Current Practice

Problems of Consent

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Intentionally to apply force to another person is the civil wrong of assault, which may render the offender liable to pay damages. Although we are accustomed to tolerate the pushes and jostles of everyday life, the merest touch can amount to an assault. A medical examination has the ingredients of assault; so has a hypodermic injection; so has a surgical operation. Yet thousands of such procedures are carried out daily without legal consequences to the practitioner. This is because a patient who consents to reasonable treatment, which he knows carries a greater or lesser risk, has no redress from the operator if something goes wrong, provided that there has been no negligence and that the manœuvre is lawful.

Subject to certain exceptions consent must be freely and fully given by a person who understands the possible results of that which is proposed.

Age of Consent

The age at which consent to treatment may be accepted as valid has never been settled in the English courts. Age of attainment of legal capacity varies for different purposes—for example, a person under the age of 21 years cannot make a valid will or vote at an election or enter into a binding contract. On the other hand, young persons can marry at 16, a girl of 16 may consent to sexual intercourse without the risk of criminal proceedings against her partner, and the Children and Young Persons Acts cease to apply at 17. A significant recent enactment is the Mental Health Act 1959, section 5 (2), which allows an infant who has attained the age of 16, and who is capable of expressing his own wishes, to seek informal admission to hospital independently of his parent or guardian. It seems therefore that, in the absence of parent or guardian, a doctor can safely act on the consent to treatment of a person over the age of 16 who appears to understand the nature of the treatment proposed. Parental consent should usually be sought as well unless the young patient expressly forbids it. If the young person is married it is wise, with the patient's agreement, to discuss the medical position with the spouse. When a patient is under 16 the consent of parent or guardian to operation must always be obtained except in an emergency.

Emergencies

In an emergency the practitioner in attendance may have to apply drastic treatment to save life. If the patient is conscious the doctor should explain his intentions as fully as is feasible, or if he is unconscious sanction should be sought from an available relative. It is often out of the question to obtain consent in an emergency, and there must be no delay in adopting such medical measures as may be indicated.

The Drinking Driver

The doctor called to a police station to examine a person whose driving ability is thought to be impaired by drink or drugs must make sure that the suspect realizes he is a doctor and why he is there; in practice the drinking driver's comprehension is usually sufficient for this purpose. It is not customary to ask for written consent to examination, but the practitioner must ensure that verbal agreement is given in the presence of witnesses. The management of the man who is dead drunk should not differ from that of any other unconscious patient. Consent is impossible, and a careful examination must be made to exclude illness or, for example, subdural haemorrhage, and removal to hospital should follow if this is thought necessary.

Mental Illness

The touchstone of valid consent by a mentally abnormal person is the degree of understanding, regardless of the psychiatric label. With an informal patient, if the intellect is relatively unimpaired and the person is amenable to explanation, he should be treated similarly to anyone else. If there is marked mental deterioration the consent of next-of-kin should be obtained. In the case of a patient who is compulsorily detained no consent other than that of the person responsible for treatment of his mental condition is required. The position is less clear in respect of general treatment for physical illness, but a compulsorily detained patient may still have sufficient understanding to comprehend the nature of, say, an operation, and the practitioner must be guided by circumstances as he finds them. In an emergency or to save life the overriding principle of the patient's welfare comes into play.

Language Difficulties

Many foreigners with a limited command of English now dwell in the United Kingdom. The language barrier to cooperation in treatment may be considerable. Fortunately most foreign communities in this country include members who speak fluent English and who can act as interpreters: if a medical man who speaks the patient's language can be found the task is simple. The patient must fully understand what is to be done, and no pains should be spared to enlist adequate interpretation.

It has been shown that the ability to give valid consent to treatment may be impaired by unconsciousness, drink, or disease, by the language barrier, or by being under 16. The other requisite for free consent depends on the doctor's skill in enlightening a layman. Consent may be expressed or implied, written or verbal. It would be farcical to exact written consent to every minor medical procedure, such as hypodermic medica-

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tion; and the act of lying on an examination couch, baring the arm for the needle, or even going to the doctor's, is regularly taken as tacit consent to treatment. A degree of knowledge by the general public of the less potentially harmful forms of treatment is, reasonably, assumed every day.

