



Emergency Doctors Medical Services Organisational & Operational Policy (OOP)

Policy Title	Consent to Care and Treatment
Policy Number	EDOOP.015
Purpose	To ensure a robust and structured framework exists for gaining appropriate consent to care and treatment and to clarify procedures for emergencies where explicit consent cannot be gained.
Author	Dr Anup Mathew – Clinical Director
Responsible officer/s	Dr Aaron Pennell – Clinical Director James Callaghan - Operations Director
For use by	All Clinical Staff
This policy complies with or has been guided by	Health and Social Care Act 2008 Guidance about Compliance, Essential Standards of Quality and Safety, Care Quality Commission, March 2010, HMSO Good Practice in consent implementation guide. Consent to examination or treatment. Department of Health
CQC outcome compliant	CQC Outcome 2
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Equal Opportunities, Health and Safety, Employment conduct and Professional Liabilities Assessment:	
<p>EDMS has ensured given every reasonable means and with the information available at this time that this policy will not discriminate either directly or indirectly in any way against employees, patients or customers on the grounds of race, religion, colour, age, gender or sexual orientation, disability, marital status or culture. EDMS has assessed this policy in terms of current health and safety guidance and has ensured that where requirements have been stipulated these are met. EDMS has ensured that it holds appropriate insurance for this policy to be fully endorsed. EDMS has assessed this policy for any impact it may have on corporate or individual professional requirements and conduct and has ensured any such impact meets with the approval of any professional bodies it may encounter. This policy can be made available in Braille or voice recording and can be translated into other languages</p>	

Executive Summary and background:

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. For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question (this will be the patient or someone with parental responsibility for a patient under the age of 18, someone authorised to do so under a Lasting Power of Attorney (LPA) or someone who has the authority to make treatment decisions as a court appointed deputy). Acquiescence where the person does not know what the intervention entails is not 'consent'.

The Human Rights Act 1998 came into force in October 2000, giving further effect in the UK to the rights enshrined in the European Convention on Human Rights. All public authorities are required to act in accordance with the rights set out in the Human Rights Act, and all other statutes have to be interpreted by the courts so far as possible in accordance with those rights. The main articles that are likely to be relevant in medical case law are Article 2 (protection of the right to life), Article 3 (prohibition of torture and inhuman or degrading treatment or punishment), Article 5 (the right to liberty and security), Article 8 (the right to respect for private and family life), Article 9 (freedom of thought, conscience and religion), Article 12 (the right to marry and found a family) and Article 14 (prohibition of discrimination in the enjoyment of Convention rights).

This policy is part of Emergency Doctors Medical Services (EDMS) compliance with its responsibilities under the Health and Social Care Act 2008. It outlines how AMS will ensure the requirements to consent to care and treatment are met for all its service users.

What is 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, 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.

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 professionals 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. Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for him or herself, in principle one adult may not provide consent for the medical treatment of another adult. There are however some exemptions under the mental health act. 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 advanced decision and must be the least restrictive intervention. For further details on advanced decisions see the Department of Health's *Reference guide to:*

consent for examination or treatment (chapter 1, paragraph 19) <http://www.dh.gov.uk> & The Mental Capacity Act Code of Practice. <http://www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf>

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 unless an emergency
- 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
- The treatment is part of a project or programme of research being conducted by EDMS

Completed forms should be kept with the clinical record and a copy should be offered to the patient. 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 you have 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 helpful to do so.

Procedures for when patients lack capacity to give or withhold consent:

Where an adult patient does not have the capacity to give or withhold consent to investigation or treatment, this fact should be documented along with the assessment of the patient's capacity and 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 EDMS 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 clinical record.

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity (this will clearly not apply if the patient is unconscious). You should involve appropriate colleagues in making such assessments of capacity 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. Where a communication difficulty arises because the patient does not have sufficient command of the English language, then the support of interpreters should be provided and a record of this should be recorded. 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 is potentially serious, a court declaration may be sought.

Emergencies:

In an emergency the clinical team may progress such treatments as is necessary to preserve life, prevent deterioration and to relieve suffering without explicit consent so long as there is no previous statement made by the patient to withhold consent as only so far as to save life and stabilise the patient. This applies to adults and children of all ages.

When do health professionals need consent from patients?

There are 12 key points regarding consent in the UK

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.

