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### Consent in psychiatry – an ethical review

The aim of this article is to give a historical overview of the concept of consent to treatment and its development – one of the most important ethical and legal issues in recent years. Through the discussion of a number of high-profile examples, it deliberates the ethical and legal aspects of consent to treatment today and their implications for psychiatrists' clinical work.

Despite its importance, certain circumstances limit the patient's right to consent to treatment. It is therefore not an absolute construct, but needs to be examined carefully on an individual basis. Practitioners need to be alerted to any changes in the law and its interpretations, therefore special emphasis will be given to the Human Rights Act 1998, its consequences and the different legal thinking that will gradually be developed out of its introduction.

#### The different concepts of consent

Consent can be express, tacit, implied or presumed. It can be more or less informed and it includes the notion of refusal as well as permission. If consent is given to a procedure or participation in research in an informed way, it implies that one is competent to act, receives a thorough disclosure of benefits and risks, comprehends the disclosures, acts voluntarily and consents to the intervention (Beauchamp & Childress, 2001). This definition was made on the basis that most legal, regulatory, philosophical, medical and psychological literature tends to favour these factors as the vital components of informed consent (Gelder *et al*, 2001). 'Informed consent' is, in most cases, the ideal form of consent because it includes all aspects of meaningful decision-making. 'Express consent' includes informed consent in that it covers all forms of consent that are actively expressed by a patient. 'Tacit consent', in contrast, originating from the Latin verb '*tacere*' (meaning: to be silent), describes consent that is expressed silently or passively by omission. 'Implied consent' describes the notion that by acting in a certain way (e.g. by consulting a doctor), a patient expresses consent to a limited number of interventions. 'Presumed consent' is particularly important in cases of emergency. It is based on the general theory of human good and rational will. Critics lament that it is not bona fide consent, because consent should refer to an

individual's actual choice rather than presumptions about potential choices (Beauchamp & Childress, 2001). The British Medical Association clarifies the situation in its guidelines, pointing out that medical treatment that is immediately necessary to save life or avoid significant deterioration in the patient's health may be provided in an emergency, where consent cannot be obtained. Guidelines also state that treatment should not be given if the patient is an adult and there is clear evidence of a valid advance refusal of a particular treatment (such as a refusal of blood by a Jehovah's Witness). It is, however, added that 'any advanced statement is superseded by a clear and competent contemporaneous decision by the individual concerned' (British Medical Association, 2001).

#### The concept of rights

The concept of consent is closely linked to the concepts of rights and autonomy. Whereas the ancient societies of Rome and Greece as well as early Christian communities placed all emphasis on the well-being of the community as a whole rather than the individual in particular, the era of Enlightenment brought a gradual change to this thinking. The Prussian philosopher Immanuel Kant developed the ideas that not only are all men of equal worth, but that they all have rights and duties that ought to be respected. Politically, these ideas of equality between men gave rise to the American Declaration of Independence (1776) and the French Revolution (1789). This emphasis was strengthened in Europe with the development of parliamentary democracies. Even though it took until the First World War and its aftermath for women's rights to become fully incorporated into all European societies, there is no doubt that as early as the 18th century, a fundamental change had happened towards the rights of the individual. The 1930s and the Second World War saw large-scale atrocities being committed against human rights as we accept them today. The acknowledgement of this failure to protect human rights brought into existence the Declaration of Human Rights 1948. The Declaration gives an overview of basic human rights and has been implemented by all member states of the European Union. In Britain it was implemented as late as 1998 in the form of the Human Rights Act 1998 (with full effect in 2000), although its content had been



opinion  
& debate

accepted de facto in Britain since the 1950s. It guarantees all citizens rights and freedoms against the state and its bodies including the right to life, liberty, a fair trial, marriage and family and privacy, as well as freedom from torture and discrimination, and freedom of assembly and expression (Human Rights Act 1998). It also added an aspect of coded law into English and Welsh law. Coded law is used in most of Continental Europe. It uses coded instructions instead of precedence. It does not rely heavily on case law and is therefore less dependent on individual judges' interpretations of the law. Instead, it sets minimum standards of rights and freedoms that are not subject to interpretation. The Act may yet build the foundations of a future constitution (Röttgers & Lepping, 1999).

