

The logo for Weightmans, featuring the name in white text on a dark teal, wavy rectangular background.

Weightmans

Weightmans

Medical Treatment – communication, consent and capacity

Royal College of Podiatry
21 November 2025

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Our Healthcare Practice

Our people

150+

specialist healthcare lawyers



180+

local government and public sector lawyers



Our clients



166 NHS Bodies

NHS Trusts, ICBs and national bodies (including NHS Resolution, NHS England)



200+ Primary Care Practices

GP surgeries, pharmacies and dental practices.



15 Medical Defence Organisations

Royal Colleges, medical insurers and practitioner membership bodies.



242 Local & National Government Organisations

Local and regional councils, central government departments and government funded bodies.



140+ Private and Independent Health and Care providers

Care homes, charities, healthtech companies and private secondary care providers.

Instructing us

We are appointed to the main national NHS frameworks including:



Award success



HSJ Partnership awards (2024): Bronze winner – Best legal services partnership with the NHS

Health Investor awards (2024): Finalist – Public Sector Legal advisors of the year

Health Investor awards (2023): Finalist – Transactional Legal advisors of the year

What our clients say

“The Weightmans health team are exceptionally good.”

NHS Client
Legal 500, 2024



“They’re always wanting to go the extra mile and find ways in which to support.”

NHS Client
Chambers and Partners, 2024



Content

- Consent – adults
- Communication (and how to not get sued)
- Consent – children
- Capacity and best interests / benefit

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Consent – adults making choices



Consent

- Consequences of treatment without consent
- No consent without
 1. Capacity
 2. being freely given
 3. informed

- What should a patient be told?
- Doctor knows best?
 - Hatcher v Black (1954)
 - Bolam (1957)
 - Sidaway (1984)
 - Montgomery (2015)

