Important legal principles of consent and mental capacity

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Abstract

Consent is an essential part of healthcare practice, allowing patients to make autonomous decisions. However, this changes when a patient has mental incapacity or is unable to make decisions for themselves for a duration of time. This month's Policy column looks at some of the key principles of the Mental Capacity Act 2005, and how this can be applied in community nursing practice.

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The right to consent to (and refuse) treatment is a fundamental right that has been established in law for a significant period of time (Jackson, 2022). In the UK, the case of Chatterton v Gerson [1981] emphasised the need for healthcare practitioners to provide sufficient information to a patient before asking them to consent to treatment; likewise, patients also had the right to refuse treatment. In 2015, this law was expanded to include information that should be provided to a patient. In the case of Montgomery v Lanarkshire [2015] the patient must be informed of all the material risks and other treatment choices, otherwise it is unlikely to be seen by the courts as a valid consent.

However, for the patient who has a mental incapacity the law is less clear. The assessment of mental capacity remains a complex area for many healthcare practitioners (Kong and Keene, 2018).

There are five key principles of the Mental Capacity Act 2005:

- A presumption of capacity
- The right to be supported to make a decision
- To make an unwise decision
- To act in the best interests of the person
- To follow the least restrictive intervention.

As stated in the first principle, the community nurse must always assume the patient has capacity. Nevertheless, if the patient is showing signs of mental incapacity, for example confusion, the community nurse needs to make an assessment. The assessment of mental capacity from a legal perspective is laid out in section three of the Mental Capacity Act 2005. The patient must be able to understand what is being proposed, retain the information, is able to weigh up the benefits and risks of the treatment, and be able to communicate the decision back to the healthcare professional seeking consent. If a patient is able to do all of these steps, they are deemed to have mental capacity to make a decision, including the right to refuse treatment. If the patient was to not meet one or more of these stages, the patient will be deemed to not have full mental capacity. The patient is allowed to make unwise decisions, so a refusal of treatment might result in poorer outcomes for the patient, but as long as they understand the risks of their refusal, if they are assessed as having capacity, they are entitled to make their choice. In the case of Re C [1994], a patient with schizophrenia refused a foot amputation (he had gangrene in his foot), part of his rationale being that he wished to die with both of his feet. The court ruled that although he had schizophrenia, he was able to refuse because he understood the information, retained it and weighed up the consequences of not having the procedure. The doctors may have seen C's decision as unwise, but he was still entitled to make that decision. Likewise, as seen in C's case, having a pre-existing condition does not preclude a patient from providing a valid consent or refusal. For example, Ranvir has dementia, but is able to make most decisions on a day-to-day basis. Having dementia in itself does not mean Ranvir has lost capacity, so it is important that the community nurse does not make assumptions on the basis of the patient's condition or illness, and in this case the community nurse can support Ranvir to make an informed decision regarding care or treatment.

Section four of the Mental Capacity Act outlines the situation if a patient has no or limited mental capacity. In these circumstances, the community nurse must act in the best interests of the patient. Best interest in this regard also includes making a decision on behalf of the patient that also considers the patient's previous wishes and beliefs. It is also a requirement of the Mental Capacity Act to include relatives and carers in the decision making, although the healthcare professional is not necessarily bound by their decisions.

The assessment of capacity must be time-specific and procedure-specific. For example, the community nurse visits Brian for a dressing change. Brian has been under the influence of alcohol due to attendance at a wedding, and he is finding it difficult to retain and communicate his decision to the nurse. His dressing has seepage all around the edges and there is considerable staining on the surface of the dressing. The community nurse can make one of two choices:

- Rearrange the visit for another time, hoping Brian will then be able to provide a valid consent
- Change the dressing immediately, due to an increased risk of the wound becoming infected.

