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Informed Consent in Healthcare Settings

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The law of informed consent requires permission for the clinician to treat or examine the patient. It protects patients' rights to decide what happens to their bodies. The Supreme Court decision of *Montgomery v Lanarkshire HB* [2015] enhanced protection of patient rights to include information about the risks involved in proposed treatment, and information on alternative treatments. **This briefing provides context in light of the Scottish Government's commitment to review the consent process, mental capacity and mental health legislation.**

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Contents

Executive Summary

The information in this briefing is for general guidance on the principles of informed consent and the impact of recent case law. Nothing in this briefing constitutes legal advice. It is based on law and guidance applicable at the time of publication.

> “ *Consent to treatment is the principle that a person must give permission before they receive any type of medical treatment, test or examination. This must be done on the basis of an explanation by a clinician.* ”
>
> NHS, Consent to treatment. Retrieved from https://www.nhs.uk/conditions/consent-to-treatment/. Accessed 23/10/2018.

Laws governing consent for medical treatment protect **human rights** including **patient autonomy**. They also make treatment more effective and provide health professionals with a defence to what might otherwise constitute assault. Two legal aspects of consent are *valid consent* and *informed consent*. This briefing is primarily concerned with informed consent.

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Informed consent is protected by the laws of clinical negligence, which set out rules on informing patients of risks, benefits and alternatives to proposed treatment.

Gaining informed consent in a medical setting is the process by which a clinician and a patient agree on a course of treatment. It is not a simple matter, and the General Medical Council provide ethical and practical guidance for medical practitioners on how they should approach the issue of consent. Consultation on updated guidance is underway

Montgomery v Lanarkshire Health Board [i] is a recent case which enhanced the legal protection of patients’ autonomy.

- It asserts a new patient-centred standard by which disclosure of information to the patient is judged. A clinician must take reasonable care to ensure that a patient is aware of any ‘material’ (relevant) risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.
- The test of materiality is whether, in the circumstances, a reasonable person in the patient’s position would be likely to attach significance to the risk, or the clinician is' or should reasonably be aware' that the particular patient would be likely to attach significance to it.

Montgomery moves away from an approach of ‘doctor knows best’ and embraces patient self-determination. Montgomery requires health professionals to:

- Give patients the information they need to make a decision;
- Focus on the particular patient’s needs;

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[i] Throughout this briefing Montgomery v Lanarkshire Health Board [2015] UKSC 11 will be referred to as 'Montgomery'. See Section 2.1 for an outline of the case

- Discuss risks and benefits of proposed treatment and reasonable alternatives;
- Engage in understandable dialogue with patients;
- Not bombard patients with information they cannot use or digest;
- Properly record discussions, information and decisions in the patient's notes.

Montgomery endorsed guidance by the General Medical Council which has for some time taken a patient-centred approach. The practical impact of Montgomery is **evolutionary** rather than revolutionary.

The emphasis in *Montgomery* on **dialogue** and **partnership** extends beyond the disclosure of risks and benefits in treatment cases. It bolsters ethical obligations with respect to information provision, personalised care and partnership more generally.

Montgomery applies to adult patients who can think, understand and reason for themselves.The underlying principles and values are nonetheless relevant in treatment cases involving children and adults whose capacity is compromised.

In 2016, the Scottish Government committed to carrying out a review of the consent process, together with the General Medical Council[ii] and Academy of Medical Royal Colleges.

[ii] GMC consultation on new draft guidance closes in January 2019. See GMC, Review of our Consent guidance. Retrieved from https://www.gmc-uk.org/about/get-involved/consultations/review-of-our-consent-guidance. Accessed 24/10/2018.

Chapter 1 Consent to medical treatment

1.1 Why seek consent?

Informed consent is a cornerstone of healthcare practice. Before a clinician or other healthcare professional touches the patient to administer care or treatment, the patient should give a meaningful and informed consent. The onus is on the clinician to make sure this is in place.

- A failure to obtain informed consent can breach the law and professional ethics;
- It can damage trust and therefore harm the clinician-patient relationship;
- It can potentially result in a clinical negligence claim, criminal prosecution, and / or a complaint to a professional regulatory body, such as the General Medical Council.

Article 8 of the European Convention on Human Rights protects the **right to autonomy**. Laws and guidelines on informed consent help ensure that patients make informed, autonomous treatment decisions. Two aspects of the law protect the patient's right to consent to medical treatment:

- Valid consent, and
- Informed consent.

1.2 When is consent *valid*?

Consent is agreement from the patient for a treatment or intervention. To give a valid consent, three elements must be present:

- VOLUNTARINESS: the patient must give consent voluntarily (without coercion);
- CAPACITY: the patient must have the requisite mental capacity to be able to make the decision;
- INFORMATION: the patient must have enough information to be able to understand the nature of the decision.[iii]

Consent provides a lawful justification for treatment and intervention. An absence of consent or lawful authority can infringe the patient's autonomy and violate their bodily integrity.[iv] When a clinician makes contact with the patient's body in order to deliver treatment or investigation, a failure to first obtain consent can potentially lead to investigations for criminal and civil proceedings, and even a finding of impaired fitness to practise.

[iii] *Chatterton v Gerson* [1981] QB 432.

[iv] Breaching Article 8 of the European Convention on Human Rights: *Glass v United Kingdom* [2004] 1 FLR 1019, ECtHR.

In such cases, the actionable injury, is the invasion of bodily integrity. Breaking the law occurs even if the clinician acted with the best intentions and in the best interests of the patient.

1.2.1 Express and implied consent

Consent is a **dynamic process** resulting from dialogue. The process should be reactive to changes in information and circumstances. Patients with capacity can withdraw their consent if they so wish.

For minor or routine investigations or treatments, consent can often be **implied** by the patient's actions.[v] For example, a patient who comes to see her GP and opens her mouth to allow the doctor to see her sore throat is demonstrating consent to the examination.