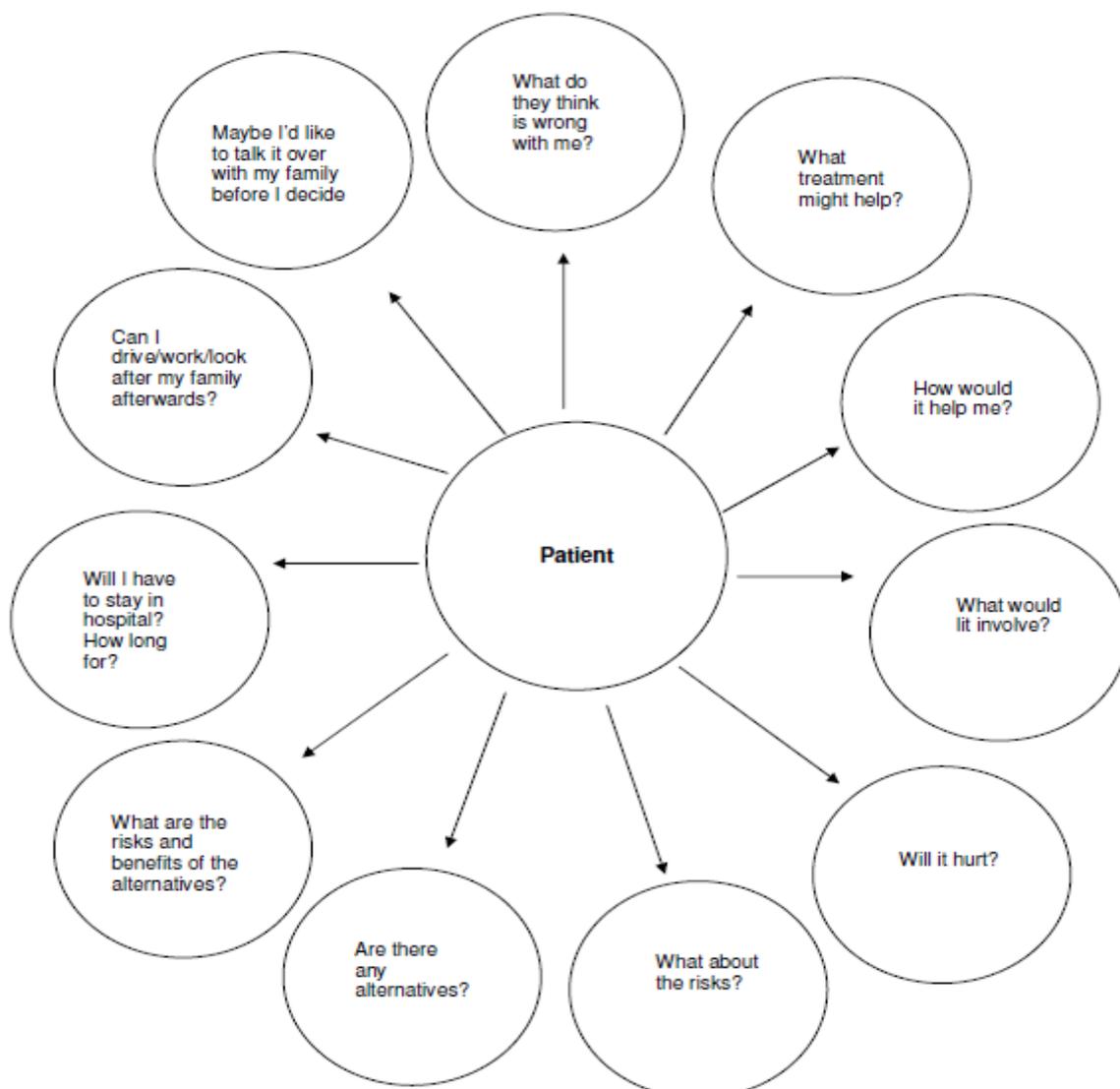
Refusal of treatment

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 save the two exceptions under the Mental Capacity Act 2005. 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.

Seeking consent: remembering the patient's perspective



Young people aged 16–17:

By virtue of section 8 of the Family Law Reform Act 1969, people aged 16 or 17 are presumed to be capable of consenting to their own medical treatment, and any ancillary procedures involved in that treatment, such as an anaesthetic. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed young person capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent person aged 16–17 may in certain circumstances be overridden by either a person with parental responsibility or a court. Section 8 of the Family Law Reform Act 1969 applies only to the young person's own treatment. It does not apply to an intervention that is not potentially of direct health benefit to the young person, such as blood donation or non-therapeutic research on the causes of a disorder. However, a young person may be able to consent to such an intervention under the standard of Gillick competence, considered below.

In order to establish whether a young person aged 16 or 17 has the requisite capacity to consent to the proposed intervention, the same criteria as for adults should be used. If a young person lacks capacity to consent because of an impairment of, or a disturbance in the functioning of, the mind or brain then the Mental Capacity Act 2005 will apply in the same way as it does to those who are 18 and over. If however they are unable to make the decision for some other reason, for example because they are overwhelmed by the implications of the decision, then the Act will not apply to them and the legality of any treatment should be assessed under common law principles. It may be unclear whether a young person lacks capacity within the meaning of the Act. In those circumstances, it would be prudent to seek a declaration from the court.

If the 16/17-year-old is capable of giving valid consent then it is not legally necessary to obtain consent from a person with parental responsibility for the young person in addition to the consent of the young person. It is, however, good practice to involve the young person's family in the decision-making process – unless the young person specifically wishes to exclude them – if the young person consents to their information being shared.

