**INFORMED CONSENT**

Every one of us makes numerous decisions each day, such as the clothes we decide to wear or the food we decide to eat. There are also other decisions we make less frequently, but are more important and examples include getting married, drawing up a will, managing finances or deciding whether to undergo a proposed treatment. These decisions are more important because there is some element of risk or hazard involved. In order to make any important decision a person must be fully informed beforehand, and this is called informed consent.

Informed consent is grounded in the principle of *autonomy*. Autonomy means self-rule and can be subdivided into autonomy of thought, autonomy of will and autonomy of action. It is therefore the key principle underpinning informed consent, and one of the core ethical principles applied by a treating physician.

**ELEMENTS OF CONSENT**

**There are four main elements to consent. These are:**

1. **Capacity** - capacity is presumed for all adults of sound mind, but this may be rebutted by medical evidence of pain, fatigue, drugs, etc
2. **Voluntariness** – the decision should be free of any coercion or influence
3. **Information** - How much is required?
4. **Decision** - How is the decision evidenced?

**MENTAL CAPACITY**

Mental capacity is the ability to make decisions, and the starting point is always the assumption that a person possesses the required mental capacity. However, both mental and physical disorders can impact the mental capacity of a person to make decisions.

In assessing whether a person possesses the mental capacity needed to make a treatment decision, the physician or health professional administering the treatment should make sure that the person:

* Understands (i) the nature, benefits and risks of the proposed intervention, (ii) the nature, benefits and risks of any alternative treatments and (iii) the natural course of the condition if no treatment is received
* Is able to retain the information for long enough to make the decision
* Is able to weigh or appreciate the information to their own individual situation (this is a higher order cognitive test than merely understanding), and
* Is able to communicate their decision

Mental capacity is decision specific, and can be revoked by the person at any time. The assessment of adolescents adds significant developmental complexity to the assessment of mental capacity, and any treatment provider should satisfy themselves that they have fully assessed the mental capacity of a youth or child prior to beginning treatment.

**VOLUNTARINESS, INFORMATION DISCLOSURE AND DECISION**

**Voluntariness** requires that any treatment decision must be made free of coercion or undue influence.

The **Information disclosure** involves what would a reasonable person expect to be told in making a treatment decision; a physician must provide all information materially relevant to decision.

The **decision** should be evidenced in written form, preferably in the person’s medical records.

**PURPOSE OF CONSENT**

The purposes of gaining consent are threefold. Firstly, the clinical purpose is to enlist the person’s faith and confidence in the efficacy of the treatment, which is a major factor contributing to the success of treatment. Secondly, there is a legal purpose which is to provide those concerned in the treatment with a defence. Finally, there is a legal / ethical purpose, which recognizes person’s right of self-determination.

**THE HISTORICAL DEVELOPMENT OF AUTONOMY AND INFORMED CONSENT**

The legal principle of autonomy is grounded in several very important legal cases. The first of these were a set of four US cases[[1]](#footnote-1),[[2]](#footnote-2),[[3]](#footnote-3),[[4]](#footnote-4) between 1905 and 1914 from different states of the US. In the last of these cases, *Schloendorff*, the judge, Benjamin Cardozo, stated:

“*Every human being of adult years and sound mind has a right to determine what shall be done with his own body… a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages*”.

The legal principle of autonomy was further refined in subsequent cases in the US. *Salgo*[[5]](#footnote-5) introduced a new type of consent, focusing on whether the physician had provided the patient with all the information needed to make an intelligent decision, including the harms, benefits, risks and alternatives of the proposed procedure. The court held:

“*A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment*”

*Canterbury v Spence*[[6]](#footnote-6) saw the US law of informed consent evolve from the professional practice standard (what a physician thought a person should know) to a reasonable person standard (what a reasonable person would want to know). This case saw the introduction of informed consent.

1980 saw two important Canadian cases regarding informed consent coming before the Supreme Court of Canada. In the first of these, *Hopp v Lepp*[[7]](#footnote-7), the court had to deal with informed consent for the first time. The court stated:

*“…a surgeon, generally, should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the* *performance of the operation”.*

The second case, *Reibl v Hughes*[[8]](#footnote-8), saw the creation of a standard whereby a physician must give the patient sufficient information so that an objective, reasonable person in the patient's position would be able to make an informed choice about a medical procedure. The court said:

“*unless there has been misrepresentation or fraud to secure consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than to battery*".