The higher the risk of the intervention, the more likely it is to require **express** consent. For higher risk interventions, such as surgery, consent should be documented **in writing** (e.g. a signed consent form and record of conversations about consent in the patient's notes).[vi]

1.2.2 Proxy consent

There are two valid forms of proxy consent:

1. The Adults with Incapacity (Scotland) Act 2000 [1] sets out procedures by which capable adults can appoint someone to make decisions on their behalf in the event that they become incapacitated.[vii]
2. Parents can consent on behalf of children under the age of 16 who lack the competence to consent for themselves.[viii]

1.2.3 Consent and refusal

Where the patient is an adult with mental capacity, the right to decide about medical treatment extends to refusing to undergo treatment, even if the treatment is needed to prevent harm or sustain life.[ix]

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[v] Consent: Patients and Doctors Making Decisions Together (2008), para 45. Retrieved from https://www.gmc-uk.org/-/media/documents/consent---english-0617_pdf-48903482.pdf. And GMC (2018) Decision making and consent: supporting patient choices about health and care: Draft guidance for consultation, para 47. Retrieved from https://www.gmc-uk.org/-/media/ethical-guidance/related-pdf-items/consent-daft-guidance/consent-draft-guidance.pdf.

[vi] Consent: Patients and Doctors Making Decisions Together (2008), para 47-49. Retrieved from https://www.gmc-uk.org/-/media/documents/consent---english-0617_pdf-48903482.pdf. And GMC (2018) Decision making and consent: supporting patient choices about health and care: Draft guidance for consultation, paras 48-50. Retrieved from https://www.gmc-uk.org/-/media/ethical-guidance/related-pdf-items/consent-daft-guidance/consent-draft-guidance.pdf.

[vii] See chapter 5 below.

[viii] See chapter 6 below.

[ix] *Re MB (An Adult: Medical Treatment)* EWCA Civ 1361.

1.2.4 Advance directives and statements

Patients with capacity can make **'directives'** to refuse treatment at a later date when they have lost capacity and cannot make decisions. Sufficiently clear directives will be taken into consideration. The Adults with Incapacity (Scotland) Act 2000 [1] requires that decisions are made that benefit the person, and take into consideration their past and present wishes.

People with mental ill health can make advance **statements** while they are well, in anticipation of a potential relapse. Their statements may include requests for treatment or care. There is no guarantee that requests made in the statement will be followed, but the Mental Welfare Commission for Scotland advises that they will be taken into account. [2]

1.2.5 Emergencies

In an emergency, a Valid consent should be obtained if the patient is capable of providing it. If the patient cannot consent (for example, if they are unconscious), medical treatment can be provided without consent if treatment is:

- in the best interests of the patient and
- immediately necessary to save their life or avoid significant harm.

If the patient is a child under 16 and cannot consent (whether due to lack of capacity or illness), someone with parental responsibility can provide consent. If no such person is available, then clinicians can treat the patient in an emergency, provided the treatment is immediately necessary and in the patient's best interests.[x]

1.2.6 Recording decisions

The decision should be recorded, usually in the patient's medical record and on a consent form. The record should include information discussed, specific requests and concerns of the patient.[xi]

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[x] See further: GMC, Consent: Patients and Doctors Making Decisions Together (2008), paras 50 and 79. Retrieved from https://www.gmc-uk.org/-/media/documents/consent---english-0617_pdf-48903482.pdf. And GMC (2018) Decision making and consent: supporting patient choices about health and care: Draft guidance for consultation, paras 90 and 91. Retrieved from https://www.gmc-uk.org/-/media/ethical-guidance/related-pdf-items/consent-daft-guidance/consent-draft-guidance.pdf.

[xi] See further: GMC (2008). Consent: patients and doctors making decisions together, para 51. Retrieved at https://www.gmc-uk.org/-/media/documents/consent---english-0617_pdf-48903482.pdf. And GMC (2018) Decision making and consent: supporting patient choices about health and care: Draft guidance for consultation, paras 96 and 97. Retrieved from https://www.gmc-uk.org/-/media/ethical-guidance/related-pdf-items/consent-daft-guidance/consent-draft-guidance.pdf.

1.3 When is consent *informed*?

If enough information is given to enable basic understanding of the decision, there will be a valid consent. **However, the patient may still have a claim in negligence if they were not given sufficient information about risks and alternative options.**

Clinical negligence occurs when the clinician acts in a way that falls below the acceptable standard and causes the patient harm.[xii] Clinical negligence claims sometimes relate to treatment and sometimes to the information provided to the patient. This briefing concerns the latter.

[xii] B*olam v Friern Hospital Management Committee* [1957] 1 WLR 582.

Chapter 2 *Montgomery v Lanarkshire Health Board*

Montgomery is a landmark decision from the Supreme Court that changed the law on informed consent. It has implications for clinicians and patients and for the Scottish Government, which has undertaken to review consent processes. The principles it endorses are relevant when considering consent-related issues in the review of mental health and mental capacity legislation (discussed in chapter 5) and when advising in cases involving children where there are legal uncertainties (discussed in chapter 6).

2.1 The facts

Nadine Montgomery gave birth to Sam Montgomery in 1999. She was told that her baby was likely to be bigger than average, because she had insulin dependent diabetes. She was of small stature. She worried that these factors would make vaginal delivery difficult. The treating obstetrician did not offer caesarean section or warn of the risk of obstructed labour. Sam's delivery was complicated by shoulder dystocia (a form of obstructed labour) which resulted in a delay in delivery. Sam sustained injuries that resulted in severe disabilities.

2.2 Montgomery in the Scottish courts

The pursuer, Nadine Montgomery, claimed that the defendant consultant obstetrician had negligently failed to give sufficient information about the risks of vaginal delivery and the alternative options.

The claim ultimately resulted in a change in the law, but not until it reached the Supreme Court. At this point, Sam was 16 years old.

In the **Outer House Court of Session** [xiii] the judge set out the test to determine whether the obstetrician was negligent in failing to disclose relevant information to Nadine Montgomery: Best and usual practice is established by professions, and the obstetrician needs to be shown not to have adopted that practice. Furthermore, it must be shown that 'the course adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care'.[xiv]

The 1985 case of *Sidaway* [xv] was applied. In *Sidaway* it was held that the same test that applies in cases alleging negligent treatment, also applies in cases alleging negligent information disclosure. So, if a reasonable consultant obstetrician would not have given information about a particular risk, then Nadine Montgomery's consultant obstetrician would not be considered negligent for failing to mention that risk.

