**DR. SHARMA’S PRACTICE**

**BILSTON HEALTH CENTRE, PROUDS LANE,**

**BILSTON, WEST MIDLANDS WV14 6HY**

**Policy for the Consent to Examination or Treatment**

**Policy Ref :**

**Policy Statement:**

This policy sets out the standards and procedures in the practice, which aim to ensure that health professionals are able to comply with Department of Health guidance.

**This Policy Relates to**:

Documentation, When should consent be sought? Provision of information, Who is responsible for seeking consent? Refusal of treatment, Tissue, Clinical photography and conventional or digital video recordings, Training.

**Implementation Date:** April 2005

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**Managerial Responsibility:**  Practice Manager

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**I Introduction**

##### Why consent is crucial

1. Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health professionals and patients.

##### This policy

2. The Department of Health has issued a range of guidance documents on consent (see overleaf), and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards and procedures in the practice, which aim to ensure that health professionals are able to comply with the guidance. While this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

##### What consent is – and isn’t

3. “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, or in writing. For the consent to be valid, the patient must:

• Be competent to take the particular decision;

• have received sufficient information to take it; and

• Not be acting under duress.

4. 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.

5. Where an adult patient 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. For further details on advance directives see the Department of Health’s *Reference guide to consent for examination or treatment* (chapter 1, paragraph 19).

##### Guidance on consent

6. The Department of Health has issued a number of guidance documents on consent, and these should be consulted for advice on the current law and good practice requirements in seeking consent. Health professionals must also be aware of any guidance on consent issued by their own regulatory bodies.

**II Documentation**

1. 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.

##### Written consent

1. 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.
2. Where written consent is required the Practice Manager will make available a consent form designed specifically for the purpose required.

**III When should consent be sought?**

1. When a patient formally gives their consent to a particular intervention, this is only the *endpoint* of the consent process. It is helpful to see the whole process of information provision, discussion and decision-making as part of ‘seeking consent’. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness of what is proposed and the urgency of the patient’s condition.

###### Single stage process

2. In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient, e.g vaccination, joint injection, etc. In many such cases, consent will be given orally.

###### Emergencies

3. Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) will follow straight on from each other, and it may often be appropriate to use the patient’s notes to document any discussion and the patient’s consent, rather than using a form. The urgency of the patient’s situation may limit the quantity of information that they can be given, but should not affect its quality.

###### Treatment of young children

4. When babies or young children are being cared for consent is required.

5 Only people with ‘parental responsibility’ are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children (for example, unmarried fathers do not automatically have such responsibility although they can acquire it). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

**Treatment of Children and Young Adults**

1. Valid consent is just as important when treating children and young people as it is with adults. In some situations children are able to give consent themselves, and sometimes others need to take the decision on their behalf.
2. When caring for children, you have an overriding duty to act in the best interests of the child. When making decisions regarding treatment, the child or young person should be involved in the decision as much as possible, depending on their level of understanding.

**Young People - Aged 16 and 17**

1. A child’s affirmative consent (assent) to investigation or treatment deemed in their best interests, having achieved the age of 16, cannot be overruled by anyone with parental responsibility, although the court may in its capacity as parens patriae. In fact, Lord Donaldson MR, summarises that: “A minor of any age who is ‘Gillick competent’ in the context of particular treatment has the right to consent to that treatment, which again cannot be overridden by those with parental responsibility, but can be overridden by the court…”.

**Younger than 16**

1. Children under 16 can consent to medical treatment if they understand what is being proposed. It is up to the doctor to decide whether the child has the maturity and intelligence to fully understand the nature of the treatment, the options, the risks involved and the benefits.
2. A child who has such understanding is considered Gillick competent (or Fraser competent). The parents cannot overrule the child’s consent when the child is judged to be Gillick competent. For example, a 15-year-old Gillick competent boy can consent to receiving tetanus immunisation even if his parents do not agree with it.
3. Children under 16 who are not Gillick competent and very young children cannot either give or withhold consent. Those with parental responsibility need to make the decision on their behalf.
4. In an emergency situation, when a person with parental responsibility is not available to consent, the doctor has to consider what the child’s best interests are and then act appropriately. The treatment should be limited to what is reasonably required to deal with the particular emergency. Wherever possible, it is advisable to discuss the case with a senior colleague, if available. In all cases, it is important to document fully what decisions were made and why.

