

Education

Patient Consent, the Anaesthetic Nurse and the Peri-operative Environment: Irish Law and Informed Consent

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Consent is a fundamental prerequisite for all medical treatment. Patient autonomy, respect for such autonomy and the right to information underpins this concept of consent [Barneschi *et al*, 1998; Madden, 2002; White, 2004]. Patients have a right to make their own decisions about their medical care, basing this decision on the information provided to them by the healthcare professionals responsible. Corollary to this right to make their own decisions is the right to information; in that information is necessary to enable patients to make an informed decision. Informed consent is recognised as an important legal and ethical principle in health care [Kennedy and Grubb, 2000; Madden, 2002].

Now, more than ever, patients are willing to challenge professional medical opinion regarding all aspects of their healthcare and healthcare treatment. Patients are no longer unquestioningly deferential to 'doctor's orders'. In today's society people are more likely 'to act like a suspicious consumer rather than an unquestioning patient' [Haug and Lavin, 1983]. These patients demand a 'right to information, [and a] right to decision making' and are more than willing to challenge physician authority [Haug and Lavin, 1983]. As a consequence, dissatisfaction regarding the lack of information given about medical treatment, along with the rise of the 'active citizen' [Salter, 2000] and so-called patient consumerism in healthcare, can and does result in litigation [White, 2004]. Right of access to information, the right to consent to medical treatment and the ever constant threat of litigation therefore

render it necessary for anaesthetic nurses working in the peri-operative environment to have a knowledge and understanding of the legal requirements for a valid and informed consent.

The purpose of this article is to discuss the law relating to consent that must be taken into account by those anaesthetic nurses in the peri-operative setting, focusing in particular on Irish case law. This article will identify the components essential for the formation of a valid and informed consent, and will examine how a patient's capability and competency affects the legal, ethical and professional requirements of obtaining valid consent. First, a brief overview of the various sources of law in Ireland is given here to help the reader understand the nature of Irish law and the reason why Irish courts can refer to cases from other common law jurisdictions.

SOURCES OF IRISH LAW

The Irish legal system is part of the common law system, which is based on the decisions of judges. (Most countries that belong to the common law system are those which were colonised by the English.) Decisions made by courts in any of the common law countries can be taken into account by judges in Irish cases, and this can be very useful as a guide where there are no existing Irish decisions dealing with a particular issue. This is why reference can be made to judgments from Australia, England, America, Canada and New Zealand by the Irish courts [Byrne and McCutcheon, 2001].

There are a number of different sources of law in Ireland, including the written constitution, *Bunreacht na hÉireann* 1937, case law (judicial decisions) and

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legislation. The primary source of law in Ireland is the Constitution which sets up the institutions of the state and sets out the fundamental rights of citizens such as the right to life. In addition to the Constitution, legislation and case law are valid and binding sources of law. As a consequence of Ireland's membership of the European Union, all European Union treaties, legislation and case law are additional sources of law in this jurisdiction, which should be taken into account where relevant. These various sources of law are of relevance in varying degrees to this issue of consent and will be discussed where appropriate in this article.

THE PATIENT'S RIGHT TO CONSENT TO MEDICAL TREATMENT

Legal recognition of the competent patient's right to consent to medical treatment is well established throughout the world in case law and legislation. In the American case, *Schloendorff v Society of New York Hospital* [1914], Justice Cardozo states that:

[E]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.

The European Charter of Patients' Rights places emphasis on the importance of a patient providing consent, provided that it is predicated on sufficient information regarding the healthcare treatment or procedure, including information about any possible risks or side effects. Supporting the right to consent are the concomitant rights to information and equally as important, the right to free choice (European Charter of Patients' Rights, 2002 – to date, this Charter has not been implemented in EU or Irish law so it is useful as a persuasive guide only). Recognition of a person's right to consent to medical treatment is also enshrined under Article 8 of the European Convention on Human Rights, which protects an individual's right to a private life [*Junke v Turkey*, 2008]. (The European Convention on Human Rights has been incorporated into Irish law by the European Convention on Human Rights Act 2003.)

