

Consent and the mentally handicapped

G. C. KANJILAL, Medical Director, Cranage Hall Hospital, Cranage, Crewe

(1) *Consent – what it is*

Consent to a transaction has three basic components. These are: the transaction – its nature; understanding; and response, i.e. the consent itself.

(2) *Factors which influence consent*

external; internal – patient him/herself.

External

The transaction itself can be very simple and straightforward or very complicated when a proper explanation is needed. This introduces two other elements: the position of the person carrying out the explaining and his motive and interest; in other words, there is a subjective element one cannot ignore. Accordingly it requires a responsible person to undertake this task. In the case of a patient in a hospital, this is usually the consultant in charge and, when the patient is in a Social Services home, the most senior person responsible, e.g. Officer-in-charge. When in his own home, however, the parents usually take on this responsibility. The interest of the patient should be the principal governing factor. The transaction should be explained fully by an unbiased person though there is doubt as to whether this is achievable in the end. Even with the simplest transaction, much depends on the stance of the person or persons doing the explaining and the rapport they have with the patient.

Internal

Understanding of the transaction by the mentally handicapped person is no less important. For severely handicapped patients the simplest transaction can be difficult to understand, so what chances have they with complicated ones? With complicated transactions the same applies to many handicapped persons.

Response of the patient is the most important component in the consent. Besides the degree of handicap of the patient, inconsistency, suggestibility, unreliable, unpredictable and impulsive behaviour are other elements which complicate the process, as does superadded mental illness.

(3) *Valid consent*

For a consent to be valid i.e. stand challenge in a Court of Law, it must fulfil the following criteria.

- (i) The nature, purpose, and likely effects of the transaction are fully explained (Informed consent).
- (ii) It must be carried out by a person or persons who are unbiased and have the mentally handicapped person's interest in mind.
- (iii) The mentally handicapped person must understand the transaction fully (Real consent).
- (iv) The response, i.e. the consent, must be of his/her own free will.

(4) *Present law relating to consent*

The law presumes that every adult is able to take responsibility for his/her own affairs and his/her own actions.

When a patient attains the age of 18, he/she can give consent to any transaction regardless of his/her mental disorder, which includes mental handicap. The patient is 'adult' in chronological age, but a 'child' intellectually and socially. He/she may be severely handicapped but can give valid consent to a course of action. This applies to handicapped persons even when the transaction is more complicated. A person suffering from mental disorder is deemed capable of giving a valid consent, e.g., to a surgical operation, provided he/she understands the nature of the operation he/she is consenting to.

However, the law recognises that certain persons are in need of special protection because they are 'under disability'. While, therefore, a person who is mentally disordered can enter into a binding contract, that contract is voidable at the option of the mentally disordered person if it can be shown that he/she was incapable of understanding the nature of the transaction, and when the other party to the contract was aware of his/her incapacity. The fact of mental disorder does not invalidate the contract.

(5) *Current practices*

Practices which are being carried out are:

- (i) In hospital: while the practice may vary, the consultant in charge usually decides if the patient is

capable of giving consent, and in this he is guided by the multidisciplinary team. He also seeks the support of the parent or next of kin when available.

If it is agreed that the patient cannot give consent, as in severe handicap, the consultant usually acts on behalf of his patient, and gives consent, e.g. to leave out of the hospital, treatment to be received, dealing with finance, consent to anaesthetic and operation. The parents are kept fully informed and when available give the consent instead. However, in an emergency, the consultant gives the consent and obtains the parents' consent as soon as practicable.

This practice can be extended to some mentally handicapped patients where it is deemed they are not able to give consent. Of those who are, the question remains whether the consent is valid. Most hospitals have a consent form which is used in this context.

Two areas of controversy needs to be referred to. Firstly, if there is a difference of opinion between the consultant and the rest of the multidisciplinary team, and secondly, if there is a difference between the team including the consultant and the parents. This has become a particular issue with consent to discharge from hospital. In pursuance of the Government's discharge policy from the hospitals into the community, a multidisciplinary assessment takes place regarding suitability of discharge. There are occasions when the consultant finds himself on his own against the rest of the team. Should his role prevail, or should he be overruled by the rest of the team? Similarly when the parents are opposed to the discharge against the rest of the team including the consultant, whose view should prevail?

There is a suggestion that in such cases an advocacy system be brought in and a legal representative argue the case in support of one or the other before a decision is taken. In the case of the consultant against the rest of the team, a suggestion is that there should be a review by an independent person or persons organised by the Health Authority, i.e. the consultant should not have the ultimate say.

- (ii) The practice in Social Services establishments differs considerably from that of the Health Services. The patients give consent to a number of transactions considered undesirable from within the hospital setting, e.g. consent to treatment, operations, financial transactions, voting etc. The Officer-in-charge takes some of this responsibility and obtains parents' approval as he considers necessary.
- (iii) While at home, however, the parents or next of kin usually take the initiative and give consent,

and are considered over-cautious and over-protective in the process. They are often blamed for not acting in patients' best interests and for exploiting them, e.g. regarding financial transactions. It appears from the above (1, 2 and 3), that the Health Services are taking a course of action which is between the apparent extremes of parents on the one hand and Social Services on the other.

- (iv) In the wake of all the differences and difficulties, more establishments and authorities are setting up guidelines for "Good Practices". To add to this is the DHSS's Health Services Development in the Mental Health Act 1983: *Draft Code of Practice* which gives helpful guidance with regard to consent to treatment when dealing with patients under the Mental Health Act 1983, both informal and detained.

(6) *Revival of tutors-dative**

It appears that certain specified powers were sought from the Court for a limited duration, i.e. five years, and as a result the parents of a mentally handicapped adult were appointment joint tutors-dative, it being accepted that the term "guardian" as used in the Mental Health (Scotland) Act 1984, and Mental Health Act 1983 was a misnomer. The final sentence concluded "It also illustrates the ability of Scots Law to adapt old principles and procedures to modern circumstances without having to wait for new legislation". At the moment the Law Society in England are formulating proposals for the welfare of mentally handicapped adults, and no doubt they will take notice of this example.

(7) *Need to change the law and safeguard the handicapped*

It is clear that the present law which presumes that all adults irrespective of their mental handicap can give a valid consent needs to be changed, and that this issue is decided by an Act of Parliament. A severely handicapped person cannot give a valid consent and, as the term "guardian" seems a misnomer some person or persons must be made responsible to give consent on his behalf.

With respect to a mentally handicapped person a group of people, including a specialist in mental handicap, a parent/next of kin where available, and a legal person acting as advocate, should meet and decide whether he/she can give valid consent. If the answer is no the responsibility must be extended to a person or persons adjudged appropriate.

*available on request from the author.