

Eastville Medical Practice Consent Protocol

INTRODUCTION

The purpose of this protocol is to set out the Practice's approach to consent and the way in which the principles of consent will be put into practice. It is not a detailed legal or procedural resource due to the complexity and nature of the issues surrounding consent.

Where possible, a clinician must be satisfied that a patient understands and consents to a proposed treatment, immunisation or investigation. This will include the nature, purpose, and risks of the procedure, if necessary by the use of drawings, interpreters, videos or other means to ensure that the patient understands, and has enough information to give 'Informed Consent'.

Implied Consent

Implied consent will be assumed for many routine physical contacts with patients. Where implied consent is to be assumed by the clinician, in all cases, the following will apply:

- The clinician will explain to the patient what s/he is about to do, and why.
- The explanation will be sufficient for the patient to understand the procedure.
- In all cases requiring an intimate physical examination a verbal confirmation of consent will be obtained and briefly entered into the medical record. A chaperone will also be offered and this will be documented (see Chaperone Policy).
- Where there is a significant risk to the patient an "Expressed Consent" will be obtained in all cases (see below).

Expressed Consent

Expressed consent (written or verbal) will be obtained for any procedure which carries a risk that the patient is likely to consider as being substantial. A note will be made in the medical record detailing the discussion about the consent and the risks. A Consent Form may be used for the patient to express consent (see below).

Obtaining Consent

- Consent (Implied or Expressed) will be obtained prior to the procedure.

- The clinician will ensure that the patient is competent to provide a consent (16 years or over) or has “Gillick Competence” if under 16 years. Further information about obtaining consent for children is set out below, as is information on obtaining consent from an adult patient who lacks capacity/is not competent to give consent.
- Consent will include the provision of all information relevant to the treatment.
- Questions posed by the patient will be answered honestly, and information necessary for the informed decision will not be withheld unless there is a specific reason to withhold. In all cases where information is withheld then the decision will be recorded in the clinical record.
- The person who obtains the consent will be the person who carries out the procedure.
- The person obtaining consent will be fully qualified and will be knowledgeable about the procedure and the associated risks.
- The scope of the authority provided by the patient will not be exceeded unless in an emergency.
- The Practice acknowledges the right of the patient to refuse consent, delay the consent, seek further information, limit the consent, or ask for a chaperone.
- Clinicians will use a Consent Form where procedures carry a substantial degree of risk or where, for other reasons, they consider it appropriate to do so.
- No alterations will be made to a Consent Form once it has been signed by a patient.
- Clinicians will ensure that consents are freely given and not under duress (e.g. under pressure from other present family members etc.).
- If a patient is mentally competent to give consent but is physically unable to sign the Consent Form, the clinician should complete the Form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.
- In certain circumstances, refusal of consent will be reviewed as appropriate (e.g. if a cervical smear has been refused once this does not count as a permanent refusal and the patient will be given the option of a smear again the next time it is due).

Other aspects which may be explained by the clinician include:

- Details of the diagnosis, prognosis, and implications if the condition is left untreated
- Options for treatment, including the option not to treat.
- Details of any subsidiary treatments (e.g. pain relief).

- Patient experiences during and after the treatment, including common or potential side effects and the recovery process.
- Probability of success and the possibility of further treatments.
- The option of a second opinion.

Immunisations

Informed consent must be obtained prior to giving an immunisation. There is no legal requirement for consent to immunisation to be in writing. Doctors and Nurses will generally record verbal consent in the patient's records, unless they feel that completion of a Consent Form is necessary (as detailed above).

Consent for children

Everyone aged 16 or over is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him/her to understand fully what is proposed" (known as Gillick Competence), then s/he will be competent to give consent for him/herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign a Consent Form for themselves, but may like a parent to countersign as well. Competency should be assessed by a clinician during an appointment.

For children under 16 (except for those who have Gillick Competence as noted above), someone with parental responsibility should give consent on the child's behalf by signing accordingly on the Consent Form, or giving verbal consent (as above for immunisations).

Legally, parental responsibility applies to:

- The child's parents, if married at the time of conception or birth.
- The child's mother if the parents are not married, unless the father has obtained legal parental responsibility (evidence of such is required).
- The child's legally appointed guardian (evidence required).
- A person with a court residence order concerning the child (evidence required).
- A local authority designated in a child's care order (evidence required).
- A local authority or other authorised person who holds an emergency protection order in respect of the child (evidence required).