In Ireland, a competent adult patient has the constitutional right to consent to, or refuse, any form of medical treatment. Failure to obtain a properly informed consent can have serious consequences for the healthcare professional in regards to legal liability.

To treat a patient without valid consent amounts to trespass against the person in civil law, and a breach of an individual's constitutional right to consent to, or refuse, medical treatment, which could result in the healthcare professional being sued. Failure to obtain a properly informed consent could also amount to battery in criminal law, which could mean that the healthcare professional would be prosecuted. Healthcare professionals may also face disciplinary action, which could lead to suspension or being struck-off. Therefore all healthcare professionals, including nurses working in the peri-operative environment, must be conscious of their duty and responsibility in relation to obtaining a patient's consent to medical treatment.

CONSENT AND THE IRISH CONSTITUTION

There is no specific reference in the Irish Constitution to a patient's right to consent to treatment. Instead, the patient's right to consent to treatment in Ireland is linked to the idea that every person has a constitutional right to bodily integrity. The Irish Supreme Court recognised this constitutional right to bodily integrity in the case of *Ryan v Attorney General* [1965] IR 294. What this means is that every person has the right to object to any form of bodily interference or restraint. This principle forms the legal underpinning to the concept that every patient must consent to any form of medical intervention. Subsequent to this decision, it is therefore a legal requirement that consent is obtained for all aspects of medical treatment; from examination, diagnosis and treatment. In *Walsh v Family Planning Services Limited* [1992] 1 IR 496, the Supreme Court emphasises the right to bodily integrity as an important constitutional right that will give rise to an action by patients for assault or battery if a medical procedure is carried out without their consent. Such consent can be given expressly or it may be implied [Brazier, 1992]. It is possible in some scenarios to imply consent from a patient's conduct and behaviour, for example, consent can be implied by virtue of a patient holding out his or her arm for an injection. Implied consent as a valid and genuine consent is recognised by both the courts and by the medical profession.

Professional guidelines for nurses and medical practitioners also identify the importance of obtaining a valid and informed consent from patients undergoing any type of healthcare treatment [Van Dokkum, 2005]. For example, the Irish Medical Council's Guide to Ethical Conduct and Behaviour [2004] stipulates that a

patient's consent to medical treatment is implied for many standard medical examinations and treatments by virtue of the patient attending the general practitioner for medical treatment. Irish law would also imply consent in such circumstances [O'Mathuna *et al*, 2005]. The Code of Professional Conduct for each Nurse and Midwife, issued by An Bord Altranais (the Irish Nursing Board), stipulates that:

It is necessary for patients to have appropriate information for making an informed judgement. Every effort should be made to ensure that a patient understands the nature and purpose of their care and treatment. In certain circumstances there may be a doubt whether certain information should be given to a patient and special care should be taken in such cases. (An Bord Altranais, The Code of Professional Conduct for each Nurse and Midwife, April 2000)

WHAT IS NEEDED TO FORM A GENUINE CONSENT?

While it is apparent from the law, and from ethical and professional guidelines, that consent should be sought from any patient undergoing medical treatment, what is perhaps not often clear is that the fulfillment of particular criteria is necessary in order for a genuine consent to be given. Capacity, disclosure of information and voluntariness are the three elements that are essential to forming a properly informed consent to medical treatment. The lack of any one of these could potentially render the consent given to be untenable or void. If this was to happen, it could mean that the healthcare professional may be in breach of the patient's constitutional right to bodily integrity, or at worst, the healthcare professional could face criminal action for assault or battery. In a Canadian case, *Allan v New Mount Sinai Hospital* [1980] 109 DLR (3d) 536, where a woman who had clearly indicated that she wanted to be injected in her right arm but was injected by the doctor in her left arm, the court made it clear that any medical procedure conducted without any written or oral consent from the patient will constitute an assault and battery on that patient. The court in this case firmly places the responsibility on the doctor responsible to obtain the patient's consent. (The patient in *Allan v New Mount Sinai Hospital* was successful in suing for battery.) Even though the judge placed the onus on the doctor responsible for the medical treatment in this case, this does not exonerate any nursing professional from the legal obligations regarding

patient consent to treatment (this decision has been relied upon by the Irish courts).