[xiii] *Montgomery v Lanarkshire HB* [2010] CSOH 104.

[xiv] [2010] CSOH 104, [191] applying *Hunter v Hanley* [1955] SLT 213 per Lord President Clyde and *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

[xv] *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871.

Had Nadine Montgomery asked specifically about the risks, the obstetrician would have been obliged to answer, but the evidence suggested she had not. The likelihood of Sam suffering injury was very small. The Outer House Court of Session held that the obstetrician was not negligent in failing to disclose information. The decision was upheld by the **Inner House**.[xvi]

2.3 Montgomery in the Supreme Court

The Supreme Court came to a different conclusion and found that the obstetrician was negligent in failing to disclose material risks to Nadine Montgomery.[xvii]

Drawing a distinction between negligent treatment and negligent information disclosure, the court overturned the 1985 Sidaway decision. [3]

To determine if information is ‘material’ to the decision the court will now ask whether:

> “ a reasonable person in the patient’s position would be likely to attach significance to the risk, or the clinician is or should reasonably be aware that the particular patient would be likely to attach significance to it. ”
>
> [2015] UKSC 11, [87]-[88].

'Negligence' can be avoided by clinicians taking reasonable care to ensure patients are aware of any material risks involved in any recommended treatment and reasonable alternative treatments. The Montgomery case moves away from a ‘doctor knows best’ approach and focuses on disclosing information that the patient would consider significant.

[xvi] [2013] CHSH 3.

[xvii] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

2.4 Guiding principles for clinicians set out in Montgomery

Montgomery endorses several principles, including:

- Clinicians should give their patient the information the patient needs to make a decision
- The patient's needs are the central focus
- Clinicians should discuss with the patient the risks and benefits of proposed treatment and reasonable alternatives
- Clinicians should engage in understandable dialogue with the patient
- Clinicians should not bombard the patient with information they cannot make sense of or digest
- Clinicians should properly record discussions, information and decisions in the patient's notes

These principles have been incorporated into draft guidance from the GMC (2018) which recommends: [4]

1. Support patient decision making.
2. Listen to your patient and those close to them.
3. Share information that is relevant to your patient.
4. Understand the different roles you and your patients play in decision making.
5. Respect your patients' decisions.
6. Recognise the importance of the decision-making process.
7. Presume, assess, maximise and review capacity.
8. Involve your patient as much as possible in discussions and decisions about their care, even where they cannot make a decision.
9. Involve others when making decisions where patients are unable to do so.

2.5 From medical paternalism to patient autonomy

The move away from medical paternalism to enhance patient autonomy is the central justification for the legal change. Lords Kerr and Reed said:

> “ [S]ocial and legal developments … point away from a model of the relationship between the doctor and the patient based upon medical paternalism. … What they point towards is an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors … treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.”
>
> Montgomery, [2015] UKSC 11, [81].

The commitment to patient autonomy (the patient's right to decide) is based on principles of human rights. **The language of formal consent is gradually being replaced by a focus on partnership, person-centred care and supported decision-making**:

> “ While informed consent for discrete interventions remains important, this aspect only forms part of a broader requirement for healthcare professionals to support patients to make their own decisions. People should be ‘in the driving seat’ of their own healthcare decisions.”
>
> Informed consent: Learning from complaints. (2017). Page 7. Retrieved from https://www.spso.org.uk/sites/spso/files/communications_material/research/Informed%20Consent%20SPSO%20March%202017%20%28PDF%2C%20246KB%29.pdf[accessed 23 October 2018]

2.6 Alternatives to claiming in clinical negligence

Not all patients who suffer harm as a result of inadequate information disclosure wish to sue. Alternatives include the following:

- **Complaining to the local provider**

Many are concerned with securing an explanation and apology and with lessons being learned. The NHS Inform website details the process and potential outcomes of complaints about local NHS care. In the case of private healthcare, each hospital or clinic has its own complaints procedure.

- **Complaining to a professional regulatory body**

Clinicians are registered with professional bodies that can investigate allegations of professional misconduct and have powers to suspend a clinician or remove them from the medical register if it is found that they are no longer fit to practise.

2.7 Candour

If a lack of information results in a serious incident, the organisational duty of candour applies. The Scottish Government introduced a duty of candour in 2018.[5] This requires openness and transparency from the organisation. The aims are to promote a culture of learning and improvement and to enhance support for patients and their families.

Chapter 3 Implications of *Montgomery* for clinicians

The commitment to patient autonomy in *Montgomery* was broadly welcomed. However, *Montgomery* raised concerns of a loss of professional autonomy, increased litigation and defensive medicine. There was an initial increase in cases which have tested the boundaries of Montgomery. However, the practical implications of *Montgomery* have proved to be limited.

3.1 Evolutionary not revolutionary change

The *practical* changes brought by *Montgomery* are modest. *Montgomery* confirmed an evolutionary change in law and endorsed an approach already adopted in practice. [6] Farrell and Brazier say:

> “ The reality is that the decision will make little difference to healthcare practice and consent in the UK. The Supreme Court has endorsed a view that most lawyers and doctors thought already prevailed, and it reflects the General Medical Council's guidance on the issue of consent in any case.”
>
> Farrell, 2016[7]

The underlying approach was prefaced by:

- **Case law**: Several pre-*Montgomery* cases from England and Wales gradually moved the law away from a paternalistic approach to emphasise patient autonomy. [8]
- **Professional guidance**: Pre-*Montgomery* guidance for health professionals already adopted an approach based on patient autonomy.

Montgomery endorses 2008 guidance from the General Medical Council which requires that doctors must:

> “ [S]hare with patients the information they [the patients] want or need in order to make decisions.”
>
> General Medical Council, 2008[9] (para 2(c)). (Note: this guidance is under review.General Medical Council, 2018[4])

So whilst the legal endorsement of a patient-centred test is significant, the changes in practice are more modest.

3.2 Realistic medicine

One concern about Montgomery is that it might exacerbate **defensive medicine**. Defensive medicine can result in tests, procedures and treatments that are unlikely to benefit the patient, but which the clinician recommends out of fear of possible litigation. However, this threat is mitigated by focus on **‘realistic medicine’**.