As a consequence of the Nuremberg trials in the late 1940s, many accounts of medical experiments on humans in concentration camps came to light. This led to many ethical questions about the relationship between doctor and patient. Questions were raised surrounding consent and the restrictions of what doctors should be allowed to do without formal consent. It was in this context that the concept of informed consent was first mentioned, although it was not examined much beyond this until the 1970s (Beauchamp & Childress, 2001), when authors like the American psychiatrist Jay Katz started to question whether existing professional codes of practice were sufficient guidance in medical practice, especially with regards to research involving human subjects. He concluded that a much more robust ethical discussion was needed because it had been uncritically assumed for too long that ethical questions could be resolved by fidelity to undefined principles as *primum non nocere* (First, do no harm) or codes of practice (Katz, 1972). In an environment where medical paternalism was widespread, this kind of ethical discussion was likely to be criticised. However, medical developments and changing social attitudes accelerated the discussion in a medical world where ethical dilemmas were becoming more and more commonplace. In medicine, discussions about abortion, fertility treatments and intensive care provisions are worth mentioning in this context. In psychiatry, institutionalisation and the use of electroconvulsive therapy (ECT) in particular were discussed in an ethical context. We have moved in the past 30 years from a paternalistic view of medicine, in which the doctor decided what was best for the patient, to a discussion about whether, in some cases, full disclosure might harm the patient. Many authors see the latter as a valid reason not to disclose all facts. Harris specifically makes this point, calling it 'implausible' that there should be a positive duty to disclose everything that might be relevant to autonomous decision-making (Harris, 1985).

However, these discussions eventually led to the development of new ethical codes and guidelines for medical practitioners that are constantly renewed and discussed to endeavour to remain in touch with ethical views and discussions in society as a whole. In the case of psychiatry, the Royal College published guidelines of good psychiatric practice in 2000 (Royal College of Psychiatrists, 2000); other Royal Colleges have issued similar

guidelines. With an increasing number of people suffering from dementia (an estimated 700 000+ in the UK at present (<http://www.kingshill-research.org/whatis/facts.asp>)), and other illnesses leading to long-term incapacity, advanced directives are going to play a more important role in the future as a means for patients to express their wishes and give consent in cases of later incapacity. As Jarmulowicz (2000) pointed out, advanced directives are not presently legally binding. He emphasises the potential risks of advanced directives, as consent is only valid if all relevant facts regarding specific treatment are available. Since advanced directives are often made years before mental incompetence, the relevant facts may well change significantly. This might prevent the patient from receiving treatment he/she was unable to foresee when the directive was signed.

In contrast to this, Wilks, quoting the Lord High Chancellor, points out that the government is satisfied that the guidance contained in case law, together with the British Medical Association's (1995a) code of practice, is sufficient to provide the necessary clarity and flexibility advanced directives require, without the need for additional legislation (Wilks, 2000). This discussion emphasises that there is still a high degree of differing opinion surrounding advanced directives among professionals in the health and legal professions that will need clarification. In the future, any legal framework may well have to take into account advanced directives made by the patient prior to his illness when considering the patient's best interest in order to come as close to informed consent as possible. In Scotland, the Adults with Incapacity (Scotland) Act 2000 clarifies the legal situation of those with long-term mental incapacity, but omits legislation on advanced directives (Scottish Executive, 2000). The situation is somewhat different for anticipatory refusals, because the Court of Appeal held in the case of *ReT* (*ReT*, 1992) that an adult refusal of treatment that an advance refusal of treatment would be legally binding if it were 'clearly established, applicable to the current circumstances and made without undue pressure from other people' (British Medical Association, 1995b).

## The concept of autonomy

The other important concept that has to be considered in the context of consent is that of autonomy. Since the 1970s, the primary justification given for requirements of informed consent has been to protect autonomous choice. Isaiah Berlin pointed out that personal autonomy is, at a minimum, self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding that prevents meaningful choice. He carries on to say that the autonomous individual acts freely in accordance with a self-chosen plan; analogous to the way an independent government manages its territories and sets its policies (Berlin, 1969). There are, however, conditions and circumstances that limit autonomy and therefore also autonomous choice. A prisoner, for example, is restrained in his/her autonomous choice by institutional constraints, while those with



a learning disability or a mental or physical illness may be permanently or temporarily incapacitated to make autonomous choices due to their condition. Given that we respect a person's autonomy to make choices for him or herself, we cannot accept others making choices against the wishes of an autonomously acting person. In a medical context, we therefore need to be sure that full informed consent is given to any procedure by any autonomous person in order to respect that person's autonomy. Patients have a right to have their autonomy respected and therefore, a right to be empowered to give or refuse consent. Difficulties arise when autonomy is unclear. In these cases, the concepts of capacity and competence become paramount in determining the extent to which a person's autonomy is restricted.