Nurses cannot ignore patient concerns or overlook a patient's lack of understanding about the nature of both their treatment and consent to such treatment. If anything, the anaesthetic nurse's responsibility for the patient's care both before and after surgery exposes the responsible nurse to greater opportunities to identify any patient concerns about information or consent. A nurse's job is to care for the patient when they are in hospital, and part of this nursing care includes identifying the patient's care needs and responding to these [Oakley, 2005]. This is a professional, ethical and legal duty. It is made clear within An Bord Altranais' (Irish Nursing Board) Code of Professional Conduct for each Nurse and Midwife that nurses have a duty to ensure that patients understand both the nature and purpose of their healthcare and treatment. From this professional guidance, it can be taken that nurses should be conscious of patients' questions and concerns about the information that has been given about their healthcare and treatment. If it becomes apparent that a patient has perhaps misunderstood the information that they have been given, then action should be taken to redress this. This could involve the nurse contacting the healthcare professional in charge of that individual's treatment plan to highlight the fact that the patient is unclear about, or indeed has misunderstood, the information provided.

DUTY TO INFORM PATIENTS

It is generally accepted that there exists a legal and ethical onus on healthcare professionals to provide patients with information to enable the patient to decide whether to consent to medical treatment or not. So how much information should patients be given about their healthcare treatment? The law is unclear as to precisely how much information healthcare professionals must provide a patient. There is certainly evidence within the literature that patients have much greater expectations about the amount of information they believe they should be given by those responsible for their healthcare treatment than can be the reality [Burns *et al*, 2005].

The Irish courts have provided some guidance regarding the amount of information healthcare professionals must give a patient as required by law. The Irish Supreme Court had to consider the extent of the healthcare professional's duty to disclose information to patients in the case of *Walsh v Family Planning Services*

Limited [1992] 1 I.R. 496. In this case, the patient elected to undergo a vasectomy operation. He was not told of the possible risk of orchialgia, which is a known but exceptionally rare consequence of a vasectomy operation. The Supreme Court held that there is a duty upon a surgeon to obtain a patient's informed consent, however the Supreme Court did recognise that this duty is dependent upon nature of the operation. Thus, if the medical procedure is imperative to maintain life, the healthcare professional's duty to inform is not as stringent. Therefore it is possible to limit the provision of information to discussion of possible harmful side effects. In *Walsh v Family Planning Services Limited*, the Supreme Court also stated that there is a greater duty to disclose all relevant information, including all possible consequences, for elective procedures. This view of the Supreme Court is certainly one that is also shared by patients themselves. In their study on the levels of knowledge and information patients expected prior to signing consent forms for surgical procedures, Burns *et al* [2005] found that 73 per cent of those patients surveyed expected to be told of any known complications, even if the risk of the complication occurring was less than one per cent [Burns *et al*, 2005, p. 20].

In regards to the amount of information that should be given, and what this information should include, the Supreme Court in *Bolton v The Blackrock Clinic Ltd* (unreported, 23rd January 1997) expanded upon the legal principles set down by the court in *Walsh*. The patient had surgery for a pulmonary condition. The first operation was initially successful but restenosis occurred rendering it necessary for the patient to undergo a complete pneumonectomy to remove her left lung. The patient sued on the basis that she had not given an informed consent to either the first sleeve resection operation or the pneumonectomy because the surgeon had not explained all the risks of the operations. The High Court found in this case that the surgeon had properly disclosed all risks to the patient [*Bolton v The Blackrock Clinic Ltd*, unreported, 20th December, 1994]. The patient then appealed to the Supreme Court, which rejected her appeal. Chief Justice Hamilton held that before obtaining an informed consent, the surgeon has to satisfy four conditions, first the surgeon must explain the necessity of the operation; second, in addition to explaining to the patient the necessity of the operation, the surgeon must explain the consequences of failing to have the operation; third, the surgeon must explain to the patient the nature of the operation and finally the surgeon must inform the patient of any possible harmful consequence arising from the operation.