As long as the nurse has assessed Brian as having no capacity via section three of the Mental Capacity Act (colloquially referred to as the four-stage test), the nurse can continue to treat Brian as outlined via section four (best interest). However, if the dressing did not show any signs of leakage and looked clean and intact, it may be more pertinent for the community nurse to revisit Brian at a time when he has regained capacity so he can make a fully informed consent for the dressing to be changed. Managing a patient who has intermittent capacity is referred to as fluctuating capacity. Alcohol is one example, although severe pain, confusion due to infection, or a head injury are some of the other examples of when a person's mental capacity can be compromised, although after a short period of time capacity may return. In the case of Re MB [1997], a pregnant woman refused a caesarean due to a needle phobia. The health authority applied to the court, and the court gave leave to the obstetrician to operate on MB. The Court of Appeal agreed that her needle phobia was irrational; therefore, at the time, the patient did not have the mental capacity to be able to refuse treatment.

In regard to the procedure, if the procedure is straightforward the patient may still be able to meet the four steps as outlined under section 3 of the Mental Capacity Act. However, the more complex the procedure or care, there is a possibility that the patient will find it more difficult to understand the risks and benefits of the proposed procedure or care. There is an onus upon the community nurse to try and explain to the patient in the simplest of terms so that they can still provide a valid consent (or refusal). However, if even after taking those steps the patient is still unable to understand the proposed procedure or care, the community nurse can act in the patient's best interest in accordance with section four of the Mental Capacity Act.

In some cases, the patient may have made an advanced decision. An advanced decision allows a person who has full mental capacity to make a decision for the refusal of treatment for a time when they may not have full mental capacity. An advanced decision, if in relation to refusal of life sustaining treatment (eg cardiopulmonary resuscitation) must be made in writing and the document/statement witnessed by another person, normally a solicitor or a general practitioner. The person has to be over the age of 18 years at the time of making the advanced decision. The person must also have lost capacity. If the advanced decision is valid, the community nurse must abide by its wishes. However, if there is any question in relation to the validity of the advanced decision, or there is no evidence of there being an advanced decision, the practitioner can continue to treat in the patient's best interest via section four of the Mental Capacity Act.

Section nine of the Mental Capacity Act, also allows a person with full mental capacity (referred to as the doner) to appoint a lasting power of attorney (LPA) to another person (referred to as the donee) to make decisions in relation to either finances and property or health and welfare (or both) for a time when the doner is unable to make a decision because of mental incapacity. The LPA must be registered with the Office of the Public Guardian (OPG) to be legally valid. The donee must act in the best interests of the patient and can only make decisions on behalf of the patient once they have lost capacity. If the patient retains full mental capacity, the decision-making remains with them. Even when the patient has lost capacity the donee must abide by any advanced decisions made by them. However, an LPA cannot be used if the patient has been sectioned via the Mental Health Act 1983, and associated treatment provided under the Act. The donee can refuse the use of electroconvulsive therapy (ECT). The donee can also refuse treatments such as cardiopulmonary resuscitation, blood transfusions and medications, except during emergency situations, unless there is a clear direction as part of the LPA. If the community nurse suspects the donee of acting beyond their powers or is not acting in the best interests of the patient, this would need reporting to the OPG.

Consent is essential in healthcare practice as it enshrines the right for patients to be able to make autonomous decisions for themselves. Nonetheless, there are times when the patient cannot give a valid consent or refusal because of having compromised mental capacity, either for a short-term period or for a longer period of time. The community nurse must understand the key principles of the Mental Capacity Act, and the steps required to assess the patient. If, after undertaking the assessment, they deem the patient to have incapacity, there is a statutory legal defence for the nurse to treat and care for the patient in accordance with their best interest. The community nurse must ensure before the commencement of treatment, that they adhere to any valid advanced decision in place, and also to ensure that any person with a lasting power of attorney is included in the decision-making process. **BJCN**

Declaration of interest: None

Chatterton v Gerson [1981] 1 All ER 257

Jackson E. Medical Law: text cases and materials. Oxford: Oxford University Press; 2022

Kong C, Keene AR. Overcoming challenges in the Mental Capacity Act 2005. London: Jessica Kingsley Publishers; 2018

Montgomery v Lanarkshire Health Board [2015] UKSC 11

Re C (Adult: refusal of medical treatment) [1994] 1 All ER 819

Re MB (Caesarean section) [1997] EWCA Civ 1361