

Open Research Online

The Open University's repository of research publications and other research outputs

Refusing, or being unable, to provide consent

Journal Item

How to cite:

Cornock, Marc (2015). Refusing, or being unable, to provide consent. Orthopaedic & Trauma Times(26) pp. 9–10.

For guidance on citations see [FAQs](#).

© [not recorded]



<https://creativecommons.org/licenses/by-nc-nd/4.0/>

Version: Accepted Manuscript

Copyright and Moral Rights for the articles on this site are retained by the individual authors and/or other copyright owners. For more information on Open Research Online's [data policy](#) on reuse of materials please consult the policies page.

oro.open.ac.uk

Refusing, or being unable, to provide consent

by

Marc Cornock

PhD, LLM, LLB (Hons), BA (Hons), BSc

Senior Lecturer

Faculty of Health & Social Care

The Open University

Address:
Faculty of Health & Social Care
The Open University
Horlock Building
Walton Hall
Milton Keynes
MK7 6AA

e-mail: marc.cornock@open.ac.uk

Word count: 1921 excluding abstract and reference list

Abstract

An earlier article (Cornock 2015) discussed what consent is, the legal principles of consent and the ways in which consent provides self-determination for patients. This article will expand upon this by examining the situation when patients refuse to provide consent, or are unable to do so.

Introduction

'Consent provides the patient with the right to determine what happens to their body, the ethical principle of self-determination. Without this principal individuals would have no control over what happens to their bodies' (Cornock 2015 at page 18).

The principles required for a legally valid consent were stated, in the previous article, as being that:

- The person who provides the consent must be competent to do so;
- The person consenting must be adequately informed about the nature of the procedure or treatment;
- The person must be acting voluntarily; and
- The person not be providing their consent under duress or undue influence.

(Kennedy & Grubb 1998 at page 111)

Thus, we can determine when consent has been provided, but what is the legal position when a patient either refuses to give their consent, or is unable to do so? Are patients legally able to withhold their consent for a treatment that the health care practitioner believes is beneficial for them to receive?

Refusing to consent

If the principle of self-determination is concerned with a person controlling what happens to their body, and the legal principle of consent provides legal protection for this, it follows that a person has to be able to refuse to consent to treatment as well as being able to consent to the same treatment. If the individual was only able to consent to treatment then they would not be able to self-determine what happens to their body as any refusal could be overridden.

A health care professional's ability to treat a patient is subject to the patient's consent. If the patient will not consent to that treatment, and is competent, then it is not legally possible to treat them.

There are many legal cases that have considered the issue of patients refusing to consent to treatment and the legal and health consequences of this refusal. One of the first and most important legal cases to consider the refusal of a patient to consent to treatment was that of *Re T* [1992]. This case concerned a woman who was 34 weeks pregnant and had been involved in a road traffic accident. It was decided that it was clinically necessary for Miss T to receive a blood transfusion. Miss T refused the blood transfusion. The blood transfusion was subsequently given without Miss T's consent and this resulted in the case being brought before the courts.

In the judgment of *Re T*, Lord Donaldson stated that 'an adult patient who...suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered...This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent' (at page 652-3).

In practice this means that an adult who is competent (for a discussions of competence see [Cornock 2015](#)) to consent for a procedure or treatment is able to refuse that same procedure or treatment. They may refuse even if the treatment or procedure is a life-saving one and the refusal will result in their death. The patient may refuse for whatever reason they choose, even if that reason is deemed to be irrational. Indeed, the patient does not even have to explain their reasons for refusing the treatment.

However, there is one important point to make. A patient who is refusing treatment needs to have sufficient information on which to base their decision. They have to understand the 'nature and effect of the procedure' (*Re T* [1992] at page 663) that they are refusing.

Having considered the right of a patient to refuse to consent to a particular treatment, the situation where a patient consents and then withdraws their consent is considered next.

Withdrawing consent

Consent is not a simple one off event. Rather, in order to fully underpin the principle of self-determination, consent has to be enduring. It has to be obtained prior to the treatment or procedure for which it is necessary but then it has to exist throughout the whole time of the treatment.

Provided that the patient is competent, at any point during the time of their treatment they can withdraw their consent. At that point the legal position is that the consent does not exist and no further treatment can be given. There are some caveats to this. For instance it has to be safe to stop the treatment; if the health care practitioner is in the middle of undertaking a procedure that cannot be left half-finished then they should do the minimum that is necessary to make the patient safe and minimise any risk to them. If the patient has received medication that affects their cognitive ability then it may be that they are not competent, at that particular point in time, to make a decision and the health care practitioner would need to use their judgement as to what needs to be done.

However, to continue to treat a competent patient who has withdrawn their consent could result in both civil and criminal proceedings against the health care practitioner. Where such a situation arises a recommended course of action would be to seek the advice of someone more senior or experienced.

