Market Street Medical Practice

Consent to Examination or Treatment Policy

1. Introduction

It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a person. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice. A healthcare professional (or other healthcare staff) who does not respect this principle may be liable both to legal action by the patient and to action by their professional body. Employing bodies may also be liable for the actions of their staff.

This policy sets out the standards and procedures in this Practice which aim to ensure that health professionals are able to comply with the guidance.

2. Defining Consent

"Consent" is a patient's agreement for a health professional to provide care. Patients may indicate consent:

- non-verbally (for example by presenting their arm for their pulse to be taken)
- orally
- in writing

For the consent to be valid it must be voluntary and informed, and the person consenting must have the capacity to make the decision. These terms are explained below:

- **Voluntary** – the decision to either consent or not to consent to treatment must be made by the person themselves, and must not be influenced by pressure from medical staff, friends or family.
- **Informed** – the person must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments and what will happen if treatment does not go ahead.
- **Capacity** – the person must be capable of giving consent, which means they understand the information given to them, and they can use it to make an informed decision

The context of consent can take many different forms, ranging from the active request by a patient of a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice.
In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them.
Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.

2a. For children under 16 (except for those who have Gillick Competence – see below), someone with parental responsibility should give consent on the child's behalf by signing accordingly on the Consent Form.

2b. Children under 16 may be deemed to be 'Gillick competent' to consent for themselves to medical treatment, research, donation etc because they have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention. The concept of Gillick competence stems from an important case in law and reflects a child's increasing development to maturity. The understanding required for different interventions will vary considerably and a child under 16 may have the capacity to consent to some interventions but not to others. The child's capacity to consent should be assesses carefully in relation to each decision that needs to be made and training undertaken by practice staff will support this.

2c. Young People aged 16-17 are presumed to be capable of consenting to their own medical treatment unless there is sufficient evidence to suggest otherwise. As for adults consent will only be valid if it is given voluntarily by an appropriately informed young person capable of consenting to the particular intervention.

2d. Where an adult lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves**, no-one else can give consent on their behalf.** However, treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable advance directive.

Reference guide to consent for examination or treatment (second edition) provides a comprehensive summary of the current law on consent and overruling refusal and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. This may be accessed on the internet at:
https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition

3. Documentation

For significant procedures, it is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussions which led up to that agreement. This may be done either through the use of a consent form (with further detail in the patient's notes if necessary), or through documenting in the patient's notes that they have given oral consent.

4. Written Consent

Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is *evidence* that the patient has given consent, but is not *proof* of valid consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract.

It is rarely a legal requirement to seek written consent, but it is good practice to do so if any of the following circumstances apply:

- the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications')
- the procedure involves general/regional anaesthesia or sedation
- providing clinical care is not the primary purpose of the procedure
- there may be significant consequences for the patient's employment, social or personal life

If the patient is unable to read or write, that person may be able to make their mark on the form to indicate consent. It would be good practice for the mark to be witnessed by a person other than the clinician/practitioner seeking consent, and for the fact that the person has chosen to make their mark in this way to be recorded in the case notes. Similarly, if the individual has capacity, and wishes to give consent, but is physically unable to mark the form, this fact should be recorded in the notes, or on the consent form.

Completed forms should be kept with the patient's notes.

It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if the health professional has any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past), it would be prudent to do so.

5. Procedures to Follow When Patients Lack Capacity to Give or Withhold Consent

Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented, along with the assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's **best interests**, and the involvement of people close to the patient. The standard consent forms should never be used for adult patients unable to consent for themselves. For more minor interventions, this information should be entered in the patient's notes.

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. Appropriate colleagues should be involved in making such assessments of incapacity, such as specialist learning disability and speech and language therapists, unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal ways where appropriate.

Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. Where the consequences of having, or not having, the treatment are potentially serious, a court declaration may be sought.

6. Who is Responsible for Seeking Consent?

The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.

Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will naturally be done by the health professional responsible. However, team work is important and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent. If the person cannot write or is physically unable to sign a form, a record that the person has given verbal or non –verbal consent should be made in their notes or on the consent form.

7. Completing Consent Forms

The standard consent form provides space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: either because they themselves carry out the procedure, or

because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

8. Immunisations

Informed consent must be obtained prior to giving an immunisation. Although there is no legal requirement for consent to immunisation to be in writing, a signature on a consent form is not conclusive proof that consent has been given, but serves to record the decision and discussions that have taken place with the patient, or the person giving consent on a child's behalf.

9. Withdrawing Consent

A person with capacity is entitled to withdraw consent at any time, including during the performance of a procedure. Where a person does object during treatment, it is good practice for the practitioner, if at all possible, to stop the procedure, establish the person's concerns and explain the consequences of not completing the procedure.

A Withdrawal of Patient Consent Form will be required to be completed and the withdrawal of consent will be documented on the patient's medical record. If a patient is mentally competent to withdraw consent but is physically unable to sign the form, the clinician should complete the form as usual, and ask an independent witness to confirm that the patient has confirmed they wish to withdraw their consent orally or non-verbally.

10. Training

All clinical and management staff in the Practice will undergo annual training in consent. This will normally be through undertaking the Blue Stream Consent module which covers: when consent is needed, provision of information, refusal of treatment and the legal background.