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 essence of the case is that the patient consented 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 lends weight to the capacity to consent (Fitzpatrick & Anor v K & Anor [2008] BHEL 34). 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 compus mentis and has refused medical treatment.

Facts of the case

K gave birth to a baby boy at the Coombe Hospital in September 2000. Shortly afterwards, she suffered a significant post-partum haemorrhage, resulting in cardiovascular collapse. As part of the resuscitation procedures, when blood was being replaced by intravenous 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 certificate that K was entitled to refuse the order.

K counterclaimed on a number of grounds, including 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 transfusion. The hospital 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 impairment. 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 available choices.

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:

   a. The patient has not weighed the likely outcomes of accepting or refusing treatment, and has not thus been able to make a rational decision.

   b. The patient has not considered the purpose and effect of the appropriate treatment, the consequences of accepting or not accepting it, and the risks and consequences attached to the choice available to the patient.

   c. The patient has not assessed the balance in arriving at the likely outcomes, in the alternative choices and the likely outcomes, in the balance in arriving at the decision.

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

   e. The patient has not considered, in particular, that death may be the likely outcome.

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

The court held on the evidence that the patient’s allegations were not well substantiated and that the patient had understood the nature of the proposed treatment. The court held that the hospital had not committed an assault or trespass.

The court held that the hospital was entitled to give the patient the blood transfusion.

Comment

This was a case where the court was asked to intervene in the case of an adult patient who alleges they are compus mentis and have refused medical treatment. The court held that the hospital was entitled to give the patient the blood transfusion.

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 carried the above headline went on to state that Luxembourg leads the first Euro Consumer Heart Index with a score of 856 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 all performance indicators, Ireland’s score placed it slightly below average, behind the major Western European systems.

Dr Arne Björnberg, Research Director of 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 European systems.

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 downright 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 exemplary, the findings should not be dismissed as random findings.”

Indeed one might ask why the Index? The main sources of information for the various indicators on which the Index bases its conclusions are cited, but with little reference to academic reviews with national CVD Experts and healthcare officials, national registries and/or other studies, surveys commissioned by HCP or importantly the sources from which the Irish data were derived are not referenced with any notable exception, namely a reference to the Health Protection Surveillance Centre, Ireland 2006 (http://www.nidc.ie/hspsc/2006en.pdf).

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