Not only do healthcare professionals owe patients a duty of care [*Dunne v National Maternity Hospital* [1989] IR 91], the Irish High Court in *Geoghegan v Harris* [2000], emphasises the principle that doctors have a duty to warn patients of any known or foreseeable complications of an operation, even if that complication is extremely rare. The patient in this case alleged that the dentist did not disclose the risk of chronic neuropathic pain resulting from a dental implant. The High Court made it clear that when trying to assess whether or not information about the risks and complications of the medical treatment should be given to a patient, the test to be used is that of the reasonable patient. As such, this could mean that it may not be necessary to disclose all information about a medical procedure and any risks or complications because in law the reasonable patient would not require such disclosure. However, it would appear from the findings of Burns *et al* [2005] mentioned above, that the reasonable patient would expect to be told about the risks and complications, however small the risk may be.

In terms of obtaining consent from a patient for any type of healthcare treatment, what is clear from both the High Court and the Supreme Court decisions is that information about the treatment must be provided, and that this information should be as comprehensive as is both necessary and possible. This should enable the patient to give an informed consent.

CAPACITY TO CONSENT TO MEDICAL TREATMENT

The provision of sufficient information, as demanded by the so-called reasonable patient, is not enough on its own to guarantee that a valid, genuine and informed consent has been given by a patient. An individual patient's ability, or rather, capacity to consent to treatment is also of relevance [Tomkin and Hanafin, 1995].

There is a presumption in law that every adult has the capacity to consent to or refuse medical treatment. However, this presumption can be challenged in certain circumstances. As a consequence, doctors and nurses are entitled to assume that an adult is competent and capable of consenting to, or refusing, medical treatment. The capacity of a patient can have a fundamental impact upon the patient's ability to comprehend the information being relayed to them. Difficulties arise in the healthcare setting where the patient is incapable or incompetent, and thus unable to consent to or refuse medical treatment. This can give rise to serious problems when treating patients in the peri-operative environment.

CAPACITY AND THE COMPETENT PATIENT

The law in Ireland on consent to medical treatment requires that the patient who consents to any type of medical treatment has full capacity to do so, and that he or she is deemed in law at least to be a competent adult of sound mind. This right of self-determination includes both the right to consent to treatment and to refuse treatment. In addition to this, the consent must be given voluntarily and the patient has been given sufficient information to enable them to reach an informed decision. It was in the Irish Supreme Court decision, *In Re a Ward of Court (withholding medical treatment) (No. 2)* [1996] that the Irish courts held that a competent adult patient has the right to refuse medical treatment even if that treatment is life-saving. In his judgment in *In Re a Ward of Court*, Justice O'Flaherty stated:

there is an absolute right in a competent person to refuse medical treatment even if it leads to death.

Provision is made within Irish legislation to allow competent minors over the age of sixteen to consent to treatment. Section 23(1) of the Non-Fatal Offences Against the Person Act 1997, stipulates that anyone over the age of sixteen has the capacity to consent to any surgical, medical or dental treatment.

ASSESSING COMPETENCE

How is competence assessed? Capacity to consent is determined by legal principles based on fact [Van Dokkum, 2005]. There are inherent difficulties in attempting to assess the competence of adult patients. There exists no precise test in Irish law to determine whether an adult patient is sufficiently competent to consent to medical treatment. This is by way of contrast to the English courts which has set out a test to assess an adult patient's competence in the Court of Appeal decision, *Re MB* [1997]. The English Court of Appeal in *Re MB* [1997], held that a patient is incompetent in one of two situations, firstly, if the patient is unable to comprehend and retain any information that is material to consenting to or refusing medical treatment; and secondly, if the patient is unable to use the information to reach a decision as to whether to consent to or refuse medical treatment. In this decision, the English Court of Appeal did recognise that temporary factors could erode capacity. Essentially this means that a person who is normally competent and would be deemed capable of making his or her own decision regarding medical

treatment could be temporarily deemed incompetent. For example, if the normally competent adult is rendered unconscious as a consequence of an accident, or if that person goes into a coma, such a person would not be competent to make any decisions on their own behalf due to this temporary incapacity. In the event of such circumstances, a decision regarding their medical treatment could be made on their behalf, by way of the courts making that person a ward of court.