Listening and understanding what is material to the patient

Nadine Montgomery wins £5m from NHS Lanarkshire over brain damage to son

11 March 2015 | Glasgow & West Scotland

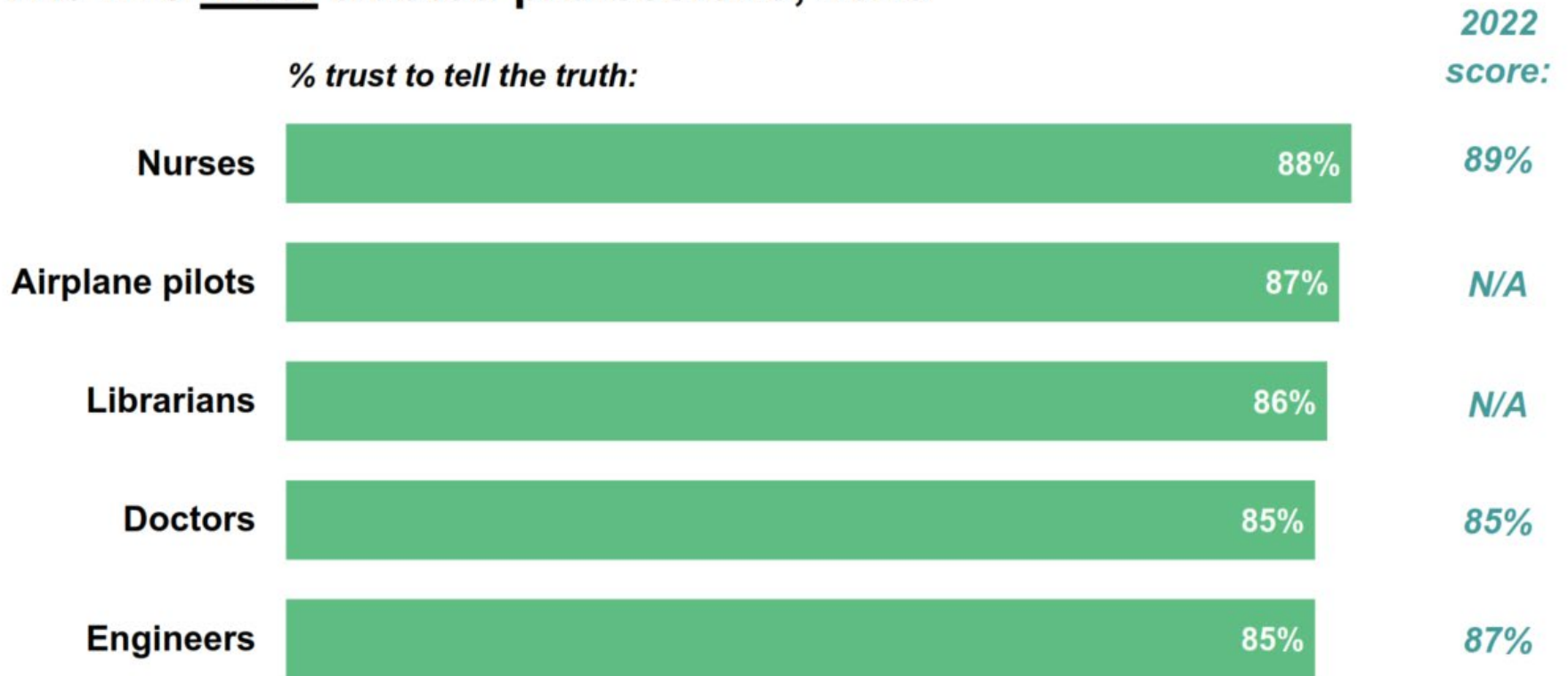


Nadine Montgomery has won a 16-year legal fight for damages for her son Sam

A Lanarkshire woman whose baby suffered brain damage during birth has won a 16-year fight for £5.25m compensation.

Nadine Montgomery, 40, claimed medics neglected to give her proper advice which may have led to her son Sam having a safer caesarean birth in 1999.

The five most trusted professions, 2023



Base: 1,020 and 1,015 British adults aged 16+, interviewed by telephone 8 – 14 November and 15 - 21 November 2023

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He's one of the busiest men in town. While his door may say *Office Hours 2 to 4*, he's actually on call 24 hours a day.

The doctor is a scientist, a diplomat, and a friendly sympathetic human being all in one, no matter how long and hard his schedule.

According to a recent Nationwide survey:
MORE DOCTORS SMOKE CAMELS
THAN ANY OTHER CIGARETTE

DOCTORS in every branch of medicine—113,397 in all—were queried in this nationwide study of cigarette preference. These leading research organizations made the survey. The gist of the query was—What cigarette do you smoke, Doctor?

The brand named most was Camel!

The rich, full flavor and cool mildness of Camel's superb blend of costlier tobaccos seem to have the same appeal to the smoking tastes of doctors as to millions of other smokers. If you are a Camel smoker, this preference among doctors will hardly surprise you. If you're not—well, try Camels now.



Your "T-Zone" Will Tell You...

T for Taste . . .
T for Throat . . .

that's your proving ground for any cigarette. See if Camels don't suit your "T-Zone" to a "T."



CAMELS *Costlier Tobaccos*

Listening

- Percentage of patients allowed to complete their opening statement without interruption?
 - 23%
- The average time a patient is allowed to talk before a doctor interrupts?
 - 18 Seconds

Assumptions....

For patients with breast cancer,
keeping the breast is a top priority:

- Doctors – 71%

PATIENTS' PREFERENCES MATTER
Stop the silent misdiagnosis

Al Mulley, Chris Trimble, Glyn Elwyn

Assumptions....

For patients with breast cancer,
keeping the breast is a top priority:

- Doctors – 71%
- Patients – 7%

PATIENTS' PREFERENCES MATTER
Stop the silent misdiagnosis

Al Mulley, Chris Trimble, Glyn Elwyn

Common Language

Descriptor	Clinician's usage	Lay usage
Very common	>10%	65%
Common	1 - 10%	45%
Uncommon	0.1 - 1%	18%
Rare	0.01 - 0.1%	8%
Very rare	<0.01%	4%

“Illiteracy”

- 1 in 6 adults has “poor literacy skills”
- Of the adult population (16-65):
- 43% lack the literacy skills to cope with typical health information
- (61% for numeracy skills)
- Rises to 57% in age group 16-44
- Up to 96% in the lowest income group.

Research

Gillian Rowlands, Joanne Protheroe, John Winkley, Marty Richardson, Paul T Seed and Rima Rudd

A mismatch between population health literacy and the complexity of health information:

an observational study

Abstract

Background Low health literacy is associated with poorer health and higher mortality. Complex health materials are a barrier to health.

Aim To assess the literacy and numeracy skills required to understand and use commonly used English health information materials, and to describe population skills in relation to these.

Design and setting An English observational study comparing health materials with national working-age population skills.

Method Health materials were sampled using a health literacy framework. Competency thresholds to understand and use the materials were identified. The proportion of the population above and below these thresholds, and the sociodemographic variables associated with a greater risk of being below the thresholds, were described.

Results Sixty-four health materials were sampled. Two competency thresholds were identified: text literacy (47%) and text + numeracy (25/57/95 participants (47%) were below the text-only threshold, while 29/62/67 (47%) were below the text + numeracy threshold. Univariable analysis of social determinants of health showed that those groups more at risk of socioeconomic deprivation had higher odds of being below the health literacy competency threshold than those at lower risk of deprivation. Multivariable analysis resulted in some variables becoming non-significant or reduced in effect.