> “ Realistic Medicine puts the person receiving health and care at the centre of decision-making and creates a personalised approach to their care. Its aim of reducing harm and waste and simplifying care while managing risks and innovating to improve are essential to a well-functioning and sustainable NHS.”
>
> CMO for Scotland. (2017). Realising Realistic Medicine. Page 3. Retrieved from https://beta.gov.scot/publications/chief-medical-officer-scotland-annual-report-2015-16-realising-realistic-9781786526731/ [accessed 23 October 2018]

This concept has been developed by the Chief Medical Officer for Scotland, Dr Catherine Calderwood, in a series of three annual reports:

- Realistic Medicine: Chief Medical Officer for Scotland annual report 2014-2015 (2016).
- Realising Realistic Medicine: Chief Medical Officer for Scotland annual report 2015-2016 (2017).
- Practising Realistic Medicine: Chief Medical Officer for Scotland annual report 2016-2017 (2018).

The focus on realistic medicine is a global phenomenon supported by the ‘**Choosing Wisely**’ [10] initiative. Choosing Wisely emphasises the importance of informing patients of risks, benefits and alternatives to treatment, including the alternative of no treatment. The choice should be reached through a partnership model.

Partnership combines …	Clinical judgement and evidence based medicine
	Patient values, wishes and preferences

The CMO’s 2018 report [11] welcomes synergy between the Realistic Medicine campaign and the emphasis in *Montgomery* on patient-centred medicine, dialogue and informed choice. *Montgomery* does not require doctors to offer treatment that is unlikely to benefit the patient.

3.3 Revisions to guidance and processes

Montgomery has resulted in evolutionary change that leads us away from medical paternalism. It embraces a partnership model designed to support the patient to make the best choice for them. Several professional bodies have updated their guidance to reflect this change. Examples include:

- Medical Protection Society (2017) An Essential Guide to Consent: Advice for the UK. [12]
- Royal College of Surgeons (2016) Consent: Supported Decision-Making: A Guide to Good Practice. [13]

In 2016 the Scottish Government undertook to review the consent process, together with the General Medical Council and the Academy of Medical Royal Colleges. [14] (page 15).

The General Medical Council's 2008 guidance 'Consent: Patients and Doctors Making Decisions Together' was endorsed in *Montgomery*. It is being updated to give more practical guidance to doctors. [4]

Chapter 4 Questions remaining

Several questions about the scope and application of *Montgomery* remain to be resolved by future cases and guidelines. This issue has been explored by a group of scholars investigating *Montgomery's* impact. [15]

4.1 How should reasonable alternatives be identified?

In *Montgomery*, Lords Kerr and Reed said:

> “ The doctor is therefore under a duty to take reasonable care to ensure the patient is aware of any material risks involved, any recommended treatment, and of any reasonable alternative or variant treatments.”
>
> [2015] UKSC 11, [87].

It is uncertain how courts will determine whether the alternatives put to the patient were reasonable. Reasonableness will be influenced by how far the judge is convinced by the evidence on each side.[xviii]

4.2 The more information the better?

Montgomery requires disclosure of sufficient information to make an informed decision, but balance is required. The clinician is not required to bring the patient’s knowledge up to her own expert knowledge. To do so could obfuscate important issues. In *Montgomery*, Lords Kerr and Reed said:

> “ This role will only be performed effectively if the information provided is comprehensible. The doctor’s duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form.”
>
> [2015] UKSC 11, [90].

The practical question of how much information to disclose requires responsiveness to the particular patient. If a case is brought in negligence, it will be determined on the evidence. As new professional guidelines are developed, specialist-specific guidance will aid clinicians making this judgement.

4.3 Whose view of risk counts?

In *Montgomery*, it was decided that the reasonableness of the clinician's decision would not be judged in accordance with other clinician's views, but would instead be determined by judges:

[xviii] *Holdsworth v Luton and Dunstable University Hospital NHS Foundation Trust* [2016] EWHC 3347, [64] per Judge Freedman.

> “ Responsibility for determining the nature and extent of a person's rights rests with the courts, not with the medical professions.”
>
> [2015] UKSC 11, [83].

Clinicians and patients might have different conceptions of what counts as a risk. *Montgomery* makes clear that risks are ‘material’ if either the reasonable patient would find them so, or if the particular patient would, and the clinician does or ought to know this.

A negligence case is dependent on proof of harm. This means that cases are brought when a risk has materialised. Since *Montgomery*, the courts have been wary of the effects of **hindsight**. They will look for evidence that risks would have been significant to the patient at the time of treatment rather than at a later point in time when harm has occurred.

4.4 How much responsibility should patients take for determining risk?

In *Montgomery*, Lords Kerr and Reed recognised the need for patients to take responsibility for their informed choices. Patients should be recognised as:

> “ adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.”
>
> [2015] UKSC 11, [81].

For the patient to be held responsible,[xix] clinicians are required to inform them of material risks and alternatives. This places a duty on the clinician to disclose information and reduces emphasis on the patient researching the matter themselves or asking for the specific information. However, it was also recognised in *Montgomery* that:

> “ Social and legal developments … point away from a model based upon a view of the patient as being entirely dependent on information provided by the doctor.”
>
> [2015] UKSC 11, [81].

The question of how much responsibility patients should take for determining risk is likely to be developed in future case law and professional guidance.

4.5 What exceptions are there to the duty to disclose information?

Lords Kerr and Reed made reference to two exceptions to the duty to inform patients of material risk:

- **Necessity**: The defence of necessity will apply in an emergency, which is outlined in 1.2 above.

[xix] [2015] UKSC 11, [82].

- **Therapeutic exception:** The therapeutic exception to the duty to disclose material information applies when the clinician reasonably believes that disclosure would cause serious detriment to the patient's health. For example, if a clinician would normally disclose a risk of nerve damage, she might not do so if there is evidence that this information may lead to a particular patient attempting suicide. Lords Kerr and Reed refer to it as a limited exception that must not be abused.[xx]

The *Montgomery* case did not involve application of the therapeutic exception and nor has any case since. Questions arise as to its scope and application:

> " The possibility of this exception presents significant legal difficulties for doctors."
>
> Royal College of Surgeons, 2016: para 4.2.

