

● Medico-legal advice

Capacity to consent to treatment



Aisling Gannon, Partner and Head of Healthcare with Beauchamps Solicitors, writes that issues of consent can be complex – as was the case recently when a patient refused a blood transfusion

The essential basis of the consent process is that the patient consents voluntarily and that consent is based on sufficient relevant information. Where relevant, capacity, age and mental capability must also be considered.

A recent case in the High Court looked at the issue of capacity to consent (*Fitzpatrick & Anor v K. & Anor* ([2008] IEHC 104). The court was asked to decide whether and, if so, in what circumstances a court may intervene in the case of an adult patient who alleges they are *compos mentis* and who has refused medical treatment.

Facts of the case

K gave birth to a baby boy at the Coombe Hospital in September 2006. Shortly afterwards, she suffered a significant post-partum haemorrhage, resulting in cardiovascular collapse. As part of the resuscitation pro-

cedures, when blood was being prepared for immediate transfusion, the medical personnel present were told that K would not take blood because she was a Jehovah's Witness.

The Master of the Coombe was called to the delivery suite and had doubts as to whether it was a valid refusal. The hospital was concerned that she would die without the transfusion and obtained an emergency High Court order allowing the transfusion to go ahead at the time.

The hospital subsequently sought, at the court's behest, a declaration that it was entitled to seek the order.

K counterclaimed on a number of grounds, including that that her rights had been breached under the European Convention of Human Rights; that she was entitled to refuse medical treatment; that she was in a position to make a fully-informed decision to refuse



consent; and that the hospital had committed an assault and trespass on her person by giving her the transfusion. She claimed that she was entitled to damages as a result.

Decision of the court

The court restated the relevant principles applicable to the determination of capacity, which are as follows:

(1) An adult has the capacity to refuse treatment, but it is a rebuttable presumption.

(2) The patient's cognitive ability must be so impaired that s/he does not sufficiently understand the nature, purpose and effect of the treatment and the consequences of accepting or rejecting it, in light of all the choices available.

(3) The cognitive ability will have been impaired to the extent that s/he is incapable of making the decision to refuse by reason of the following factors:

● The patient has not comprehended and retained the treatment information and the consequences likely to ensue from their refusal;

● The patient has not believed the treatment information, in particular, that death may be the likely outcome;

● The patient has not weighed the treatment information, the alternative choices and the likely outcomes, in the balance in arriving at the decision.

(4) The clinician is under a duty to impart information as to the medically-advised appropriate treatment, the risks and consequences and the choices available to the patient.

(5) The clinician must recognise and note if misunderstanding and misperception of the treatment information is an issue as this may be evidence of a lack of capacity. An irrational decision or a decision made for irrational reasons is irrelevant to the assessment.

(6) Regard must also be had to the gravity of the decision and the consequences that are likely to ensue.

The court held on the evi-

dence that the hospital staff were objectively justified in doubting K's capacity to consent for a number of reasons including K's seriously compromised medical status; the communications difficulties which arose given that K's first language was not English; and her late disclosure, after the haemorrhage, that she was a Jehovah's Witness, having booked into the hospital as a Catholic.

Comment

The court further added that it would be helpful if guidelines were put in place to avoid similar circumstances arising in the future. This decision is of critical interest to all healthcare service providers, not just in the field of obstetrics, and is a useful guide in determining the capacity of a patient to consent.

If you would like any further details on this case, please contact Aisling Gannon at Beauchamps Solicitors.

● **Aisling Gannon**, Partner and Head of Healthcare Beauchamps Solicitors. Email: a.gannon@beauchamps.ie

● Cardiology

Evidence needs to be robust

The President of the Irish Heart Foundation examines the Euro Consumer Heart Index, that ranks Irish heart care only 16th out of 29 European countries

A rather dramatically-worded press release issued from Brussels on 3 July 2008 carrying the above headline went on to state that Luxembourg leads the first Euro Consumer Index with a score of 836 points from a possible 1,000 followed by France, Norway and Switzerland, with Ireland scoring 652 points, well after, for example, the UK and Slovenia.

Put another way in five categories covering 28 performance indicators, Ireland's score placed it slightly below average, behind the majority of Western European systems.

Dr Arne Björnberg, Research Director for the Heart Index, commented that: "Despite being very active in establishing measures to curb smoking, Ireland scores poorly overall in prevention" and Mr Johan Hjertqvist, President of the Health Consumer Powerhouse (HCP), went on to comment that: "Ireland can improve their prevention activities through introducing national screening for heart disease and taking measures to control blood



pressure (sic)". The Irish Heart Foundation has been to the fore in reminding government of the need to invest in the nation's cardiovascular health, but in doing so has been insistent that we spend according to the demands of well-researched data.

And one of the Irish weaknesses has been the deplorable investment in information technology that would allow us to have available data on which to plan future financial and managerial policies. However, we must not allow ourselves to

be driven by weak and perhaps irrelevant data, however expedient this might be, to bring pressure on healthcare providers. We need to stand back, therefore, and look critically at this new Euro Consumer Heart Index and its recommendations for Ireland.

Who is behind the Heart Index?

The Index was initiated by, and is produced by the HCP, a private healthcare analyst and information provider registered in Sweden which holds

the copyright to the Index. The Index has been supported by an unrestricted grant from Pfizer, Inc. Six eminent European experts are listed as comprising an 'external expert reference panel' but perhaps notably are not listed as actual authors of the Index.

How was the data researched?

The greatest weakness in the Euro Consumer Heart Index is an astounding lack of referencing of the data sources on which the conclusions of the report

are based. It should go without saying that if the sources for data are flawed, it follows that all conclusions can at best be approximate surmises, and at worst can lead to down-rightly misleading recommendations.

Indeed the Index acknowledges this by stating: "The first and most important consideration on how to treat the results is... 'with great care and restrictions against drastic conclusions!'"

The Index even goes further by answering the question "Is this really research?" with the frank admission: "It is compiled consumer information. It is not clinical research and is not to be looked upon as research in the true academic sense... while by no means claiming that the Heart Index 2008 results are dissertation quality, the findings should not be dismissed as random findings."

Indeed one might ask 'and why not?' The main sources of input for the various indicators on which the Index bases its conclusions are cited as 'interviews with national CVD Experts and healthcare officials, national registries and/or other studies, surveys commissioned by HCP'

Importantly the sources from which the Irish data were derived are not referenced with one notable exception, namely a reference to the Health Protection Surveillance Center, Ireland 2006 (<http://www.ndsc.ie/hpsc/AboutHPSC/AnnualReports/File,2667,en.pdf>) which brings one to the Annual Report from this body – a report that deals solely with infectious diseases and has nothing whatever to do with cardiovascular disease!

How should we react to the data in the Index?

There is never smoke without fire and even given the weaknesses to which I have referred there may be some anecdotal evidence in the Index indicating what we already know from much better scientific reports, namely that there is much room for improvement in the way we manage cardiovascular disease in Ireland.

But in deciding how best to go about this task let's rely at all times on evidence rather than whimsy, which as I have said, should oblige us to collect the evidence and to do urgently.

● **Prof Eoin O'Brien**, President, Irish Heart Foundation.