

Getting consent from the 'incompetent patient'



When a child has to undergo treatment, consent is needed from a parent or guardian.

The need to obtain proper consent from patients and documenting the consent procedure has become more apparent in recent years.

Court cases frequently revolve around the issue of whether the material risks of a particular procedure were explained to the patient prior to the patient agreeing to the procedure.

Patients, in general, have also become more aware and request more information about the benefits and risks of a procedure before agreeing to be treated.

When taking consent from an 'incompetent patient,' careful thought must be given as to the appropriate person who can give consent prior to treatment. The term 'incompetent patient' refers to a person who is unable to give consent himself, such as unconscious patients, minors and mentally incapacitated patients.

When treating unconscious patients in emergencies, it is a general rule that life-saving measures can be taken even though the patient is unable to consent. The law assumes that if the patient was conscious, he would consent to procedures to preserve his life. Care must be taken, however, to perform only procedures or tests that are life-saving. Elective procedures which can be postponed should not be done at this time.

It has become common in some countries for patients to prepare advance directives, or 'living wills', to specify in advance how they are to be treated in certain circumstances. A patient may, therefore, refuse treatment in advance, for example, by stating that he is not to be given artificial feeding if he is in a persistent vegetative state. The legal status of living wills, however, has yet to be determined in Malaysia.

In the case of minors, it is generally accepted that for those under the age of 18, the consent of at least one parent or the child's legal guardian is required before any procedure can be done. Although the United Kingdom, in the *Gillick* case, has recognized that children may at times give valid consent to treatment if they are able to

understand the nature of the treatment, this case has not been applied in Malaysia; thus, there is no law allowing children to validly consent to any medical procedure on their own. Should it be shown that treatment was provided to a minor without the consent of the parent or legal guardian, the doctor may be liable to a claim for battery, which is *actionable per se*, meaning that no injury needs to be shown for a valid claim to be brought.

Although parents have much say in the treatment given to their children, they do not have the final say. In all matters concerning children, the child's best interests must be of paramount consideration. Therefore, although parents can generally refuse to consent to treatment, if a doctor believes that a refusal is not in the best interests of the child, the parents' refusal can be challenged in court and treatment can be authorized without the parents' consent.

With the introduction of the Child Act 2001, a child may also be taken into temporary protective custody by the department of social welfare or a police officer and produced before a court. If the child is placed in the protective custody of a 'protector' or police officer, that person may authorize medical investigations and treatment for the child to diagnose the child's condition. Any medical investigation or treatment, however, must be in the best interests of the child. In reality, taking a child into temporary custody is primarily used in cases of abuse and it remains to be seen whether it can be applied to remove children from parents who refuse to consent to a particular form of treatment.

Where mentally disordered patients are involved, it is now recognized as good practice that whenever possible, if the patient is able to understand the nature of the treatment involved, the patient himself should give consent to the treatment. If the comprehension of the patient is in doubt, the patient

may be referred to a psychiatrist for assessment. This is set out in the Mental Health Act 2001. However, this Act has yet to come into force. The Act expressly allows legal guardians to consent for minors who are mentally disordered and for a relative to consent for a mentally disordered adult.

Until the Mental Health Act 2001 comes into force, the Mental Disorders Ordinance 1952 will continue to apply. If the mental capacity of a patient to consent to treatment is in doubt, an application can be made to the court for a ruling that the person is of unsound mind and incapable of managing himself or his affairs. If the court finds that a person is of unsound mind, it can appoint a committee to be in charge of the person and to make decisions, such as whether or not the patient needs to be admitted to a mental hospital for treatment.

The Mental Disorders Ordinance, however, is a rather old piece of legislation and may not cater to all situations that may arise, for example, when a person of unsound mind is capable of understanding certain basic treatments and refuses them. It also may not cover elective procedures where treatment is deemed helpful to the patient, but not immediately necessary. When there is doubt, it is prudent to apply to the court for a declaration that the treatment is in the best interests of the patient.

The 'best interests' test has been accepted and applied in the United Kingdom. It is now accepted as the test to apply when treating mentally incompetent patients, such as in the landmark case of *Bland*, where it was held that discontinuing life-sustaining treatment to a patient in a persistent vegetative state was in his best interests as it was of no benefit to him.

For private hospitals, the Private Healthcare Facilities and Services Regulations 2006 state that written consent can be obtained from the spouse, parent or next of kin of a mentally and physically disabled person before a procedure is performed. It is arguable, however, that this provision must still be subject to the best interests test, and a

mentally disabled patient's relative still cannot consent to procedures which would not be in the best interests of the patient. It is interesting that the Regulations have put mentally and physically disabled patients in the same category as far as consent taking is concerned. Certainly, those who are physically disabled may not necessarily have problems comprehending issues and giving their own consent for medical procedures.

PRACTICAL TIPS:

- Express consent to perform life-saving procedures during emergencies is not required from unconscious patients.
- Obtain consent from a minor's parent or legal guardian.
- Send a patient who seems unable to comprehend for psychiatric review.
- If the person is mentally disabled, doctors in public hospitals still technically need to make an application to court, whereas doctors in private hospitals can obtain consent from the spouse, parent or next of kin.

The general rule remains – valid consent must be obtained before treatment can be performed on any patient. In competent patients, consent must be obtained from the patient himself and an express refusal of treatment must be respected, even if withholding treatment harms the patient. For a patient who is unable to consent, care must be taken to identify the correct person who can consent on that person's behalf, and the process of explaining the procedure, the material risks and documenting the discussion must still be adhered to ensure good medical practice. **MI**

* Article courtesy of Raja, Darryl and Loh.