The therapeutic exception is problematic insofar as it is potentially confusing in practice and could distort and diminish the focus on patient autonomy. [16]

4.6 How will the right to information be developed beyond the scope of informed consent?

The law of negligence has developed post-*Montgomery* to further protect patients from misleading and incomplete information, and can be expected to develop further.

An important decision is the English case of *Darnley v Croydon Health Services NHS Trust*.[xxi]

THE FACTS: Michael Darnley suffered a head injury and attended his local Accident and Emergency department. He was told by a receptionist that there would be a 4-5 hour wait. In fact, it was normal to see patients with head injuries within 30 minutes, for initial assessment. Put off by the prospect of a long wait, Darnley went home. His condition worsened. He suffered permanent brain damage.

THE LOWER COURTS: The lower courts held there was no negligence. A distinction was drawn between the duties of clinical and non-clinical staff. Darnley was required to take responsibility for his decision to return home without informing Reception. There was a fear that imposing liability would open the floodgates and that it would be an unfair imposition on hospitals working in difficult circumstances.

THE SUPREME COURT: The Supreme Court unanimously allowed the appeal. The court held that there is no distinction on these facts between clinical and non-clinical staff. The hospital's duty is to provide accurate information, particularly when a failure to do so could lead to physical harm, as was the case here. The hospital's breach of this duty of care caused Darnley's permanent brain damage.

IMPLICATIONS: Some hospitals will need to review policies and information provision in A&E.

[xx] [2015] UKSC 11, [88], [90].

[xxi] [2018] UKSC 50.

Chapter 5 Applying *Montgomery* when capacity is compromised

> “ Capacity means the ability to use and understand information to make a decision, and communicate any decision made.”
>
> NHS. Assessing Capacity. Retrieved from https://www.nhs.uk/conditions/consent-to-treatment/capacity/. Accessed 23/10/2018.

In some cases, a patient may not be able to provide valid consent because their capacity is compromised. Sometimes others need to make a decision on behalf of the patient, in which case the patient should, where possible, have the opportunity to participate in the decision. Special rules and guiding principles apply to protect patient rights and interests. The rights-based principles set out in *Montgomery* are relevant in two ways:

- in the interpretation of current law and
- in the review and reform of mental health and mental capacity legislation in the future. [17]

5.1 Substitute and shared decision-making

The Mental Welfare Commission for Scotland describes three relevant laws that authorise where substituted decision-making : [18]

1. The Adults with Incapacity (Scotland) Act 2000, [1] which provides for guardians and attorneys, and sets out procedures to authorise medical treatment where a person lacks decision-making capacity.
2. The Mental Health (Care and Treatment) (Scotland) Act 2003, [19] which allows for detention and compulsory treatment linked to significantly impaired decision-making ability.
3. The Adult Support and Protection (Scotland) Act 2007, [20] which allows for short term interventions for ‘adults at risk’.

The CMO encourages ***shared* decision-making** where a person lacks capacity but is able, with support, to contribute to the decision. Shared decision-making requires participation of the person who lacks capacity:

> “ Shared decision-making must become embedded in routine clinical practice. ... It is the key to strengthening relationships between professionals and individuals, and to reducing unnecessary harm and regret caused by inappropriate or unwanted treatments.”
>
> CMO Scotland. (2018). Annual Report 2016-17: Practising Realistic Medicine. Page 14. Retrieved from https://beta.gov.scot/publications/practising-realistic-medicine/pages/3/ [accessed 23 October 2018].

Information disclosure is therefore of key importance:

1. To help a person with borderline capacity make an informed and valid treatment decision.
2. To allow participation of a person who lacks decision-making capacity so that their will and preferences are central to any treatment decision made in their best interests.

5.2 Mental health

A legal basis is always required for treatment. For those with mental disorder, as with other patients, the legal basis may be their valid consent. In some cases, treatment without consent may be authorised under the **Mental Health (Care and Treatment) (Scotland) Act 2003**.[xxii]

Some types of treatment carry special conditions set out in Part 16 of the 2003 Act [21] . For example, one of the conditions for neurosurgery, deep brain stimulation and electroconvulsive therapy is that patients with capacity provide their written consent.

Some treatments for mental ill health can be given in the **absence of consent**, subject to legal safeguards including benefit to the patient. The Mental Welfare Commission for Scotland advises that practitioners:

- Give the person as much information as possible about the treatment in a way the person can understand.
- Take the person’s views about the treatment into account.
- Take account of any previously expressed wishes, including an advance statement. *[See Chapter 6]*
- Take account of the views of others.
- Ensure that any treatment will benefit the person …
- Respect the person’s religious and cultural beliefs …
- Think about the range of options available for the person. … This must be balanced with the principle of maximising benefit. [18] (page 17).

People with learning disabilities or mental disorder have a right to **independent advocacy** under the 2003 Act. [22] They can also appoint a **‘named person’** to protect their interests. The Mental Health (Scotland) Act 2015 amended the 2003 Act to require the written consent of the named person. [23] The named person has a right to be consulted and to receive certain records and information.

[xxii] Hereafter referred to as the 2003 Act.

For those under the age of 16, the named person will automatically be the parent or guardian, the local authority or a carer.

If the adult patient lacks capacity and has not named a person, the 2015 Act gives powers to '**listed initiators'** to make applications or start an appeal. [24] The listed initiators include:

1. Any guardian of the patient
2. Any welfare attorney of the patient
3. The patient's primary carer (if any)
4. The patient's nearest relative.[xxiii]

The Scottish Government has set out a template for named persons and listed initiators on the Mental Health Act forms page.

See further S. Nowell (2014) SPICe Briefing: Mental Health in Scotland SB 14/36

5.3 Incapacity

5.3.1 How is incapacity defined?

The Adults with Incapacity (Scotland) Act 2000 [1] sets out a presumption of capacity for people aged 16 and over. Incapacity is defined as being incapable of any of the following because of mental disorder or inability to communicate due to physical disorder:

- acting on a decision
- making a decision
- communicating a decision
- understanding a decision
- retaining (remembering) a decision.

