Cambridge University Hospitals NHS
NHS Foundation Trust

Consent and capacity

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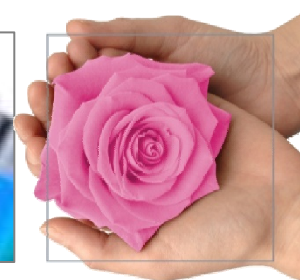

Tracey case

- NB this case did not concern a patient who lacked capacity (more on that later) but it is important because it relates to serious medical treatment decisions at the end of life.
- Background:
  - Mrs Tracey had been made the subject of a DNACPR shortly after admission to Addenbrooke's following a serious road traffic accident.
  - She was suffering from terminal cancer and leaving aside the effects of the rta had a life expectancy of nine months.

Tracey case continued

– The first DNACPR was cancelled after Mrs Tracey's family objected to it.
– Subsequently, at a point when Mrs Tracey lacked capacity to make her own decisions a second DNACPR notice was imposed.
– Mrs Tracey died after a deterioration in her condition.

Tracey case continued

- Claim brought by Mrs Tracey's family against the Trust was that it had breached her Article 8 European Convention on Human Rights because in imposing the first notice the Trust had failed to:
  - Adequately consult Mrs Tracey or members of her family.
  - To notify Mrs Tracey of the decision to impose the notice.
  - Failed to offer a second opinion.
  - To make the DNACPR policy available to Mrs Tracey.
  - To have a policy that was clear and unambiguous.

Tracey case continued

- Also a claim against the Secretary of State for Health under Article 8. The Secretary of State had failed to:
  - Failed to publish national guidance to ensure that the process of making DNACPR is clear and accessible etc .

  Claim against Secretary of State dismissed by Court of Appeal.

Tracey case continued

Decision against the Trust: breach of Article 8 but limited:

- Since a DNACPR decision is one which will potentially deprive a patient of life-saving treatment, there should be a presumption in favour of involving the patient. There needs to be convincing reasons for not involving the patient.
- It is inappropriate to involve the patient in the process if the clinician considers that to do so is likely to cause the patient to suffer physical or psychological harm. Merely causing distress is not sufficient reason not to involve the patient.
- Where the clinician's decision is that CPR will be futile, there is an obligation to tell the patient that this is the decision. The patient may then seek a second opinion although if an MDT has agreed that CPR would be futile they are not obliged to arrange it.

Tracey case continued

- Renewed focus on end of life care and consultation with patients.
- The Trust has introduced the UFTO, ensure you are familiar with the principles and published research.

Consent and capacity

Consent:

- The voluntary and continuing permission of the patient to receive a particular treatment.
- Implied, express, verbal, written. Process not just a signature.
- Based on an adequate knowledge of the purpose, nature, likely effects and risks of treatment including the likelihood of its success and any alternatives to it (may include doing nothing).
- Permission given under any unfair or undue pressure is not consent.

Recent case: *Montgomery v Lanarkshire Health Board [2015] UKSC11*

- Informed consent to medical treatment (patients with capacity) is now firmly part of English Law.
- The clinician is under a duty to take reasonable care to ensure the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. Materiality means: whether in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.
- A doctor is not obliged to discuss the risks with a person who makes it clear that they would prefer not to discuss the matter. A clinician is entitled to withhold information from the patient if it is considered the disclosure would be seriously detrimental to the patient's health (Judgement paragraphs 86 – 93).

Mental capacity

- Capacity is presumed unless otherwise established.
- Patient does not have capacity if:
  - It is established that there is an impairment of or disturbance in the functioning of the mind the person's mind or brain.
  - It is established that the impairment or disturbance is sufficient to render the person incapable of making that particular decision (decision specific).

Assessing capacity

Taking the second bullet point from the previous slide, it means that a person must be unable to:

- Understand the information relevant to that specific decision.
- Retain the information.
- Use or weigh the information as part of the process of decision making.
- Communicate the decision that he/she has made.

Making the patient comfortable

When taking consent or assessing capacity a clinician should:

- Minimise anxiety or stress.
- If communication or language barriers exist try to overcome them using perhaps SALT, interpreter, consult family.
- Have an awareness of cultural, ethnic or religious factors.

What happens if capacity is lacking?

Best interests

Consider the following:

- P’s past and present wishes and feelings (any written statements made when they had capacity).
- The beliefs and values that would be likely to influence their decision if they had capacity.
- The other factors that thy would be likely to consider if they were able to do so.
- Take into account views of carers, family, close friends, GP and social workers.

Court of Protection

- Serious medical treatment:
  - May or will cause serious and prolonged pain, distress or side effects.
  - Have potentially major consequences for the patient.
  - Have a serious impact on the patient’s future life choices.
  - Court can make declarations as to what would be in the best interests of the patient.

Consider in each case

- Capacity.
- Best interests.
- Consultation with interested parties.
- LPAs, Advanced Decisions of Deputies.
- IMCA.
- 2nd opinion – MDT.
- Involving the Official Solicitor.

Leading case

A NHS Trust v K and Others [2012] EWHC 2922 (COP)

- 61 year old female lacked mental capacity.
- Delusional beliefs that she wanted children, apparently ignorant that she had three sons already.
- Diagnosed with cancer of uterus.
- Recommended hysterectomy in her best interests.
- Weight = 133kg
- BMI = 52
- Insulin dependent diabetes.
- Significant asthma.
- Limited mobility.
- Psychotic disorder with chronic schizophrenia.

Leading case

- Patient refused hysterectomy.
- Treating oncologists, surgeons and anaesthetists recommended surgery.
- Community Psychiatrists and GPs uncertain as the best interests of the patient.
- Independent experts concerned about lack of compliance in pre-operative and recovery period.
- Patient’s sons agreed that it was in the patient’s best interests to have surgery.
- The Official Solicitor opposed the Trust’s application.

Leading case

Mr Justice Holman held:

- Lawful to perform surgery.
- In the event that the patient refused, lawful to sedate the patient to carry out the treatment considered necessary to ensure her survival.

Futile treatment

Courts generally hold that treatment that is futile is not in a patient's best interests. There is no strict definition but the generally held principles are:

- Where there is no reasonable hope of cure and where the treatment will provide no benefit to the patient.