TOPIC 2 – MEDIAL TREATMENT: CONSENT AND REFUSAL

2.1 ELEMENTS OF CONSENT

- Very critical aspect as it applies to a majority of adults
- There will be a very different test that we use when it comes to children
- Here when we are looking at consent and refusal generally we are going to look at the actual elements that constitute patient consent
- **Consent is required by:**
    - The patient (must give the consent themselves)
    - Sometimes will have a substitute decision maker (someone else other than the patient because they are not competent or cognitive to give it – a whole regime for this and a complex interplay of a number of statutory provisions which we will look at)
    - Consent can be provided by other lawful justification
        - E.g. in situations of emergency (which is quite distinguishable from necessity – a very fine line and often they are used interchangeably but they are not interchangeable)
        - Lawful justification can also be mandated by court order or by
        - Statutory authority – may compel something to occur or that consent can be waived
- **If consent is not obtained it could constitute:**
    - a) Tort – battery (direct application of force); assault (threat of harm); false imprisonment (deprived of freedom, usually of movement – this can be quite extensive when we are looking at healthcare because it can be via drugs or through psychological control)
    - b) Criminal offences will apply – actual assault if there has been no consent
    - c) May constitute grounds for disciplinary action – complaint – may be disciplined under the Health Practitioners Act – again, each type of HP is covered under a particular board
- **Reasons for consent/why is it important to get consent:** ethical, autonomy and self-determination (liberal theory v communitarians), medical, patient cooperation, trust, compliance
    - Ethically – you would use the virtuous theory to argue that it is the right thing to do to get someone's consent
    - Ensuring that the persons autonomy over their body is respected and protected – a critical aspect of this theory is respect for the *I* – the respect for self-determining that if you don't get the necessary information then you could be making the wrong decision – it is determined for yourself as an autonomous being
        - These ideas are very much anchored in the jurisprudential theory – the right to control ones like and self-determine – stems from JS Mill's theory – the ideal of the individual liberty without state intervention
        - E.g. many patients might consider the medical advice that they are given and want to make their own decisions based on this – therefore they will participate – by either saying that they will accept the risk/endure the pain or that they do not accept that type of risk

        - Immunizations is an interesting case as this is not ostensibly mandated but there are some ways in which the state can control this (as you cannot attend childcare or kinder if you are not vaccinated – enforces a particular type of behaviour)
    - Judicial statements of self-determination are some of the most highly welcomed types of explorations of self-determination in Canadian/US decisions
        - Some Australian cases have been increasingly more so as well – the more current ones reflecting the idea of making ones own choice
        - Those that believe that such ideas undermine the community may be arguing that they should have more communitarian ideals
    - There are also medical reasons for consent – the fact that a procedure could actually cause a lot of harm and the patient needs to be ok with this
        - A lot of times medical procedures might have a long recovery and if the person does not consent it will make the recovery hard/the possibility of healing unlikely – the therapeutic relationship becomes critical because otherwise treatment can't be effective – a lot of recovery is about the psychological state of being – so the happier that you are with the treatment and the acceptance of certain side effects the more willing you will be to take on effective treatment and enhance honesty (eg. If something is painful, if you forget medication etc.)
        - Enhances trust an compliance and you get patients cooperation
    - Sometimes you may equally want to argue that it is important not to get consent (don't have much time and cant wait)
- **Fors of consent:**
    - Express (in writing/oral) – to the specific form of treatment
    - Implied
        - If consent is not expressed there are many different ways in which you can imply consent
        - E.g. offering your arm for an injection
        - It is an implication from the conduct as to what your state of mind is
        - But if you are resisting at all costs then consent is not implied or expressed by any means by this sort of conduct
- **ELEMENTS OF CONSENT**
- CAPACITY
- "Every human being of adult years and sound mind has the right to determine what is to be done to his [or her] own body": *Schloendorff v The Secretary of the New York Hospital* per Cardozo J (American Judge).
- The absence of sound mind is critical here because the attribute means that the patient no longer has the competency nor the capacity to determine what is to be done to their body
- However, capacity is not static/permanent and it can change and evolve
    - E.g. a psych patient may be limited into entering certain contracts and deemed to have capacity for treatment but in other respects cannot do certain undertakings

    - The big question is whether they are capable of understanding the nature and effect of the proposed treatment
- In law for adults, it begins with the presumption that every human being has a right to determine what is to be done to their body
    - The cases that seem to enhance many of these primary concepts come from refusal of treatment cases
- 3 aspects to capacity:
    - A) Take in and retain info about their treatment
    - B) Believe the treatment information and
    - C) Be able to weigh that information; balance the risks posed with their own needs
- i) Processing information
- The aspect that we are dealing with in terms of taking in and retaining information is about processing information – this comes from a very famous case:
- eg: *Re C (adult: refusal of medical treatment)* – this case developed 3 criteria for processing information which is reflected in almost all statute talking about capacity or competency
    - This case involved a 68 year old who was sentenced to imprisonment for stabbing his former girlfriend
    - He was diagnosed as suffering chronic paranoid schizophrenia and gets 7 years imprisonment
    - He gets transferred to Broadmoor Mental Institution (maximum security) and is treated with drugs and ECT
    - He later develops some gangrene in his right foot and is referred to the National Health Hospital
    - He tells them that he knocked his foot in the shower, saw a vascular surgeon and his right leg becomes infected with a necrotic ulcer
    - The surgeon says to him that he will die if his leg is not amputated below the knee
    - With conventional treatment the chances of survival were not more than 15%
    - C refused amputation and chose the conventional treatment (which was successful) despite the 85% chance of imminent death
    - It was also likely that the gangrene would reoccur
    - Cs solicitors requested an undertaking from the hospital not to do any further surgeries or amputations and the hospital refused – because they thought that this was dangerous
    - C formed the view that dying with 2 feet was preferable to living with 1
    - Remember: C was a paranoid schizophrenic and had grandiose delusions where he fabricated a history of having an international career in medicine – but he did believe in those treating him and accepted that he might die if amputation was not performed
    - Here we are focusing on C's capacity (rather than the merits of the treatment)
    - C sought an injunction to restrain the hospital from amputating his leg now or in the future
    - Justice Thorpe granted the injunction, applying the famous case of Re T