The Adults with Incapacity (Scotland) Act requires that decisions about a person who lacks capacity take account of the present and past wishes and feelings of the adult. Also, as far as is reasonable and practical, account should be had of:

- the views of the nearest relative, named person (if one is chosen) and the primary carer
- any guardian, continuing attorney or welfare attorney
- any person whom the sheriff has directed to be consulted
- the views of any other relevant person.

[xxiii] Mental Health (Care and Treatment)(Scotland) Act, s 257A(9).

So where reasonable and practicable, **a range of people should be given relevant information,** including the patient themselves, before a decision is made.

When consulting others, clinicians should take into account their **duty of confidentiality** to the patient. This applies whether or not the patient has capacity. Any disclosure of information about a patient lacking capacity must be in their best interests. Further guidance is available from the General Medical Council.

5.3.2 Principles

Five principles govern the 2000 Act [1] :

"Principle 1 - Benefit

Any action or decision taken must benefit the person, and only be taken when that benefit cannot reasonably be achieved without it.

Principle 2 - Least restrictive option

Any action or decision taken should be the minimum necessary to achieve the purpose. It should be the option that restricts the person's freedom as little as possible.

Principle 3 - Take account of the wishes of the person

In deciding if an action or decision is to be made, and what that should be, account must be taken of the present and past wishes and feelings of the person, as far as these may be understood.

Some adults will be able to express their wishes and feelings clearly, although they would not be capable of taking the action or decision which you are considering. For example, they may continue to have opinions about a particular item of household expenditure, without being able to carry out the transaction personally.

The person must be offered help to communicate their views. This might mean using memory aids, pictures, non-verbal communication, advice from a speech and language therapist or support from an independent advocate.

Principle 4 - Consultation with relevant others

Take account of the views of others with an interest in the person's welfare. The Act lists those who should be consulted whenever practicable and reasonable. It includes the person's primary carer, nearest relative, named person, attorney or guardian, if there is one.

Principle 5 - Encourage the person to use existing skills and develop new skills

Encouraging and allowing the adult to make their own decisions and manage their own affairs, as much as possible, and to develop the skills needed to do so." [25]

5.3.3 Who decides?

For those incapable of making a decision due to mental incapacity, the Act sets out procedures for others to make decisions on their behalf. In treatment decisions this may be a clinician, who must act in accordance with law and principles designed to uphold the patient's human rights.

Section 1(2) of the Act provides:

> " There shall be no intervention in the affairs of an adult unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult and that such benefit cannot reasonably be achieved without the intervention."

Family members should, where reasonable and practicable, be consulted when making a decision that must benefit the individual.[xxiv] **However, being an individual's next of kin does not give any right to make decisions if someone loses the capacity to make their own decisions.**

5.3.4 Power of attorney

An adult with capacity can nominate a welfare attorney to make decisions on their behalf should they later lose capacity to make those decisions themselves.[xxv] A similar system operates in England and Wales under the Mental Capacity Act 2005 [26] . In Scotland, the Power of Attorney must be formally executed, certificated and then registered with the Office of the Public Guardian.

- A Continuing Power of Attorney covers decisions about money and property.
- A **Welfare Power of Attorney** (WPA) covers decisions about health and welfare.

Making decisions about medical treatment is one of a number of powers that can be conferred by a WPA.[xxvi] This can include the power to consent to, or refuse, treatment in certain circumstances.

For the WPA to make an informed medical treatment decision, they will require information about material risks, benefits and alternatives in order to make an informed consent or refusal of treatment.

5.3.5 Additional sources of information

- Age Scotland. A guide to Power of Attorney in Scotland.

[xxiv] Adults with Incapacity (Scotland) Act 2000, [1] s 1(4).

[xxv] Adults with Incapacity (Scotland) Act 2000, [1] Part 2.

[xxvi] Note that some treatments require additional safeguards and refusal may invoke a request for a second opinion. See Mental Welfare Commission for Scotland. Medical treatment under the Adults with Incapacity Act. Retrieved from https://www.mwcscot.org.uk/the-law/adults-with-incapacity-act/medical-treatment/, accessed 23/10/2018.

- Code of Practice for Welfare and Continuing Attorneys is available on the website of the Office of the Public Guardian in Scotland.
- Mental Welfare Commission for Scotland (2017). Consent to treatment: A guide for mental health practitioners.
- Scottish Government (2018). Review of Adults with Incapacity legislation.

5.4 Human rights and supported decision-making

Montgomery emphasises the importance of partnership and dialogue. Merely providing information is not enough – the information must be intelligible to the patient.

Human rights standards are relevant and provide the basis for this protection. In particular, the European Convention on Human Rights (ECHR).

- The Human Right Act 1998 brings the human rights contained in the ECHR under the jurisdiction of the UK courts.
- The Scotland Act 1998[xxvii] requires that ECHR rights are reflected in devolved legislation and policy.

See further K. Shields. (2017). SPICe Briefing: Human Rights in Scotland SB 07/01.

5.4.1 Article 8, European Convention on Human Rights

Article 8 of the ECHR protects the right to respect for private and family life which includes respect for autonomy rights. In the context of informed consent, autonomy is protected by disclosing information necessary to make an informed treatment decision. Any limitations to Article 8 rights must be proportionate and necessary.

"Article 8 ECHR: Right to respect for private and family life

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

Though the application of *Montgomery* is restricted to 'adult persons of sound mind', article 8 applies to all, regardless of their capacity.

[xxvii] Scotland Act 1998, ss 29(2)(d); 57(2).

5.4.2 Article 12 UN Convention on the Rights of Persons with Disabilities

Additional protection flows from the **United Nations Convention on the Rights of Persons with Disabilities** (UNCRPD). The Convention was ratified by the UK in 2009, which means that UK laws, which includes laws made by devolved administrations, must be interpreted in the light of the Convention. Article 12 recognises the rights of people with disabilities to exercise legal capacity on an equal basis with others. It requires safeguards to ensure that laws 'respect the rights, will and preferences' of people with disabilities.