Written Consent

For a surgical procedure, administration of an anaesthetic, or for electroconvulsive therapy written consent should always be obtained except in emergency. In court consent might be proved by evidence of surrounding circumstances and by statements of witnesses who have heard the patient assent. In practice this is so unreliable that verbal consent should not be accepted. Hospital staffs change, memory fades, and individual patients are forgotten to such an extent that the doctor's only protection is the written record. All hospitals have a form of consent to surgical and anaesthetic procedures, but as these vary from place to place the following, drafted by the Medical Defence Union, is given as an example.

"I . . . of . . . hereby consent to undergo the operation of . . . the nature and effect of which have been explained to me by Dr./Mr. . . .

I also consent to such further or alternative operative measures as may be found to be necessary during the course of the operation, and to the administration of a local or other anaesthetic for any of these purposes.

No assurance has been given to me that the operation will be performed by a particular surgeon.

Date..... Signed.....

I confirm that I have explained to the patient the nature and effect of this operation.

Date..... Signed....."

Explanation to the Patient

The nature of the operation must be explained by a medical practitioner and not by a nurse or sister. Unless a proper explanation has been given the mind of the patient cannot go with his signature and the so-called "consent" does not exist. This is why the doctor must countersign the certificate and add the date. The practice of having the patient sign a consent form blank on reception into hospital cannot be too strongly deprecated. Were such a form challenged later in court it could almost certainly be proved valueless. As it is often impossible to guarantee that a particular surgeon will perform the operation this, too, must be made clear. Some hospital forms do not include the acknowledgement of explanation by the medical officer. If this is missing the doctor concerned should add a note that he has discussed the treatment with the patient.

It is easy enough for a layman to comprehend the effect of removal of a leg or an arm or an eye; it is usually simple to tell him why this is necessary. It may be more difficult to impart the reason for sympathectomy or, say, the removal of the spleen in haemolytic anaemia. Explanation of an operation unlikely to have ill effects may be simple, but special risks or unpleasant side-effects should be mentioned. Before gastrectomy, for example, it is wise to warn the patient of reduced food capacity and the possible occurrence of "dumping," at the same time stressing that these are a small price to pay for freedom from pain and the risk of haemorrhage. There is no need to alarm the patient with horror stories, which may sap confidence in recovery. Nevertheless, in certain circumstances a patient could later claim that, had he been aware of the hazards of the operation, he would never have agreed to it, and he could go on to accuse the medical man of negligence in concealing the true state of affairs. The doctor must steer a wise course between the Scylla of failure to disclose and the Charybdis of alarming his patient.

In an action for negligence arising from damage to the recurrent laryngeal nerve during thyroidectomy a surgeon admitted that he had told the patient there was no risk to her voice. The Judge said to the jury in summing up: "... he did it for her own good because it was of vital importance that she should not worry . . . he told a lie; but he did it because in the circumstances it was justifiable. . . . But the law does not condemn the doctor when he only does what a wise doctor so placed would do. And none of the doctors called as witnesses have suggested he was wrong. All agreed that it was a matter for his own judgement. If they do not condemn him, why should you?"¹

Extent of Surgery

It is often impossible to predict the extent of an operation until the part has been explored. This is especially true of gynaecology, in which the decision as to myomectomy or hysterectomy sometimes cannot be made until the abdomen has been opened. If removal of the ovaries is likely permission should always be sought in advance. During the biopsy of a mammary tumour it may turn out that removal of the breast is indicated; the patient should be forewarned. It is not always appreciated that some of the less well-informed do not realize that hysterectomy means the end of childbearing. If it is proposed to tie the deferent ducts at prostatectomy the sterilizing effect should be mentioned, even though the patient's interest in procreation has become academic.