**What happens if the child withholds consent?**

1. If the child is not Gillick competent, the parents can consent on behalf of the child, even if the child is refusing the treatment. However, you should consider carefully whether overriding the consent of a distressed child, given the clinical circumstances at the time, is necessary. Often, if sufficient time is given, the parents will be able to encourage the child that the intervention will be beneficial. You should aim to work in partnership with the parents, assuming that the child’s best interests are paramount.
2. A competent child is legally entitled to withhold consent to treatment. However, even though the child or young person may be considered to be Gillick competent, there are some situations where their refusal can be overridden by those with parental responsibility. If the treating doctor believes that the withholding of consent may be detrimental to the patient’s wellbeing, legal advice may be required. It may be necessary for a court to determine whether treatment can be given against the wishes of the competent young person.
3. Patients aged 16-17 can withhold consent to treatment, but this can be overruled in exceptional circumstances if it is considered to be in their best interests, either by someone with parental responsibility or by the courts.

**What happens if the parents withhold consent?**

1. If a competent child refuses treatment and his/her parents agree with the decision, but you do not believe that it is in the best interests of the child, you should take legal advice on how to proceed.
2. The same principle applies if the parents of a noncompetent child choose to withhold consent for what you believe to be necessary treatment. You are obliged to act in the child’s best interests and these situations, whilst rare, will likely be fraught and legal advice should be sought. Working with the child and family to overcome the issues would be appropriate

**IV Provision of information**

1. The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments/investigations and their risks and benefits (including the risks/benefits of doing nothing). Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen and how they will feel afterwards and so on.

**Provision for patients whose first language is not English**

1. The practice is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to use children to interpret for family members who do not speak English.

Translation and interpreting services are available.

**V Who is responsible for seeking consent?**

1. The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely giving consent: it is they who will be held responsible in law if this is challenged later.

2. 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 a crucial part of the way the NHS operates, 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.

###### Completing consent forms

3. Consent form will 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.

4. If the patient signs the form in advance of a procedure the health professional involved in their care on the day should sign the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

###### Responsibility of health professionals

5. It is a health professional’s own responsibility:

• To ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and

• To work within their own competence and not to agree to perform tasks which exceed that competence.

**VI Refusal of treatment**

1. If the process of seeking consent is to be a meaningful one, refusal must be one of the patient’s options.

2. If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, you (and where possible the patient) should note this on the form.

3. Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

4. If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient the possible consequences of their partial refusal. If you genuinely believe that the procedure cannot be safely carried out under the patient’s stipulated conditions, you are not obliged to perform it. You must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, you must on request be prepared to transfer the patient’s care to that health professional.

Appendix

**12 key points on consent: the law in England**

###### When do health professionals need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent.

2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: “can this patient understand and weigh up the information needed to make this decision?” Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.

3. Patients may be competent to make some health care decisions, even if they are not competent to make others.

4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

###### Can children give consent for themselves?

5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, some-one with parental responsibility must give consent on the child’s behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent **cannot** over-ride that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

###### Who is the right person to seek consent?

6. It is always best for the person actually treating the patient to seek the patient’s consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

###### What information should be provided?

7. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.

8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

###### Does it matter how the patient gives consent?

9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient’s decision, and also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.

###### Refusal of treatment

10. Competent adult patients are entitled to refuse treatment, even when it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the fetus.

###### Adults who are not competent to give consent

11. **No-one** can give consent on behalf of an incompetent adult. However, you may still treat such a patient if the treatment would be in their best interests. ‘Best interests’ go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient’s needs and preferences.

12. If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an ‘advance refusal’), and those circumstances arise, you must abide by that refusal.