"Article 12 UNCRPD– Equal recognition before the law

1. States Parties (countries that sign up to the Convention)reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.

2. States Parties shall recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property."

See further A. Evans (2018). SPICe Briefing: Economic, social and cultural rights - some frequently asked questions SB 18/43.

5.4.3 Supported decision-making

One of the ways Article 8 ECHR and Article 12 UNCRPD are upheld in Scotland is through **supported decision-making.**

The CMO's 2018 report recognises that supported decision-making lies at the heart of *Montgomery*:

> “ Supporting people to make decisions (which is perhaps a more appropriate way to approach the issues raised post-*Montgomery* than to focus on the challenges of “consenting” people), is complex and involves more than simply eliciting information preferences – there is often a need for sensitive exploration of the values, beliefs or life experiences that have personal significance or meaning.”
>
> CMO Scotland. (2018). Annual Report 2016-17: Practising Realistic Medicine. Page 17. Retrieved from https://beta.gov.scot/publications/practising-realistic-medicine/pages/3/ [accessed 23 October 2018]

The principle of supported decision-making applies to patients whether or not they have capacity or suffer from mental disorder:

1. Patients with capacity will need varying levels of support to make a decision. When informing patients, clinicians should take into account the power differential that can exist between clinicians and patients:

> “ The gradient of power and knowledge imbalance between patients and clinicians needs to be recognised and its implications understood. Often the choices are not straightforward. When people are making decisions about treatment options with a serious condition, they may be frightened and vulnerable; at the time they may seek to be guided by the doctor. It is afterwards that they may question the merits of the treatment decision or experience regret, if their expectations are not met.”
>
> CMO Scotland. (2018). Annual Report 2016-17: Practising Realistic Medicine. Page 9. Retrieved from https://beta.gov.scot/publications/practising-realistic-medicine/pages/3/ [accessed 23 October 2018]

2. With support, some people with borderline capacity will be able to give valid and informed consent.

3. Supported decision-making is also relevant when a **substitute decision** is made for a person unable to give a valid consent. Supported decision-making can help ensure that the individual's **will and preferences** are central to the decision. It facilitates the participation of the individual in decisions about them which in turn improves their care.

The **Royal College of Surgeons** sets out principles to guide supported decision-making:

- "There is a presumption of capacity
- Capacity is time- and decision-specific
- Treat each patient as an individual
- Respect the patient’s views and wishes
- Information should be given about the option of not having treatment
- Respect the decisions of those with capacity
- Act in the best interests of patients in a medical emergency when they cannot consent."

Source: Royal College of Surgeons (2016). Consent: Supported Decision-Making, paras 3.1-3.7.

5.4.4 Additional sources of information

- Education for Scotland (2012). Think capacity think consent.
- Mental Welfare Commission for Scotland. (2010). Consent to Treatment: A Guide for Mental Health Practitioners.[xxviii]
- Murphy, R. (2016). SPICe Briefing: Child and Adolescent Mental Health -Legislation and Policy.

5.5 Commentary

The **legal requirements** outlined in *Montgomery* are relevant when the patient's capacity is compromised in the following ways:

1. If the patient has borderline capacity, supported decision-making may enable them to make a valid and informed consent.
2. If the patient lacks capacity and a substituted decision is made, the proxy decision-maker requires disclosure of risks, benefits and alternatives in order to provide an informed consent.

The human rights-based **principles** outlined in *Montgomery* also require that:

1. If the patient lacks capacity their participation in an informed decision enhances best interest decision-making and protects their human rights by ensuring that their will and preferences are central to the decision.

Article 8 was relevant in *Montgomery*, but the application of *Montgomery* was restricted to 'adult persons of sound mind'.[xxix] Article 8, however, applies to all humans. Therefore *Montgomery* has direct relevance when the decision maker is an adult person of sound mind (whether the patient or a proxy) and tangential relevance as to the possible protections afforded by Article 8 when patients lacks the ability to decide for themselves.

[xxviii] Note that this guidance predates the Mental Health (Scotland) Act 2015.

[xxix] [2015] UCSC11, [87].

Chapter 6 Children

Montgomery concerned the information disclosure requirements in relation to adult patients/ The judgement will have relevance to children who are deemed able to give a valid consent and when a proxy consents on their behalf. The principles set out in *Montgomery* are likely to be influential in cases where there is uncertainty due to gaps in established law.

6.1 Children's rights

Children are protected by the ECHR and Human Rights Act 1998. More specific protection flows from the United Nations Convention on the Rights of the Child (UNCRC).

The UK ratified the UNCRC in 1991. It has not been incorporated into law. However, Part 1 of the Children and Young People (Scotland) Act 2014 places new duties on Scottish Ministers and public bodies. They must report every three years on measures taken to give effect to UNCRC requirements. The UNCRC has four core principles:

- devotion to the best interests of the child
- the right to life, survival and development
- respect for the views of the child
- non-discrimination.

The Children (Scotland) Act 1995 (like the Children Act 1989 in England and Wales) defines parental responsibilities and the rights of children. In both statutes, the welfare of the child is the paramount consideration and protection is given to childrens' rights to express their views.

6.2 When can a child provide valid consent?

In Scotland, the term ‘child’ refers to those under the age of 16.[xxx] Unlike adults, children are not presumed in law to have capacity. Children must be *shown* to have the relevant capacity to make the decision in question. Section 2(4) of the Age of Legal Capacity Act 1991 established that:

> “ A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.”

This provision is based on the English concept of *Gillick* competence as set out in the case of *Gillick v West Norfolk and Wisbech AHA*.[xxxi] In England and Wales, the common law rather than statute governs the ability of children to provide a valid consent.

[xxx] Age of Legal Capacity Act 1991, s 1.

[xxxi] [1986] AC 112.

In Gillick, Lord Scarman commented:

> “ ... the parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision.”
>
> [1986] AC 112.