Husband and Wife

In general a married person has no right to intervene in treatment of the spouse, which is entirely a matter for the partner concerned. However, if an operation which will interfere with the reproductive function is contemplated the partner must always be apprised of its nature and a written acknowledgement of the explanation given in the presence of the other. For a woman to submit herself, for example, to hysterectomy, or a man to orchidectomy, without the spouse's consent, might well constitute the matrimonial offence of cruelty on which a petition for divorce could be founded.

Jehovah's Witnesses

Blood transfusions in Jehovah's Witnesses have achieved much publicity. The Jehovah's Witnesses are a religious sect utterly opposed to the transfusion of human blood. If a Jehovah's Witness of full age refuses transfusion nothing further can be done, and the surgeon must make up his mind whether he is prepared to continue treatment within the limits set by the patient's refusal. It is important immediately to record the fact of refusal of blood transfusion in the clinical notes; if the Jehovah's Witness will put his objection in writing absolving the surgeon from responsibility for adverse consequences of his refusal of the treatment advised, so much the better.

The case is altered if a parent declines to sanction transfusion for a child under 16 years. An expedient which has been used on a few occasions is the temporary placing of the child in the care of the children's department of the local authority by order of a magistrate under the Children and Young Persons' Acts. The local authority then gives permission for the transfusion. While this is lawful, it is not a purpose envisaged by the Acts. Further, it deliberately flouts a genuinely held religious belief, and many feel strongly that this is a stratagem which should not be employed. A practical objection is that the urgency of a case may preclude this legal proceeding.

As no doctor worth his salt can stand by and watch a child perish for want of a readily available and effective treatment,

the practitioner faced with this dilemma is advised to follow his own conscience. The worst that could befall is an action for assault, and it is on record that the defence societies would be 100% behind him if he tried to save a child's life in such circumstances against the parents' wishes.²

Clinical Trials

Although clinical experimentation comes in the sphere of ethics rather than law, the principle of full and free consent still applies. Sir Theodore Fox³ speaks of the "physician-friend" and the "physician-experimenter." A patient entering hospital puts his full trust in the doctors in the confidence that treatment is for his own personal benefit. In gratitude he may agree to some manoeuvre which is not necessary to treatment but which may further a research project. The physician-friend must be sure that this is not dangerous or painful, and that the patient understands what is to be done. This would not apply to tests on body fluids additional to those needed to regulate treatment. The physician-experimenter is liable to be an eager, obsessional fellow who may overbear

the physician-friend: when they are united in the same body the patient may suffer. Clinical research raises so many ethical problems that there is no space to discuss them in detail. No one wishes to hamper the furtherance of knowledge, but the doctor who is in doubt about a given experiment should search his conscience first and then discuss it with colleagues of experience in the clinical field.

The medical defence organizations have specimen forms of consent appropriate to various situations. Any practitioner who has a problem in connexion with consent to treatment should consult his society; in an emergency by telephone. Experienced advice is always preferable to do-it-yourself solutions. The doctor may perhaps think that life is rather short for all the foregoing recommendations, but the proper relationship between doctor and patient is founded on trust, and in the end that is what this is all about.

REFERENCES

- ¹ Hatcher v. Black, *The Times*, 2 July 1954.
- ² *Brit. med. J. Suppl.*, 1961, 1, 292.
- ³ Fox, T. F., *Med.-leg. J. (Camb.)*, 1960, 28, 132.

ANY QUESTIONS?

We publish below a selection of questions and answers of general interest.

Long-acting Insulins

Q.—What are the relative merits and role in the management of the insulin-dependent diabetic of protamine zinc insulin and insulin lente? Is there any place in therapy for using these insulins as a single injection at night after a supper and before retiring to bed?

A.—Lente insulin has the advantage over protamine zinc insulin (P.Z.I.) that its effect is more uniformly spread over the twenty-four hours. Thus P.Z.I. usually has to be given with soluble insulin, because its action does not begin for about eight hours. On the other hand, when the total daily dose of insulin exceeds 80 units it is usually found that lente insulin alone will not control the hyperglycaemia.

