patient successfully sued the medical practitioner for battery. The court held that emergency medical treatment will not necessarily be lawful under the principle of necessity in a situation where the treatment is performed contrary to the patient's express prior instructions.

Refusal of treatment

The flip side of the principle of patient autonomy is that a competent patient has the right to refuse medical treatment.

It is also important to note that a third party, be they a spouse, medical practitioner, or significant other, does not have the legal capacity to consent or refuse treatment on someone else's behalf. Generally, the courts have not been willing to override a patient's right to refuse treatment.

However, while the next of kin has no legal right to consent or refuse consent to medical treatment on behalf of a patient, seeking the consent of the next of kin may reveal whether the patient had made an anticipatory choice about the acceptance or refusal of specific treatment.

Consent by minors

The basic common law position allows parents to consent to all medical treatment on behalf of their minor children.

This is reinforced by provisions of the *Family Law Act 1975 (Cth)*. Therefore a failure to obtain parental consent can

amount to action in battery against a minor.

This principle is limited by the courts' refusal to allow parents to consent to some non-therapeutic treatment (such as sterilisation, long acting contraception, drugs of addiction etc) without first obtaining a court's consent.

In the case of *Re Marion (1992)*, the primary issue was whether the parents of a girl with a profound intellectual disability had the power to consent to a sterilisation operation, especially when the operation was not required for an immediate medical purpose.

The High Court held that parents do not have the legal authority to consent to a sterilisation operation on their child, other than as an incidental result of surgery to cure a disease.

This was because sterilisation of a minor was a 'special case', outside the ordinary scope of parental authority to consent, there was a serious risk of making an incorrect decision, and the implications of making such a decision were 'particularly grave'.

The High Court has also recognised children can consent to medical treatment for themselves once they have sufficient understanding and are capable of expressing their wishes, endorsing the view in the English case of *Gillick v West Norfolk and Wisbeck AHA (1986)*. According to the High Court, this includes children with an intellectual disability.

A parental right to consent to medical treatment ceases when the child achieves a sufficient level of maturity and intelligence to understand fully what is being proposed.

Another important aspect of consent in relation to minors is a situation where parents refuse treatment or are unavailable to give their consent.

This may arise for a number of

reasons including religion, misinformation and disagreement about preferred treatment options.

All Australian states and territories have statutory provisions authorising some form of emergency medical treatment of minors, generally blood transfusion, without the consent of a child's parent or guardian.

A child is only able to refuse medical treatment if that refusal is reasonable in the view of the medical profession. A child cannot make their own unreasonable refusal. The court's inherent jurisdiction means it can override the wishes of a person under the age of 18 years.

Conclusion

This article attempts to show the vital importance of consent to nurses and other health care professionals.

In particular, there are many important considerations when dealing with children, and patients with intellectual impairment.

When in doubt, nurses and other health care professionals should consult their managers for clarification.

By Hyder Gulam, BA, BN, LLB, Post Grad Dip (Advanced Clinical Nursing), LLM, RN (Vic, NSW, UK, USA), Barrister and Solicitor, Accredited Mediator (IAMA), FRCNA