In Scotland, children can consent provided the clinician considers them to be ‘capable of understanding the nature and possible consequences of the procedure or treatment’. NHS Inform provides further information for young people using NHS services. [27]

6.3 When can a child provide a valid refusal of consent?

6.3.1 England and Wales

Whilst the judges agreed on the matters before them in *Gillick*, aspects of their judgments are difficult to align. Lord Scarman’s approach emphasises autonomy, and Lord Fraser’s approach emphasises best interests:

- Lord Scarman’s words imply that *Gillick* competent children have a right to decide what medical treatment to have.
- Lord Fraser, on the other hand, accepted the competent child’s right to consent provided the treatment was in the child’s best interests.

In England and Wales, subsequent case law has determined that competent children can give but not necessarily withhold consent to treatment needed to sustain their life or health. In *Re R* [xxxii] it was held that parents and the court have a veto on decisions of children under the age of 16 and in *Re W* [xxxiii] the same reasoning was applied to children of 16-17.

This has led Brazier and Cave to comment that, in England and Wales:

> “ Adolescent autonomy is little more than myth, for no young person under 18 - no minor - has a right to refuse treatment.”
>
> Brazier, 2016[28]

6.3.2 Scotland

A distinction can be drawn between laws in Scotland and England and Wales with respect to 16-17 year olds. In England and Wales, powers to refuse consent for all minors under

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[xxxii] *Re R (a minor) (wardship: consent to treatment)* [1991] 4 All ER 177.

[xxxiii] *Re W (a minor) (wardship: medical treatment)* [1992] 4 All ER 627.

the age of 18 are subject to veto. In Scotland, **the likelihood is that young people of 16 and over with the requisite maturity and understanding can refuse treatment, but questions remain about those under the age of 16.** The 1991 Act refers to consent, not refusal and there has yet to be a test case.

NHS Inform advises under 16 year olds that:

> “ If you have a very serious condition and refuse treatment, your parent or guardian may disagree with you and want to discuss your case with a lawyer. If this is the case, your opinion will still be listened to and you can have your own lawyer to help you.”
>
> NHS Inform. Information for young people using NHS services. Retrieved from https://www.nhsinform.scot/care-support-and-rights/health-rights/young-people/information-for-young-people-using-nhs-services# [accessed 23 October 2018].

6.4 Parental responsibility and its limits

Where a child cannot consent for themselves, consent can be sought from a person with parental responsibility.[xxxiv]

Section 2(1)(b) of the Children (Scotland) Act 1995 confers on parents the right:

> “ to control, direct or guide, in a manner appropriate to the stage of development of the child, the child’s upbringing.”

These powers and rights are subject to limitations.[xxxv] Requests for treatment or refusal of treatment might be challenged in court if relevant others, such as clinicians, consider that those with parental responsibility are not acting in the best interests of the child. The court will give paramount consideration to the child’s interests but will take into consideration the views and human rights of those with parental responsibility and relevant others.

6.4.1 Additional sources of information

- British Medical Association Ethics Dept (2008) Parental Responsibility.
- Scottish Government (2018) Parental responsibilities and rights.

6.5 Informing children

In order for a child to give or refuse consent, they need to be given sufficient information to make the decision. The concept of best interests governs the treatment of children. The views and preferences of the child are relevant to best interests, as well as what is clinically indicated.

The views of those with parental responsibility may also be relevant, provided the duty of confidentiality is taken into consideration and disclosure is in the child’s best interest. [29] (para 12).

[xxxiv] Children (Scotland) Act 1995, s 2(1)(d).
[xxxv] Children (Scotland) Act 1995, s. 1.

Where children cannot give a valid consent, information disclosure may still be relevant to ensure that their views are taken into consideration when making a decision in their best interests.

6.5.1 Additional sources of information

- General Medical Council. (2007) (updated 2018) 0-18 years: guidance for all doctors.
- Medical Protection Society (2014) Consent – children and young people.
- Royal College of Anaesthetists. Children and young people.

6.6 Immunisations

The Government has a vaccination programme designed to protect the health of individual children and the population. For young children who cannot consent for themselves, parental informed consent must be obtained. Usually the consent of one person with parental responsibility is sufficient.[xxxvi] Where parents disagree, legal advice should be sought.

6.6.1 Human Papillomavirus (HPV)

Some vaccines are offered in school and occasionally result in disagreement over who should provide consent.

Girls are routinely offered the HPV vaccine from the age of 12. The aim is to prevent recipients getting HPV types that can cause cervical cancer. Two doses are required for full effect. Information should be provided before informed consent is obtained.

The advice on consent from NHS Inform is directed at the child. It states:

> “ You should've been given a consent form and leaflet by your school. You and your parents, or carer, should discuss the information before agreeing to have the immunisation. When you're given the consent form, your parents will be asked to sign it and return it to school even if you aren't going to have the vaccine. We recommend you get agreement from your parent or carer, but it isn't always necessary. More information on young people's right to consent. If you, or your parents or carer, have any questions about having the immunisation, speak to your nurse first if you can, or your GP.”
>
> Retrieved from https://www.nhsinform.scot/healthy-living/immunisation/vaccines/hpv-vaccine. Accessed 23/10/2018.

[xxxvi] Children (Scotland) Act 1995, s 2(2).

Commentary

Montgomery changes the law on informed consent. These changes will have an impact on consent and how it is considered in three ways:

1. In advice given to patients and clinicians. *Montgomery* has advanced understanding and expectations of disclosure of risks and alternatives to treatment. However, the practical impact of *Montgomery* on clinicians is quite modest. The case endorses General Medical Council guidance that has been in place since 2008.

2. In 2016, the Scottish Government planned a review of the consent process. [14] This briefing provides relevant context.

3. The Scottish Government has referred to an upcoming review of mental health and mental capacity legislation. [17 30] . The Government promises to deliver on a human rights based approach. Consent is an important aspect of mental health and capacity law. The human-rights based approach in *Montgomery* emphasises partnership, dialogue, supported- and shared-decision making.

RELATED BRIEFINGS

SB 14/36 Mental Health in Scotland

SB 16/66 Named Person

SB 16/76 Child and Adolescent Mental Health – Trends and Key Issues

SB 16/75 Child and Adolescent Mental Health - Legislation and Policy

SB 13/38 Children and Young People (Scotland) Bill

SB 07/01 Human Rights in Scotland

SB 18/43 Economic, social and cultural rights - some frequently asked questions

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