Long-acting insulins can be given in the evening, but preferably before the evening meal, and in the case of P.Z.I. a dose of soluble insulin will still be needed to combat the post-prandial hyperglycaemia.

"Safety" of Promethazine

Q.—Is it safe to take promethazine hydrochloride in a dose not exceeding 10 mg. nightly for an indefinite period?

A.—As in all questions of this nature, the answer depends upon the standard of safety which is required. No drug is completely "safe" in the sense that it will never produce unwanted side-effects. Promethazine, however, is a drug which has few side-effects, and the most important of these is drowsiness, which is presumably not undesirable if the dose is to be taken at night. Moreover, 10

mg. is a relatively small dose and unlikely to cause any harm.

In simple terms, therefore, the answer to the question is "yes," but this must be qualified by the statement that it is never wise to regard any form of medication other than substitution therapy—e.g., in pernicious anaemia—as being necessary for "an indefinite period," and that each time the prescription has to be renewed the question of the need to continue with the drug should be reviewed.

Hazards of Veterinary Radiology

Q.—What regulations are there for the protection of veterinary assistants who have to hold animals while under x-ray examination?

A.—No codes of practice have been developed specifically for the protection of veterinary assistants. Guidance could be obtained from the Ministry of Labour's *Code of Practice for the Protection of Persons Exposed to Ionising Radiations in Research and Teaching*,¹ in which the following appears: "No person, other than the subject of radiological examination, may place any part of his body within the useful beam." Alternatively there is *Code of Practice for the Protection of Persons against Ionising Radiation arising from Medical and Dental Use*.² This states: "Support for sick children or weak or anaesthetized patients is sometimes needed in wards and x-ray departments. This is a hazardous practice but cannot always be avoided. One person should not regularly perform this duty. Persons supporting a patient who is being x-rayed or holding films must wear a protective apron

and gloves, and should be provided with a film badge or pocket dosimeter for the occasion. A record of each incident when anyone assists in this way must be sent to the Radiological Safety Officer, who should keep some note of exceptional exposures of this nature."

Discussion about the problems has been recorded in the *Veterinary Record* and elsewhere.³⁻⁶

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- ¹ *Code of Practice for the Protection of Persons Exposed to Ionising Radiations in Research and Teaching*, 1964. H.M.S.O., London.
- ² *Code of Practice for the Protection of Persons against Ionising Radiation arising from Medical and Dental Use*, 1964. H.M.S.O., London.
- ³ Lawson, D. D., *Vet. Rec.*, 1960, 72, 1102.
- ⁴ Mole, R. H., *ibid.*, 1961, 73, 1140.
- ⁵ Douglas, S. W., and Williamson, H. D., *Principles of Veterinary Radiography*, 1963. Baillière, Tindall and Cox, London.
- ⁶ Middlemiss, J. H., *X-rays in Everyday Life*, British Veterinary Association Congress, September, 1964. Bristol.

"Menouria"

Q.—What is "menouria," and what is its cause?

A.—In 1957 A. F. Youssef,¹ of Cairo, drew attention to a rare late sequel of lower-segment caesarean section. Its presenting features are an absence of vaginal menstruation and a cyclic voiding of blood-stained urine at the expected time of the periods. Examination shows the presence of a vesico-uterine fistula above the level of the internal uterine os and a patent cervical canal, though there is no leakage of urine or menstrual flow through the cervix. Youssef coined the term "menouria" to describe this syndrome of the presence of a vesico-uterine fistula, patency of the cervical canal, absence of urinary incontinence, absence of vaginal bleeding, and "vesical" menstruation. He ascribed the absence of urinary leakage through the cervix and the passage of menstrual blood through the fistula into the bladder in these cases as due to a sphincteric action of the uterine isthmus.² When a vesico-uterine fistula is below the level of the isthmus there is normal