## The concepts of competence and capacity

Competence to give informed consent is a concept that is very closely connected to capacity. Competence is a legal term and it is therefore the courts that assess it. Capacity, in contrast, is a medical term and it is usually mental health professionals who determine a person's capacity to make certain choices. As Grisso and Appelbaum (1998) point out, however, it is worth noting that this distinction often breaks down in practice: 'When clinicians determine that a patient lacks decision-making capacity, the practical consequences may be the same as those attending a legal determination of incompetence'. It is important to consider that patients may not be capable of making certain decisions while they are quite able to make others. A man with a learning disability, for example, may not have the capacity to manage his financial affairs autonomously, whereas he is quite able to consent to taking a sleeping tablet. This exemplifies the need for a graded approach to the assessment of capacity as well as the necessity for that assessment to be valid for the task that needs to be performed (Beauchamp & Childress, 2001).

It is useful to examine first the general rules for the assessment of capacity and then proceed to discuss more problematic aspects of this matter. Two basic preconditions have to be met to render a person incapable of managing his or her own affairs. First, there needs to be an objective cognitive deficit that impairs problem-solving and decision-making and second, there must be an incapability to sensibly delegate responsibility to someone else (Gelder *et al*, 2000). For full capacity, Grisso and Appelbaum (1998) stated that a patient must be able to:

- (a) evidence a choice,
- (b) understand (retain and repeat) the given information,
- (c) appreciate (believe) its content and
- (d) reason about the information given.

These criteria are also used in most existing guidelines, for example those issued by the Royal College of Psychiatrists (2000).

## The sliding scale approach to consent

Some authors have suggested a 'sliding scale' of ability to take into account that different decisions require different levels of understanding. Those decisions of most potential risk, such as death, clearly demand greater levels of capacity than decisions of minor potential risk. Therefore, the same person, for example a child, might be competent to make a decision to accept a painkiller, but not to decide on complicated and risky surgery (Buchanan & Brock, 1989). Beauchamp and Childress (2001) insist that the sliding scale strategy rightly recognises that our interests in good outcomes legitimately contribute to the way that we inquire about and create standards for judging persons competent or incompetent. If the consequences for welfare are grave, our need to be able to certify that the patient possesses the requisite capacities increases, but if little in the way of welfare is at stake, we might lower the level of capacity required for decision-making.

There can be no doubt that the right of a person who is deemed fully capable of making an informed and valid choice is absolute and reaffirmed by legal practice. In English Law, for example, the House of Lords has endorsed the view that a doctor who proceeds without consent will be liable for trespass, assault or battery (RE F, 1990). This is in keeping with governmental and General Medical Council guidelines, as well as with Royal College of Psychiatrists guidelines (2000). It stands regardless of whether the doctor believed that what he or she did was good for the patient, and regardless of whether the doctor had any hostility. The patient does not need to have suffered any harm as a result of the doctor's actions to bring a successful action for damages. An example for the latter is the Canadian case of *Malette versus Shulman*, in which the courts ordered substantial damages to be paid because a doctor had administered a blood transfusion against the clearly-stated wishes of a competent patient, thus saving the patient's life (*Malatte v. Shulman*, 1990).

English cases recognising the right to withdraw treatment include *Airedale NHS Trust versus Bland*, a case that exemplified the futility of relying on the argument that the necessity to save lives justifies non-consensual treatment. In the above mentioned case of a Hillsborough victim in a persistent vegetative state, the court laid down that the principle of sanctity of life is not absolute: 'It does not compel a medical practitioner on pain of criminal sanctions to treat a patient who will die if he does not, contrary to the expressed wishes of the patient' (*Airedale NHS Trust v. Bland*, 1993). Further legal and ethical dilemmas can arise if the patient has an illness that can potentially threaten his ability to give informed consent. The legal test case in which this point was made was the case of *Re C* (*Re C*, 1994), who was an in-patient under section 37/41 of the Mental Health Act 1983, in a maximum-security hospital receiving treatment for paranoid schizophrenia and a gangrenous leg. His treating physician stated that he had an 85% risk of death if his leg was not amputated. Mr C refused the amputation. He was clearly deluded at the time of making this decision,



opinion  
& debate

but the delusions did not directly affect his medical condition. Mr C argued successfully that he was capable of making this decision despite having paranoid schizophrenia. He furthermore argued that the amputation would not treat his mental illness and therefore was not covered under the Mental Health Act 1983. When Mr C's capacity was tested, he was deemed competent and rational and his complaint was upheld.