Consent for adults who lack capacity/competency

Anyone over the age of 16 will be assumed to be able to give informed consent, unless it is obvious that they are unable to do so (e.g. they are unconscious) or all practical steps to help them make a decision have been taken without success (e.g. it is clear that they are unable to comprehend or retain the information they are being given). For more about assessing capacity, see below. In these circumstances a Doctor can still legally provide care and treatment, but this must take into account any Advance Decisions relating to the patient and must be demonstrably in the patient's 'best interests'. Also, in circumstances where the patient is only temporarily unable to consent (as in the above example of an unconscious patient), consideration must be given to the length of time they are likely to be in this condition and the urgency of the need to treat.

The Mental Capacity Act allows for the appointment of a Lasting Power of Attorney (LPA). An LPA can make specified welfare and healthcare decisions only if they are a personal welfare LPA (as opposed to a property and affairs LPA). A personal welfare LPA only gains this responsibility in cases where the patient has been assessed to lack capacity. In addition to this, the Court of Protection can appoint a deputy to make certain decisions on behalf of someone who has lost capacity and has not appointed an LPA. Deputies will most often be a family member or someone else who is close to the patient. For patients who have neither an LPA nor a family member or close friend to act as a deputy, and for whom very important medical decisions must be made, an Independent Mental Capacity Advocate (IMCA) should be appointed. IMCAs will represent the best interests of the patient in discussions relating to their care and potential treatment.

Advance Decisions

An Advance Decision (also known as an Advance Directive) is a declaration made by a patient about the care they wish to receive or avoid in the future. It may state a refusal to submit to certain treatment, or it may indicate what kind of treatment they would wish to receive in certain circumstances. An advance refusal to certain treatments stands as a legally binding statement, so long as the patient was fully competent at the time of making it, understood the implications of this decision, and the refusal is relevant to their current situation. (A refusal of some treatments, however, may be overridden if the individual is subsequently detained under the Mental Health Act and it is determined to be in their best

interests to undergo certain treatments.) An advance indication of preferred care is not legally binding, but should be an influential factor when deciding what treatment is in the patient's 'best interests'.

Best Interests

A decision based upon the patient's best interests should consider more than just medical benefits, taking into account factors such as their personal beliefs, their relationships with those close to them and their general well-being. Ideally, the patient's Doctor would discuss the options with those close to the patient, any carers or LPAs/deputies/IMCAs, and of course the patient if this is possible, and come to an agreement as to the course of action which addresses the patient's best interests. The focus must remain on the best interests of the patient and not be swayed by the interests of anyone else involved, and in so far as it is possible any decision made on behalf of an individual who lacks capacity should aim to choose the option which is least restrictive of their rights and freedoms. However, the overriding obligation is to act in their best interests, whether or not this is the least restrictive of the options available. In cases where an agreement is not forthcoming attempts should be made to ensure that communication is as clear and open as possible, second medical opinions are offered and mediation services are considered. If all else fails, the Court of Protection can be involved to assess the situation.

Assessing lack of capacity

Responsibility for assessing whether a patient lacks the capacity to make healthcare decisions falls to the healthcare professional who is proposing the treatment, and must be made on a case-by-case basis, i.e. a person may be capable of making some decisions but not others, and so must be assessed for each decision separately. A record must be made of the process of assessment. In making the assessment, the following must be considered:

- 1) Whether they have 'an impairment of, or a disturbance in the functioning of, the mind or brain' which may affect their ability to make the relevant decision.
- 2) Whether any of the following statements apply to the patient in this case:
 - They are unable to understand the information relevant to the decision.
 - They are unable to retain the information relevant to the decision.
 - They are unable to use or weigh the information.
 - They are unable to communicate the decision (by any means).

If any of these statements apply then they are assessed as unable to make the decision. A belief that the decision made is irrational or unwise is not grounds for an assessment of incapacity, although this may signal a need for further investigation if the decision was unexpected or out-of-character. Ultimately, the Mental Capacity Act requires that an assessment of incapacity is based on a 'reasonable belief' backed by objective reasons. Full details of the decision-making process should be recorded in the patient's records, as the Doctor may be required to justify their decisions later. Any uncertain or disputed cases can be taken up by the Court of Protection for resolution.

Confidentiality

It will obviously be necessary for anyone involved in making healthcare decisions for an incapacitated adult to be privy to information about the patient's health and treatment. However, only relevant information should be shared, and if the patient has clearly expressed a wish that certain information remain confidential then this wish should be respected. For more detail on this issue, please see the Confidentiality of Patient Information Policy.

Resources

Consent: Department of Health *Seeking Consent Guides – Working with Children, Working with Older People, Working with People with Learning Disabilities*

Gillick Competence: BMA Children and Young People Toolkit, P 7-8

BMA Mental Capacity Act Toolkit