Children under 16 – the concept of Gillick competence

In the case of *Gillick*, the court held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention. This is sometimes described as being 'Gillick competent'. A child of under 16 may be Gillick competent to consent to medical treatment, research, donation or any other activity that requires their consent. The concept of Gillick competence is said to reflect a child's increasing development to maturity. The understanding required for different interventions will vary considerably. Thus 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 assessed carefully in relation to each decision that needs to be made. In some cases, for example because of a mental disorder, a child's mental state may fluctuate significantly, so that on some occasions the child appears Gillick competent in respect of a particular decision and on other occasions does not. In cases such as these, careful consideration should be given as to whether the child is truly Gillick competent at the time that they need to take a relevant decision.

If the child is Gillick competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. It is, however, good practice to involve the child's family in the decision-making process, if the child consents to their information being shared. e. If the child seeks advice or treatment in relation to abortion and cannot be persuaded to inform her parent(s), every effort should be made to help the child find another adult (such as another family member or a specialist youth worker) to provide support to the child.

The requirement of voluntariness

Although a child or young person may have the capacity to give consent, this is only valid if it is given voluntarily. This requirement must be considered carefully. Children and young people may be subject to undue influence by their parent(s), other carers or a sexual partner (current or potential), and it is important to establish that the decision is that of the individual him or herself.

Child or young person with capacity refusing treatment

Where a young person of 16 or 17 who could consent to treatment in accordance with section 8 of the Family Law Reform Act 1969, or a child under 16 but Gillick competent, refuses treatment, it is possible that such a refusal could be overruled if it would in all probability lead to the death of the child/young person or to severe permanent injury. Where the treatment involved is for mental disorder, consideration should be given to using mental health legislation.

The changes made to section 131 of the Mental Health Act 1983 by section 43 of the Mental Health Act 2007 mean that when a young person of 16 or 17 has capacity (as defined in the Mental Capacity Act 2005) and does not consent to admission for treatment for mental disorder (either because they are overwhelmed, do not want to consent or refuse to consent), they cannot then be admitted informally on the basis of the consent of a person with parental responsibility (see chapter 36 of the Code of Practice to the Mental Health Act 1983, as amended 2008)

A life-threatening emergency may arise when consultation with either a person with parental responsibility or the court is impossible, or the person with parental responsibility refuses consent despite such emergency treatment appearing to be in the best interests of the child. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life, and it will be acceptable to undertake treatment to preserve life or prevent serious damage to health.

Child lacking capacity

Where a child under the age of 16 lacks capacity to consent (ie is not Gillick competent), consent can be given on their behalf by any one person with parental responsibility (if the matter is within the 'zone of parental control' or by the court. As is the case where patients are giving consent for themselves, those giving consent on behalf of child patients must have the capacity to consent to the intervention in question, be acting voluntarily and be appropriately informed. The power to consent must be exercised according to the 'welfare principle': that the child's 'welfare' or 'best interests' must be paramount. Even where a child lacks capacity to consent on their own behalf, it is good practice to involve the child as much as possible in the decision making process. Where necessary, the courts can overrule a refusal by a person with parental responsibility. It is recommended that certain important decisions, such as sterilisation for contraceptive purposes, should be referred to the courts for guidance, even if those with parental responsibility consent to the operation going ahead.

The Children Act 1989 sets out persons who may have parental responsibility. These include:

1. The child's mother
2. The child's father, if he was married to the mother at the time of birth
3. Unmarried fathers, who can acquire parental responsibility in several different ways:
 - for children born before 1 December 2003, unmarried fathers will have parental responsibility if they: marry the mother of their child or obtain a parental responsibility order
 - from the court register a parental responsibility agreement with the court or by an application to court
 - For children born after 1 December 2003, unmarried fathers will have parental responsibility if they: register the child's birth jointly with the mother at the time of birth
 - re-register the birth if they are the natural father _marry the mother of their child or obtain a parental responsibility order from the court register with the court for parental responsibility
4. The child's legally appointed guardian
5. A person in whose favour the court has made a residence order concerning the child
6. A local authority designated in a care order in respect of the child
7. When babies or young children are being cared for in hospital

Summary of procedures for EDMS staff regarding consent:

1. In an emergency in order to save life and stabilise the patient you may initiate treatment without specific informed consent. This applies to patients who lack the capacity for whatever reason to give consent. You must document fully your actions on the clinical report form
2. Children and young people can give consent so long as you are satisfied that they have the mental capacity to do so. If a young person with capacity gives consent this cannot be overridden by a person with parental responsibility
3. If a child or young person withholds consent a person with parental responsibility can override this
4. For the majority of processes during assessment and treatment of patients while covering events and other medical support duties, verbal consent is sufficient for the vast majority of cases
5. For more complex procedures you should gain consent and use a consent form as evidence of this process.

End

Appendix – EDMS Consent Form