Conclusion Levels of low health literacy mirror those found in other industrialized countries, with a mismatch between the complexity of health materials and the skills of the English adult working-age population. Those most in need of health information have the least access to it. Efficacious strategies are building population skills, improving health professionals' communication, and improving written health information.

Keywords health information; health literacy; numeracy; primary care; public health.

INTRODUCTION

Health literacy skills are 'the motivation and ability of individuals to access, understand, and use information in ways which promote and maintain good health'.¹ The most fundamental skills are those 'needed ... to function in everyday (health) situations to access and use information'.² Low health literacy is associated with greater use of medical services, less preventive care, greater difficulty managing long-term illnesses,³ lower levels of health,^{3,4} and higher mortality in older people.^{5,6} Levels of health literacy have been surveyed in several industrialised countries, that is, the US, Canada, Australia, and the EU, with the prevalence of low health literacy varying from 29% to 62%.³⁻⁶

Health texts are written at levels that exceed average public readings skills.^{7,8} Finding ways to reduce the mismatch between population skills and health material complexity has been identified as a priority by the US government.^{1,9}

This study sought to explore health literacy skills in an English setting, bringing together expertise from clinical practice, public health, and education. The objectives were to assess a range of health materials, to determine the threshold of health literacy

and numeracy skills needed to understand and use these; and to describe the English working-age population in relation to these thresholds.

METHOD

Health materials in England were purposively sampled using a framework developed to capture literacy and numeracy skills needed to become and stay healthy.¹⁰ This framework has been used in several national health literacy surveys.¹¹⁻¹⁴ Suitable topics within framework areas (for example, within health promotion: how to maintain a healthy weight) were discussed and agreed by the research team. Materials from topics within each framework area were independently sampled. All items were nationally publicly available in health and public libraries or via the internet. The framework, with examples and chosen subjects, is shown in Box 1.

The sampled materials were independently assessed by external experts, that is, people at a senior level (consultant or equivalent) in areas of relevance to health literacy. Health trainers (non-clinical workers providing self-management advice and signposting) were included. Prior knowledge of health

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“Compensation culture”

- How many things “go wrong”?
- c850,000 pa at least (NB inpatient care only), of which 1/2 are avoidable and 1/3 cause serious harm
- Based on c 10% of 8.5m inpatient episodes in 1999
- Now around double that.

- How many clinical negligence claims are there?
- c11,000 in 2023/24 (CNST)

- How quickly are they increasing?
- Actually, declining from peak of c12,000 CNST claims in 2013/14

>90% of those who experienced an adverse event did not sue.

So why do people sue?

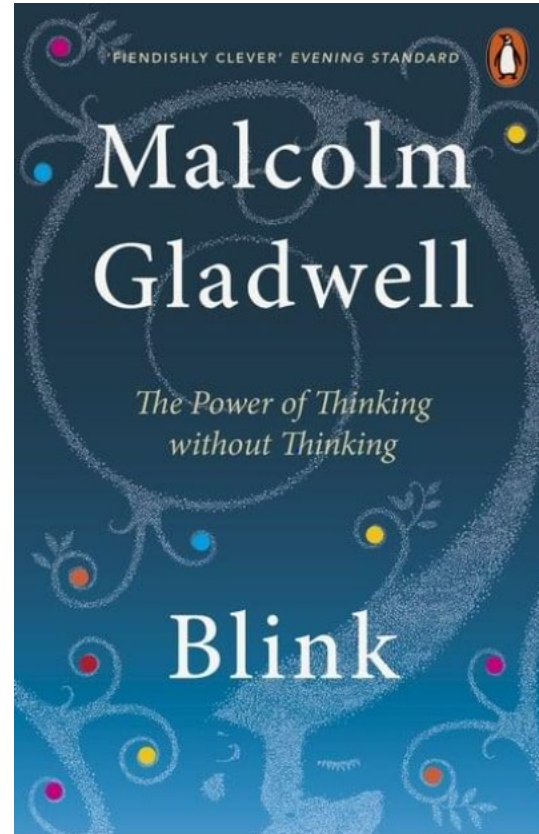


Figure 13. Reasons for making a claim



n= 556

First impressions and feeling heard...



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Children and Young people



Children

- Under 16 years – question of Gillick competence?
- MCA presumes capacity to decide over 16
- But Children Act 1989 gives parental responsibility until age 18
- Role of the Court – eg Re P, 17 year old Paracetamol Overdose (2014); Re X(2) (2021)
- Role of media and social media, especially for infants
- Charlie Gard; Alfie Evans – “zone of exclusive parental responsibility”?