    - In deciding capacity the question to be decided was whether the patients capacity was so reduced by chronic mental illness that he did not understand the nature, purpose and effects of the proposed treatment
    - Lays down 3 stages in deciding whether the patient could understand the nature, purpose and effects
        - **1. could he comprehend and retain information**
        - **2. did he believe it**
        - **3. could he weigh the information, balance the risks and then make a choice?**
    - The found that there was no clear link between the persecutory delusions that he had and his refusal
    - He demonstrated, they believed, this requisite understanding of the nature of the treatment
    - The court was completely satisfied that C had the right of self-determination and that this had not been displaced
    - Quite controversial as it was found that despite his grand delusions/paranoid schizophrenia and being in a mental institution this did not impact on his right to self-determination and he could still make decisions
- ii) Understanding the nature of the illness and consequences of the decision
- Capacity here is turning on the ability to understand the specific nature of the treatment
- In many ways it involves the artificial approach of putting the nature of the treatment and potential death of the patient to one side
- eg: *Re B (Adult: Refusal of Medical Treatment*)
- One of the most famous cases in terms of refusal of treatment
- B was a 43 year old who suffered haemorrhaging of the spinal column and there were a number of complications and medical relapses
- For 10 years she is in total paralysis from the neck down
- Later on she continues to make requests for the respirator to be turned off
- Initially there were 2 independent psychiatrists who said was very competent and prepared to withdraw the treatment, but this suddenly gets called off when the psychiatrists changed their mind
- She was prescribed sometimes some antidepressants and sometimes she expresses that she is glad and relieved that the ventilator was not switched off
- There had been some long-terms plans for her rehab in these spinal units
- Many of the hospital psychs reassess the situation but could not reach a conclusion as to her mental capacity
- An independent assessment found that she was not suffering from depression at all and that she was very competent
- Switching of the respirator, at this time, was an act that could face criminal prosecution
- The issue here is really whether B had mental capacity to choose whether to accept or refuse treatment
    - Did she have capacity to chose from the time that she requested that it be terminated

        - If yes then she is seeking a declaration that the hospital has been unlawfully treating her since that time and if this is true then she is seeking nominal damages to recognise this whole aspect of the tort of trespass (continuing despite being told no)
- B applied to the HC for a declaration that she was competent in refusing the respirator
- This was famous because it was the first time in the UK that a competent patient applied to refuse treatment
    - Dame starts off her judgement by saying that this is actually not a case about whether she live or die – it is about whether she has capacity to make the decision to have the ventilator removed – it is not even about her best interests but about her mental capacity
- Found that she had very clear accounts of her reasoning and decision making process
- One of the aspects that she notes from all of the staff, psychologists and psychiatrists – "one must allow those as severely disabled as Ms B for some of whom life in that condition may be worse than death, it is a question of values as the doctors have pointed out – we have to try to inadequately put ourselves into that position of the gravely disabled person and respect the subjective character of experience – unless the gravity of the illness has affected the patients capacity a seriously disabled person has the same rights as the fit person to respect for personal autonomy"
- **Dame Elizabeth Butler-Sloss** "…There is a serious danger, exemplified in this case, of a benevolent paternalism which does not embrace recognition of the personal autonomy of the severely disabled patient ….The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering the primary question whether the patient has the mental capacity to make the decision'
- Dame noted that the staff loved her and what it boiled down to was that they were willing to let her go – but it is not about the staff and whether they are comfortable with the decision
- For all intents and purposes the judge found that B was competent and mental competency is commensurate with the gravity of the decision
    - That is, the graver the decision, the more competent
- B was extremely lucid and intelligent and aware
- She was able to understand the nature of the illness and the consequence of the decision
- VOLUNTARY
- The second element is voluntariness
- Together with capacity this is a response in terms of understanding the treatment - must be free from undue influence, pressure, coercion and manipulation
- There is a distinction between internal and external pressure (family etc)
- a) consent must be voluntary and not coerced
    - eg: *Norberg v Wynrib* (1992) 92 DLR (4^{th}) 449
    - In this case a drug addicted patient was awarded compensation for battery against a doctor who had sex with her, to which she agreed
    - They found that as a result of her addiction and his prescription of the drugs in return for sex it was not true consent
- b) consent can also be vitiated by fraud