A similar approach has been adopted by the courts in Ireland where a medical emergency arises and the patient is unable to communicate their consent, or refusal, to medical treatment. In such circumstances, the Irish courts will allow the healthcare professionals to administer life-saving emergency treatment [*In Re a Ward of Court*; Madden, 2002, p. 400]. This is solely on the basis of an emergency arising whereby the courts will presume that the patient, if conscious and capable of communicating, would consent to the necessary life-saving medical treatment.

The Mental Health Act 2001 also contains some guidance in terms of assessing whether a patient is capable of consenting to medical treatment. Section 56(a) of the Mental Health Act 2001 does allow for any patient who falls under its remit to consent voluntarily to treatment. This is acceptable only where the patient has the ability to understand the 'nature, purpose and likely effects of the proposed treatment' [Madden, 2002]. However, it is only applicable to those who have been detained under its provisions.

CAPACITY AND THE INCOMPETENT PATIENT

A patient may have sufficient capacity to consent to some forms of treatment but may lack capacity to consent to other types of medical treatment. A patient may, for example, be deemed capable of consenting to a nurse changing wound dressings on an injury but could be deemed incompetent to consent to a procedure involving the amputation of limbs [Van Dokkum, 2005].

No Irish case law to date on the approach to be taken with a patient with a mental illness or learning disability who refuses medical intervention. Although there have been cases concerning patients who would fall under the category of being temporarily incapacitated. In one particular case, *Fitzpatrick and Ryan v F.K* [Unreported High Court, 25th April 2008], the patient had suffered a massive haemorrhage after giving birth, losing 80 per cent of her blood. She refused to consent to a blood transfusion on the grounds of her religious

belief. The patient's medical records described her as a Roman Catholic but she claimed that she was a Jehovah's Witness. The patient, who was originally from the Democratic Republic of Congo, spoke very little English and had no next of kin in Ireland. Due to the precarious nature of the patient's condition, it was recommended that she be given a blood transfusion. Attempts were made to explain the seriousness of the condition to the patient. The patient however refused to be transfused. Instead the patient asked the doctors to give her some Coca Cola and tomatoes, which she believed would help raise her blood pressure. In the circumstances, the doctors responsible felt that the patient did not have the ability to make an informed decision about the medical treatment. Given the potential risk of death by not receiving the blood transfusion, the doctors responsible for treating this patient sought an emergency order from the High Court to allow the medical team to administer a blood transfusion as they believed that the patient in question lacked sufficient capacity to make an informed decision to either consent or refuse treatment.

CONSENT AND THE INCOMPETENT PATIENT IN IRELAND

The introduction of the Mental Health Act 2001 in Ireland provides some guidance to the treatment of incompetent patients as it contains some provisions to deal with situations which may arise regarding an individual's right to consent to treatment. However, the Mental Health Act 2001 is limited as it only makes provision for incompetent adults who have been detained under the provisions of this legislation. The legislation does not extend its remit to cover adults who are perceived to be incompetent and as a consequence, lack the capacity to consent to treatment because of a learning disability or mental illness.

BEST INTERESTS

In the absence of any legislative principles, the healthcare professional in Ireland will either have to make a decision regarding that person's medical treatment based on that individual's best interests, or in some circumstances, seek to obtain consent from the incompetent adult patient's next of kin or guardian [Madden, 2002, p. 401]. This can very often be much more problematic. In regard to the best interests approach, the Irish courts may not deem this to be

constitutional because it 'vests healthcare professionals with significant and unchecked authority over the incompetent adult' (O'Mathuna *et al*, 2005). Obtaining consent from the incompetent adult patient's next of kin for medical treatment can also prove to be as problematic. It is possible for the incompetent adult patient's next of kin to lawfully consent to the withdrawal or refusal of life saving medical treatment provided that this decision is made in the *best interests* of that patient. *In Re a Ward of Court (withholding medical treatment) (No. 2)* [1996] the family of a patient who had been in a near-persistent vegetative state since 1972 went to the Supreme Court seeking a court order to remove this patient's artificial hydration and nutrition. In this case, the Supreme Court recognised that the family of an incompetent adult patient could act as a decision maker, again if this was done in the patient's best interests taking into account all relevant medical advice as well as legal and religious guidance [O'Mathuna *et al*, 2005].