Gillick v Cambridgeshire & Wisbeach HA

- A child of sufficient maturity and understanding can make a decision for themselves, without their parent's involvement
- House of Lords (1985)

1983: Mother loses contraception test case

A mother of 10 has failed to prevent doctors prescribing contraception to under-16s without parental consent.

Victoria Gillick appeared at the High Court seeking a declaration that none of her five daughters - aged 1 to 13 - could be prescribed or advised on birth control until they are 16.

Mr Justice Woolf ruled against her application and also rejected her attempt to prevent the Department of Health and Social Security (DHSS) distributing a circular advising doctors they can give contraception to under-16s without parental consent.

“ Doctors encourage children to be promiscuous ”
Victoria Gillick



Victoria Gillick says she will continue to fight for parental consent to contraception

In Context

Mrs Gillick began a nationwide petition against the DHSS ruling and claimed to have attracted between 250,000 and 500,000 names altogether.

By November 1983 200 MPs were supporting Mrs Gillick's demands.

After securing legal aid Mrs Gillick took the case to the Appeal Court in December 1984 and the

An NHS Foundation Trust v P [2014]

- 17 year old girl who had taken a paracetamol overdose
- Refused medical treatment, but assessed to have capacity
- Mother gave her consent for the treatment, but the hospital trust was reluctant to rely on this where P had capacity
- Out of hours Order made – lawful to override her refusal
- Court used its “inherent jurisdiction”
- If need be to use sedation / restraint to force the treatment – needed over 21 hours
- P’s wishes and feeling important, but not decisive, particularly where her life was in immediate danger.

Children Act 1989

- In any decision to be made by the court about a child:

“the child’s welfare shall be the court’s paramount consideration”... (s1)

Children Act 1989 s3(5)

A person who—

- (a) does not have parental responsibility for a particular child; but
- (b) has care of the child, may ... do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare.

Children (Scotland) Act 1995

- ...a parent has in relation to his child the responsibility—
- (a) to safeguard and promote the child's health, development and welfare;
- Under the age of 18.
- But MCA / AWI Act apply from age 16.



What does the future hold for us....

Welcome to *My Adult – Still My Child*

A GUIDE FOR PARENT/CARERS OF ADULTS (16+)
WHO MAY NOT BE ABLE TO MAKE DECISIONS

Co-produced and inspired by those who have experienced decision making within health and welfare settings and felt unprepared or challenged without such guidance. Welcome to *My Adult- Still My Child* is a website aimed at those new to making Best Interest Decisions and especially those caring for a young person in transition to adult services

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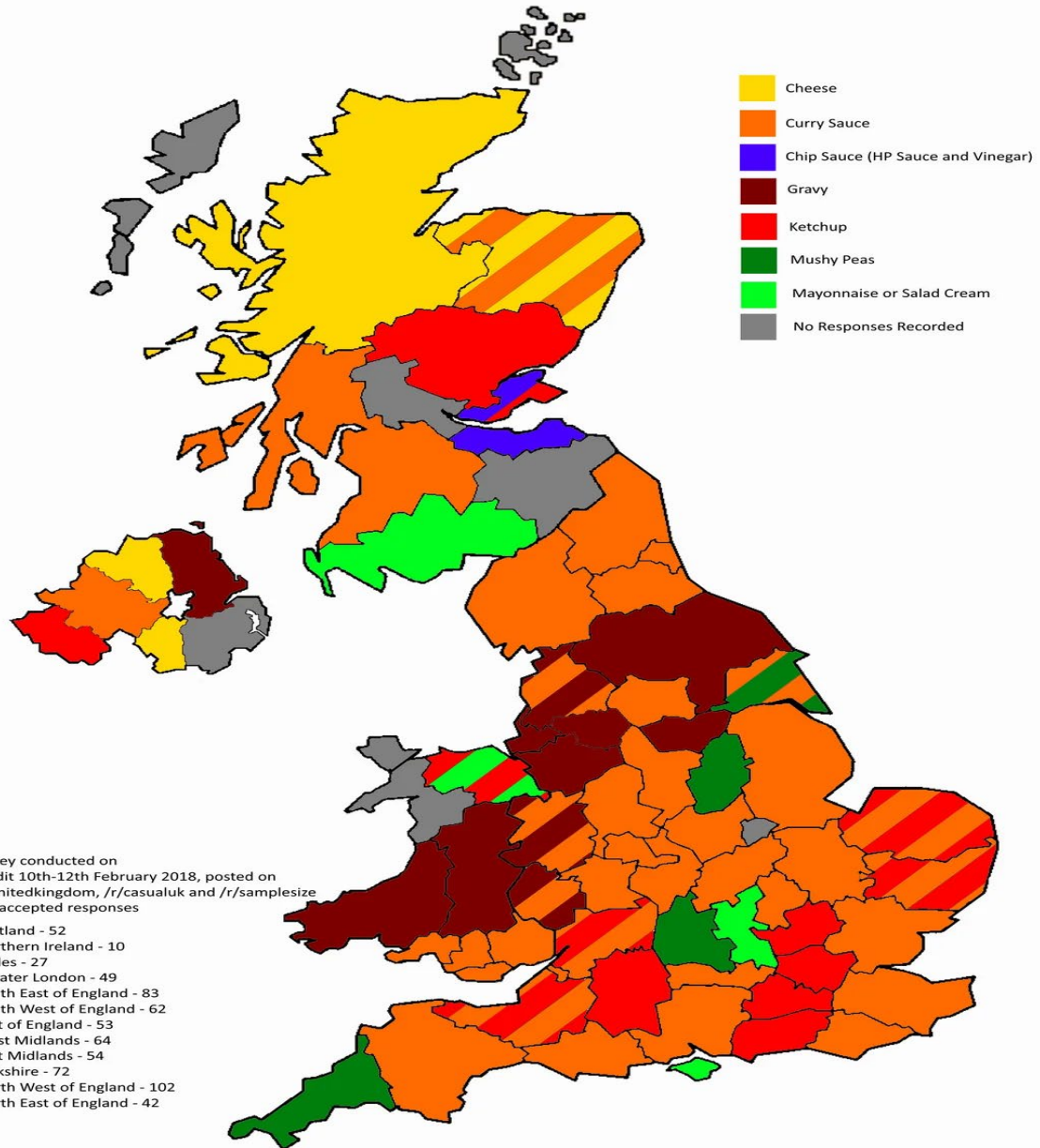
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Mental capacity