## Clinical implications

The right of patients to consent or refuse consent to medical treatments is an important right that has developed out of the ethical concepts of freedom, rights and autonomy. It is incorporated into all legal frameworks in most countries around the world, and certainly in all Western-style democracies. There are, however, important exceptions to this rule that have ethical, legal and practical reasons. It is acknowledged that some persons do not have the mental capacity to make an informed choice, in which case it is ethical to consider acting in their best interest. There can be legal reasons that restrict choice established by law or when institutional restrictions, for example in prisons, are in place. Furthermore, it is sometimes impossible to know the patient's will, in which case it is practical and justifiable to act in the patient's best interest under the rules of presumed consent. This can happen in emergency situations. There are important exceptions limiting the absolute right to consent or refusal of consent, but these do not alter the underlying principle that all medical interventions require consent of the patient. The rules and guidelines regarding consent are in constant flow. The most recent change occurred with the introduction of the Human Rights Act 1998, which has important implications for clinical practice of psychiatrists. It has clearly put the burden of proof on any detaining authority, which is likely to make mental health tribunals more scrutinising to convince the tribunal that there is no alternative to detention. The right to a fair hearing may allow witnesses to be called by the patient's solicitor to challenge arguments put forward by the responsible medical officer with regards to information given by relatives.

The White Paper for the new Mental Health Act (Department of Health, 2000) has already taken into account the necessity for much swifter reviews of decisions regarding formal admission to comply with the Human Rights Act 1998, requiring tribunals within seven days. The proposed new Mental Health Act for England and Wales also attempts to clarify the position of long-term mentally incapable individuals by providing a framework of safeguards akin to that available to people detained under the Mental Health Act 1983, but without actually detaining them subject to the Act (Department of Health, 2000). In addition to this, proposals for draft legislation on incapacity for England and Wales were announced in December 2002 ([www.bma.org.uk/ap.nsf/Content/EXT-Press+Release+Archive-Public](http://www.bma.org.uk/ap.nsf/Content/EXT-Press+Release+Archive-Public)). This may prevent a successful challenge of the Bournemouth ruling at the European Court of Human Rights. Attempts have

been made to amend the Mental Health Act 1983 to give patients, their relatives and carers the same safeguards as are available in cases of formal detention (House of Commons, 2002).

In her answer to the latest proposed amendment in February 2002, the Health Minister Jacqui Smith referred to the new Mental Health Act to clarify the future safeguards for this patient group including the new Commission for Mental Health, representation by a nominated person, an individual care plan with external scrutiny by an independent member of the new expert panel, the right to go to the new Mental Health Tribunal to challenge lawfulness of detention or for review of the care plan and the right of access to independent specialist mental health advocacy services. She also reiterated the current position that 'the ruling of the House of Lords in the Bournemouth case upheld the lawfulness of the current position whereby patients who lack capacity to consent to treatment for their mental disorder, as long as they do not show resistance, can be treated without the use of formal compulsory powers in the Mental Health Act 1983' ([www.davesheppard.co.uk/bournemouth.htm](http://www.davesheppard.co.uk/bournemouth.htm); Department of Health, 2000).

It is unlikely that the status of ECT will be changed because this was unsuccessfully attempted in 1992. The European Court of Human Rights decided at the time that ECT did not amount to torture, as was argued by the claimant, because 'no proven medical treatment can ever amount to torture' (Herczegflavy v. Austria, 1992).

There is no doubt, however, that the Human Rights Act 1998 is already challenging legislative thinking since any future legislation requires being compatible with the Act. In the long term, this has the potential to ensure that the legislative procedure takes into account human rights considerations proactively as a matter of course, rather than waiting for later challenges to existing laws.

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opinion  
& debate