WARD OF COURT

In some situations, for example a patient who is in a coma or a persistent vegetative state, an incompetent adult may be made a ward of court, which essentially means that the High Court will have full jurisdiction over all matters relating to the ward of court's person and their estate [Lunacy Regulations (Ireland) Act 1871 and the Courts (Supplemental Provisions) Act 1961]. For any cases requiring a decision about medical treatment, the High Court has the exclusive power to consent to treatment, or even to refuse treatment, if this is in the best interests of the person who has been made a ward of court.

VOLUNTARINESS

Finally, it is important that the consent is freely and voluntarily given by the patient. A patient should never be coerced into consenting to, or even refusing, medical treatment. Failure to obtain a voluntary and properly informed consent could result in breach of a patient's right to a private life, a right that is guaranteed by Article 8 of the European Convention on Human Rights. In a recent decision, the European Court of Human Rights in the decision *Junke v Turkey* [2008] found that the gynaecological examination that the applicant was forced to undergo while in custody was 'imposed on the applicant without her free and informed consent' and that such an examination was not 'in accordance with the law' or 'necessary in a democratic society' [Junke v Turkey,

2008]. The European Court of Human Rights makes it clear that:

...under Article 8 of the Convention and in the light of the Court's settled case-law, according to which any medical intervention against the subject's will, or without the free, informed and express consent of the subject, constitutes an interference with his or her private life... [Junke v Turkey, 13th May 2008, Application no. 52515/99, ECtHR]

HOW DOES THIS THEN TRANSLATE TO THE PERI-OPERATIVE ENVIRONMENT?

The anaesthetic nurse is a vital actor in the peri-operative environment, with obligations and responsibilities to the patient in regards to their particular healthcare needs. Patients in the peri-operative environment are often unaware of the precise role that anaesthetists and anaesthetic nurses have in caring for them during the course of any surgical procedure [Barneschi *et al*, 1998]. As part of nursing care, anaesthetic and recovery nurses in the peri-operative environment have a vital role to play as the patient advocate. Thus, nurses are charged with the task of listening to patients' concerns and queries, and if necessary providing the patient with relevant information or indeed informing the healthcare professional responsible that the patient needs further information to help them give an informed consent. This requires

nurses within this environment to engage in an ongoing and active discussion with patients, doctors, anaesthetists and the surgical team.

Due to the very nature of nursing care, patients will inevitably have much greater contact with a nurse than with doctors, anaesthetists or surgeons. As a consequence, patients are most likely to communicate with nurses about their healthcare procedure [Shannon and Scott, 2008]. Shannon and Scott found in their study that the majority of patients would like both doctors and nurses to provide information that is necessary for consent. Part of this may be due to the fact that patients are given information about the nature of their healthcare treatment at 'the time of initial consultation' [Burns *et al*, 2005]. This is very likely to result in patients not remembering all of the information that they were given at the initial consultation due to factors such as the lapse in time and human nature itself [Burns *et al*, 2005]. This makes it even more important for nurses to listen to patients' concerns and to relay these to the doctor or surgeon in charge of the individual patient's treatment plan. This need is perhaps even more pronounced in the peri-operative environment where the patient may not be conscious or able to communicate any concerns they may have. Taking time to listen to a patient, providing information about healthcare treatment and ensuring that the patient understands the information could ultimately prevent nurses and other healthcare professionals from the possibility of disciplinary sanctions, being sued for breach of the patient's civil and constitutional rights, or at worst facing criminal prosecution for assault and battery.

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