The United Kingdom by preferred sauce for chip shop chips



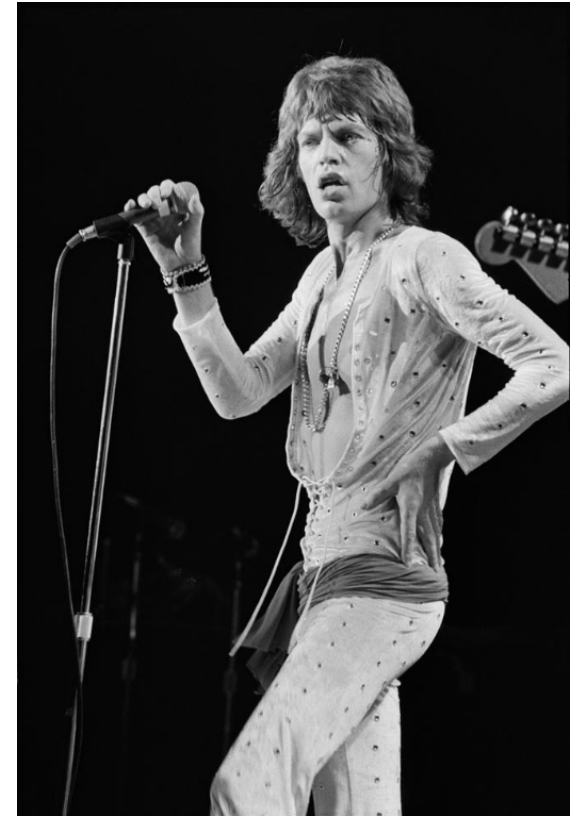
- Adults with Incapacity (Scotland) Act 2000
- Mental Capacity Act 2005 – England & Wales