**THE TEST FOR CONSENT IN ADULTS IN BC**

The UK case of *Re T*[[9]](#footnote-9) reminds us that:

*“Prima facie*, *every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death*”.

In BC, the test for consent is set out in the Health Care (Consent) and Care Facility (Admission) Act [RSBC 1996] Chapter 181[[10]](#footnote-10). In this piece of statute, consent rights are set out in s.4 and the elements of consent can be found in s.6:

**Elements of consent**

**6**   An adult consents to health care if:

1. the consent relates to the proposed health care,
2. the consent is given voluntarily,
3. the consent is not obtained by fraud or misrepresentation,
4. the adult is capable of making a decision about whether to give or refuse consent to the proposed health care,
5. the health care provider gives the adult the information a reasonable person would

require to understand the proposed health care and to make a decision, including information about

(i) the condition for which the health care is proposed,

(ii) the nature of the proposed health care,

(iii) the risks and benefits of the proposed health care that a reasonable person would expect to be told about, and (iv) alternative courses of health care, and

(f)the adult has an opportunity to ask questions and receive answers about the proposed health care.

**CONSENT IN CHILDREN AND ADOLESCENTS**

The assessment of mental capacity in children and adolescents adds developmental complexities. Children and adolescents develop physically, cognitively, emotionally, interpersonally and morally, and this occurs at different rates in different children and adolescents. All of this must be considered in ascertaining whether a child or adolescent can consent to a medical intervention.

The important case of *Gillick*[[11]](#footnote-11) in UK identifies the challenges in establishing whether an adolescent can give informed consent to a health intervention, and gave rise to the concept of Gillick competence for children under 16.

The BC Infants Act[[12]](#footnote-12) contains the test for assessment of capacity in youth at s17:

**Consent of infant to medical treatment**

(3)A request for or consent, agreement or acquiescence to health care by an infant does not constitute consent to the health care for the purposes of subsection (2) unless the health care provider providing the health care

(a)has explained to the infant and has been satisfied that the infant understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care, and

(b) has made reasonable efforts to determine and has concluded that the health care is in the infant's best interests.

**MEDICAL NEGLIGENCE / MALPRACTICE AND CONSENT**

Whether sufficient information is provided when obtaining consent for a medical intervention goes to the duty of care of the physician. A tort of medical negligence or malpractice often comes about as a result of relevant information not being provided to the patient by the physician. The components of a tort of medical negligence are:

* The physician has to owe a duty of care to the patient
* Breach of duty of care, which be the result of acts of commission or omission
* Damages which accrue from the breach of duty of care
* Proximity

The test usually applied by the courts is the ‘but for’ test. But for the act or omission, would this outcome have occurred anyway?

1. *Pratt v Davis* (1906) 224 Ill. 300 [↑](#footnote-ref-1)
2. *Mohr v Williams* (1905) 95 Minn. 261 [↑](#footnote-ref-2)
3. *Rolater v Strain* (1913) Okla. 572 [↑](#footnote-ref-3)
4. *Schloendorff v Society of New York Hospitals* (1914) NY 125 [↑](#footnote-ref-4)
5. *Salgo v Leland Stanford Jr. Board of Trustees* (1957) 154 Cal. App. 2d 560 [↑](#footnote-ref-5)
6. *Canterbury v Spence* (1972) 464 E2d 772 [↑](#footnote-ref-6)
7. *Hopp v Lepp* [1980] 2 SCR 92 [↑](#footnote-ref-7)
8. *Reibl v Hughes* [1980] SCR 880 [↑](#footnote-ref-8)
9. *Re T (Adult: Refusal of Medical Treatment)* [1992] EWCA Civ. 18 [↑](#footnote-ref-9)
10. <http://www.bclaws.ca/civix/document/id/complete/statreg/96288_01> [↑](#footnote-ref-10)
11. Gillick v West Nofolk and Wisbech AHA [1985] UKHL 7 [↑](#footnote-ref-11)
12. Infants Act [RSBC 1996] Chapter 223 [↑](#footnote-ref-12)