A recent case illustrates this legal principle even where harm will occur to the patient as a consequence, when it considered whether a patient could request that their artificial mechanical ventilation machine be switched off. The case of *Re B* [2002] concerned Ms B, who had become tetraplegic as a result of a cervical spine cavernoma and so was completely paralysed from the neck down. Ms B was unable

to breathe unaided and was receiving artificial ventilation in an intensive care unit at the time of the court case.

Ms B informed her doctors 'that she wished the artificial ventilation to be removed, even though she realised that that would almost certainly result in her death' (Re B [2002] at page 449). Although she had been assessed by two psychiatrists who had deemed that Ms B was competent to make her own decisions regarding her treatment, the clinical team treating her 'were not prepared to turn off the ventilator' (Re B [2002] at page 449). This resulted in Ms B seeking a court declaration that the treatment she was receiving was unlawful.

It was held that 'the right of a competent patient to request the cessation of treatment had to prevail over the natural desire of the medical and nursing profession to try to keep her alive' (Re B [2002] at page 450). If a patient deemed to be competent to make a decision has been 'given the relevant information and offered the available options, [and chooses] to refuse treatment, that decision has to be respected' (Re B [2002] at page 450). This is so, regardless of the belief of the health care practitioner as to the necessity of the treatment or that, in their opinion, it is preferable for the patient to have the treatment than not have it.

What the cases of Miss T and Ms B tell us is that it is an established legal principle that, where the patient is competent, any refusal by them to consent means that a health care practitioner is unable to treat that patient; that a patient is entitled to refuse for any reason; or to withdraw their consent at any time, provided that they are adequately informed to make a decision.

So far this article has considered competent patients and their ability to refuse or withdraw their consent, it will now move on to consider patients who are unable to consent.

The incompetent patient

An incompetent adult patient is one who does not have the ability to consent for themselves. This may be because they are not able to understand their condition or the treatment being proposed, or they are unable make a decision. Their

incompetence may be due to medication they are taking, or their condition, for instance they may be unconscious.

It was noted in an earlier article (Cornock 2015) that competent patients may not be treated without their consent. Incompetent adult patients are regarded differently. Firstly, it is important to recognise that consent cannot be obtained from the next-of-kin for an incompetent patient. No-one, under English law, can consent or refuse consent for someone over the age of eighteen, unless this has been expressly granted by the patient in a lasting power of attorney.

So, where there is no lasting power of attorney, it is not possible to obtain consent from someone else on behalf of an incompetent adult patient. If the situation arises in an emergency, under the principle of necessity (see Re F [1990]), a health care practitioner may do all that is need to save the life or preserve the health of the patient. This does not mean that the health care practitioner can do whatever they wish. It is limited by the fact that the action they propose has to be in the best interests of the patient. Section 4 of the Mental Capacity Act 2005 defines best interests. In Re F [1990] Lord Brandon noted that the patient's best interests would be served if a procedure 'is carried out in order to either save their lives, or to ensure improvement or prevent deterioration in their physical or mental health' (at page 55).

Where the situation is not an emergency, the same principle of necessity may arise if the procedure can be demonstrated to be in the patient's best interests. Referring to Section 4 of the Mental Capacity Act 2005, this means considering all the factors relating to the patient's condition, such as whether they will be likely to regain competence and whether the proposed treatment could wait until that time; the patient's previously expressed wishes and beliefs; and anything that would be likely to influence the patient's decision whether to have the proposed treatment if they were able to make a decision. This means that relatives and friends should be consulted where possible to ascertain the patient's wishes and values. This does not mean that relatives and friends are providing consent; rather that they are providing information upon which the health care practitioner can base a decision as to

whether the proposed treatment would be in the patient's best interests and can therefore go ahead.

If the patient has previously expressed a wish against having the proposed treatment, or has an advance decision in effect that refuses the treatment, or indeed the patient refused to consent to the treatment when competent, then it is unlikely that it would be in their best interests to have that treatment now, unless there has been a substantial change in their circumstances.

Where a health care practitioner is considering performing a treatment for an incompetent patient using the principle of necessity and/or best interests, they would be advised to discuss this with another health care practitioner,

Conclusion

Consent is not just concerned with seeking a patient's agreement to a proposed treatment. It is concerned with the patient's ability to decide what happens to their body and this includes the right to refuse a specific treatment for any reason. Similarly, it is not only competent patients who require treatment and the rights of incompetent patients need to be protected against unnecessary and unwanted treatment. This article has explored both of these issues and considered how the health care practitioner should act in these circumstances.

References

Cornock M (2015) 'Informed Consent' *Orthopaedic & Trauma Times* **25** January 2015 p. 18 - 20

Kennedy I & Grubb A editors (1998) Principles of Medical Law Oxford University Press, Oxford

Re B (Consent to treatment: Capacity) [2002] 2 All ER 449

Re F (Mental Patient: Sterilisation) [1990] 2 AC 1

Re T (Adult: refusal of medical treatment) [1992] 4 All ER 649