Capacity – making this decision

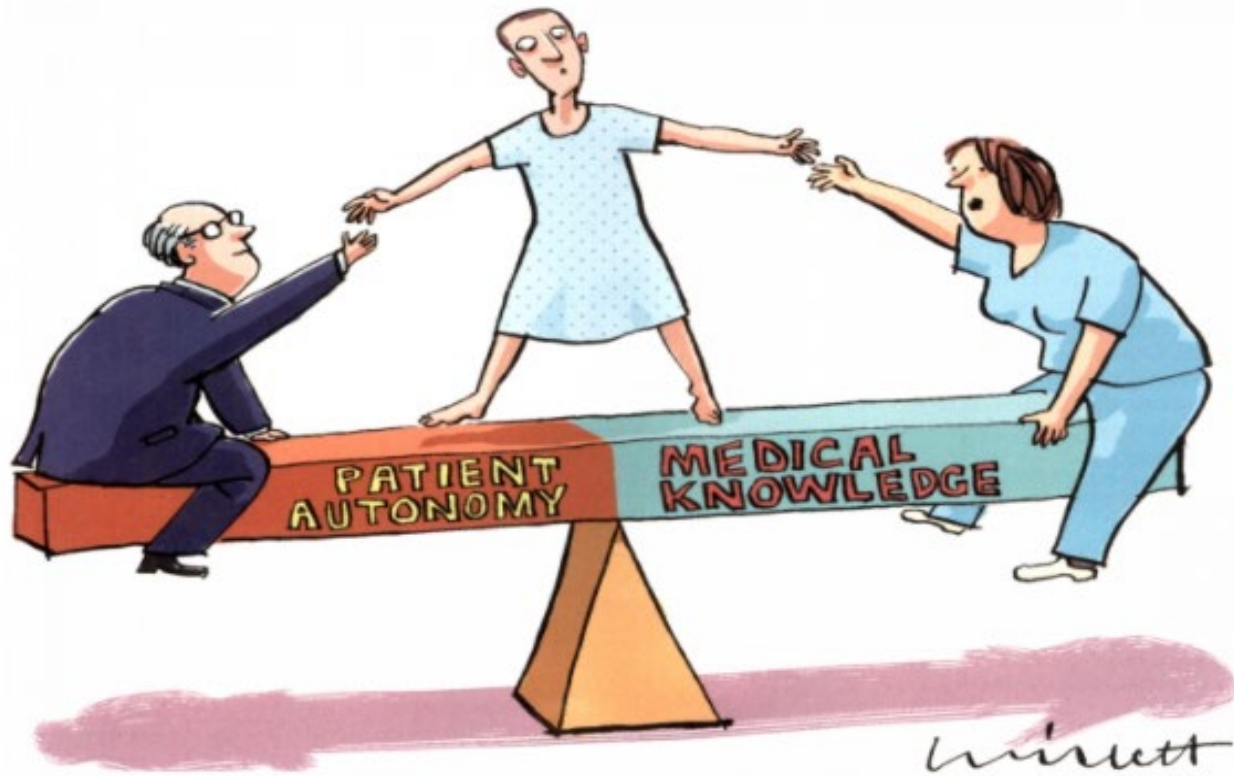


Limited options

- You can't always get what you want...
- Not a matter of best interests - *N v A CCG* (Supreme Court, 2017):
 - 'just like P, the Court can only choose between the "available options"', Baroness Hale
- Can lawfully be limited by:
 - Clinical indication / Clinical willingness (*Burke v GMC*; *AVS*)
 - Resource – availability and allocation



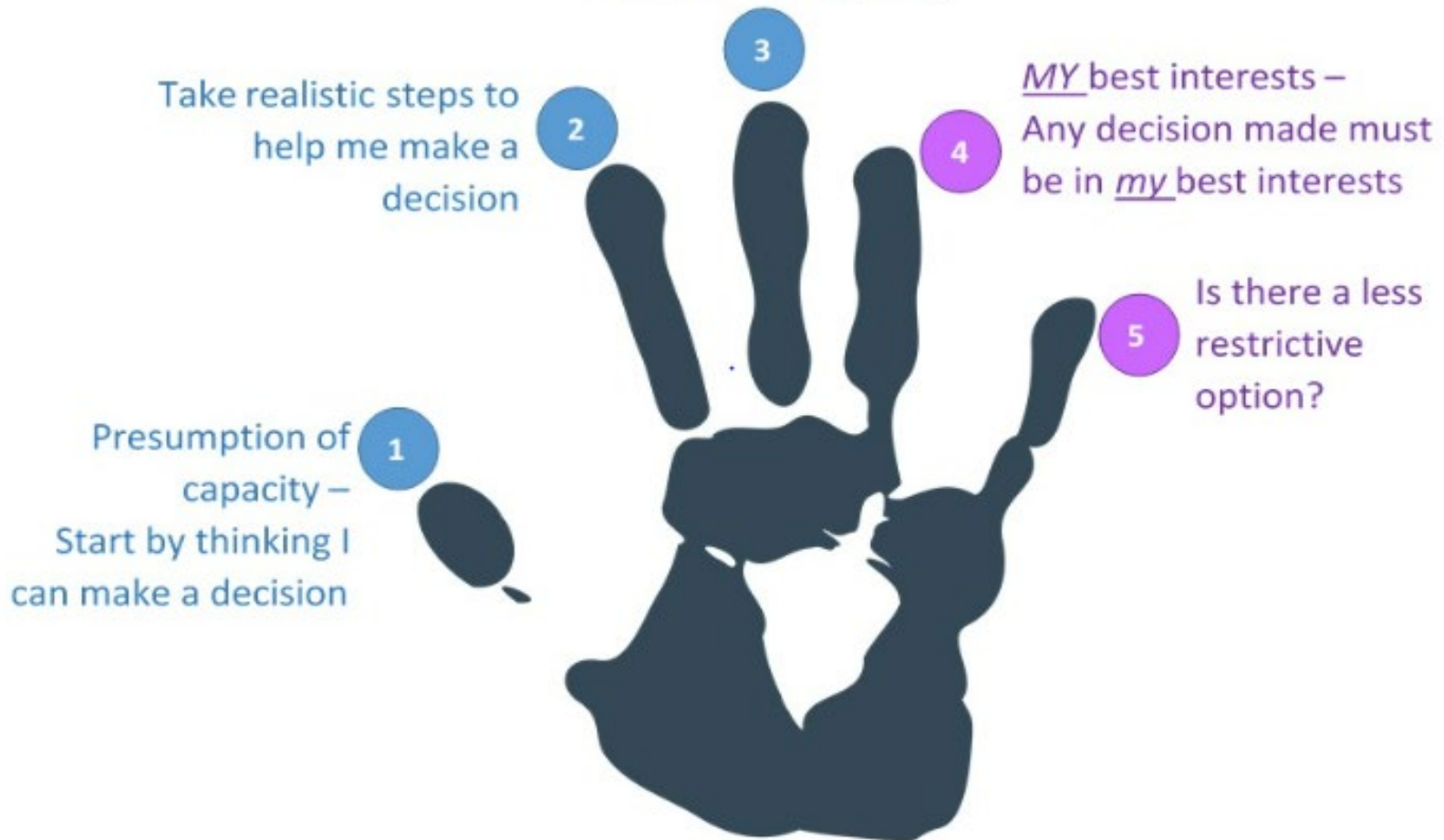
Paternalism v Autonomy



Autonomy v paternalism

- A is refusing an amputation of their gangrenous leg – “I’d rather die with two legs than live with one”...
- B wants to go home after surgery, but family (and social services) think it’s too risky and push for residential care
- C won't willingly come to hospital, though investigation is indicated for worrying bleeding, which could well be (treatable) cancer

Unwise decisions – just because I
make an unwise decision, it doesn't
mean I lack capacity



Bob “lacks capacity”

- Lack of capacity means an inability to make a decision (because unable to understand or retain or weigh information relevant to the decision because of an impairment or disturbance in the functioning of the mind or brain – or (less often) to communicate that decision)
- What decision? – the options
- When? – can it wait?
- Whose decision? – distinguish our offer v their choice

Who decides?

- Patient
- Patient in advance - ADRT
- consent vs refusal vs demands
- Patient's appointee? Ie an LPA
- Court appointee? Ie a "Deputy"
- Or You ?! - S5 MCA rule of thumb
- "Next of Kin"
- The Court

Lasting Power of Attorney

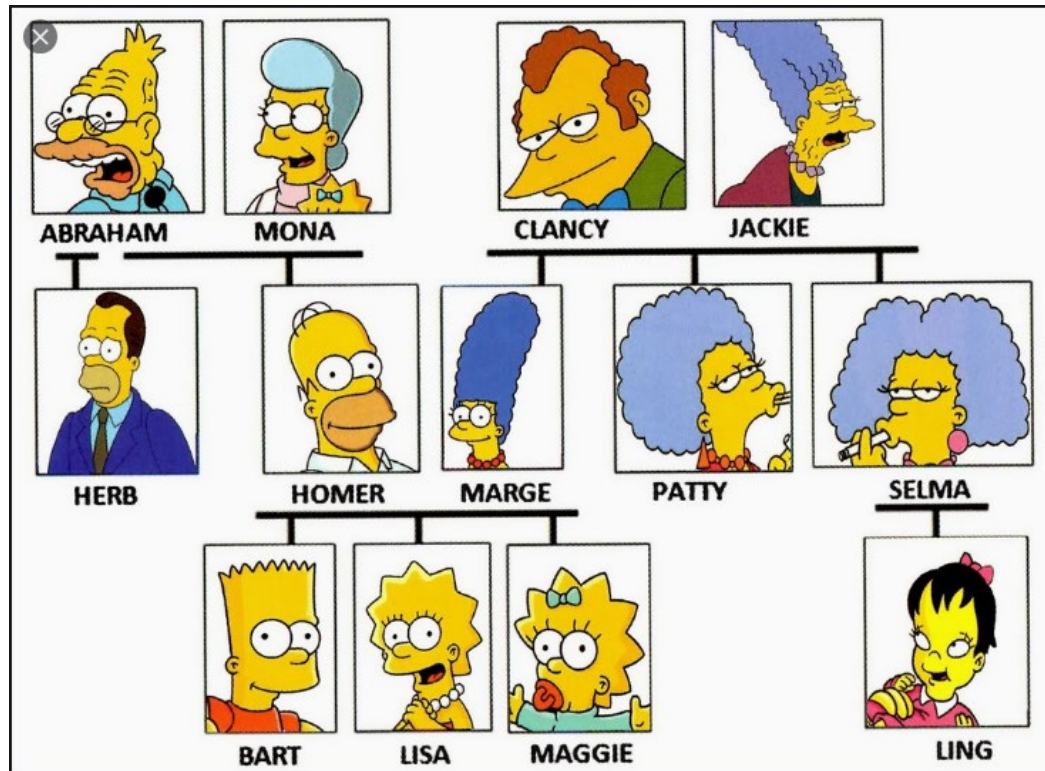
- Appointed by P – over 18 and with capacity to do so
- Can be for health & welfare or for property & finances
- For H&W decisions – P must have lost capacity to make the decision
- Only applies to decisions within scope, and only to life sustaining if explicitly says so
- Only valid if registered with the OPG.
- Only makes the Attorney a best interests decision maker – can still be challenged.

MCA s5

No liability (ie as if treatment with valid consent) if you reasonably believe that P lacks capacity for the relevant decision, and you act in a way you reasonably think is in their best interests

so show your working!

Next of kin...?



Collaborative decision-making

- The decision maker (try the MCA s5 test)
- “Those engaged in caring for P and interested in their welfare” (MCA s4(7))
- And any LPA / deputy
- And P – their own involvement, wishes, values and beliefs (MCA s 4(6))
- And the Court of Protection
- BUT NB – information sharing and confidentiality

Best interests decisions

- “The views of family members, their own wishes, feelings, religious and cultural beliefs, are, in themselves, of little, if any, relevance. I emphasise that their views are being sought solely to illuminate the likely wishes and feelings of P. Their evidence is garnered to assert P’s autonomy, not to subjugate it”.

Compromise is not always good...

“the treatment plan has **an air of compromise** about it, a negotiation between the family and the medical team. There may, sometimes, be a place for that, but not if the person at the centre of it becomes marginalised. P (the protected party) must always be afforded care, which is identifiably in her own best interests. The family's views are relevant only insofar as they provide a conduit for P's own wishes and feelings. **Families, however loving and well-meaning gain no dominion over their dying and incapacitous relatives. The family's role, which is crucial, is to promote and not subvert P's autonomy.**”

There is no such
thing as “Next of Kin”

Best interests

- Limited by the available options
- MCA s4 – people to consult and things to take into account
- Widest possible view – not just best clinical outcome, and taking P’s point of view.
- Munby LJ – “what use is it making someone safe if it only makes them miserable?”
- Role of the Court of Protection

Adults with Incapacity (Scotland) Act 2000

- Applies over age 16
- No intervention unless it will benefit P
- Least restrictive option consistent with the purpose
- Wishes of the person / views of the “nearest relative” (tied to the Mental Health (Care and Treatment) (Scotland) Act 2003 definition)
- Welfare power of attorney or Guardian

Incapable of

- (a) acting; or
- (b) making decisions; or
- (c) communicating decisions; or
- (d) understanding decisions; or
- (e) retaining the memory of decisions,
- as mentioned in any provision of this Act, by reason of mental disorder or of inability to communicate because of physical disability

AWI – medical treatment

- S47 – Doctor* can certify incapacity about treatment – for up to one year
- Gives “authority to do what is reasonable in the circumstances ... to safeguard or promote the health...”
- Does not authorise use of force or detention unless “immediately necessary”
- Or application to Sheriff
- Or use of powers of a Guardian

Summary

- What is the decision? Available options?
- Whose decision is it?
- Available options is key - defines the information relevant to be given to the patient – both for purposes of consent and for assessing capacity
- Cannot force clinicians / carers to offer what they do not want to
- “Best interests” / “benefit” – like choice for capacitous patient – can only be among available options – autonomy has limits
- Collaboration in decision making is good – compromise of P’s best interests / benefit is not.
- The Court can resolve disputes – **do not delay**.

**A PRACTICAL GUIDE TO
THE LAW OF MEDICAL
TREATMENT DECISIONS**



BEN TROKE
Law Brief Publishing 

<http://www.lawbriefpublishing.com/product/medicaltreatmentdecisions/>

**All proceeds to the
Alzheimer's Society**

Any Questions?

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