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BANES ENHANCED MEDICAL SERVICES

CONSENT TO EXAMINE OR TREAT POLICY

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1.0 INTRODUCTION

1.1 Why consent is crucial

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent is required from a patient regardless of the intervention – from a physical examination to organ donation.

1.2 This Policy

The Department of Health has issued a range of guidance documents on consent 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 BEMS which aim to ensure that health professionals and admin staff comply with the guidance. While this document is primarily concerned with healthcare, all staff should also be aware of their obligations to obtain consent before medical treatment commences.

1.3 What consent is:

"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), verbally, or in writing. For the consent to be valid, the patient must:

- Have capacity to make the decision
- Have received enough information which is focused on the individual patient and their situation. Information should include the actual procedure and any unavoidable or frequently occurring risks in a balanced way
- Not be acting under duress. Consent must be given voluntarily. Where there is professional concern that a patient's giving or withholding of consent may be affected by coercion or undue influence then advice must be sought from the Service Lead, or Safeguarding Director. This should be documented on the patient's medical record

The context of consent can take many different forms, ranging from the active request by a patient for a 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 form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be several 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 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.

Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves the processes which must be followed are legislated under the Mental Capacity Act (2005). Please refer to Section 7 of this Policy for details.

1.4 Guidance on consent

The Department of Health has issued 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.

- *Reference guide to consent for examination or treatment* (*second edition)* provides a comprehensive summary of the current law on consent and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. Copies are available from:
  Reference Guide to Consent for Examination or Treatment Second Edition (2009)

- *12 key points on consent: the law in England* has been distributed widely to health professionals working in England. This one-page document summarises those aspects of the law on consent which frequently arise and is attached at Appendix A.

2.0 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 using a consent form (with further detail in the patient's notes if necessary) or a record made on the clinical system.

2.1 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, based on 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.

In most cases a completed consent form is not a legal requirement to seek written consent, but it is good practice to do so. It is always important to work within the law that governs practice relating to Fertility and the management of human tissue. Written consent should also be obtained in the following situations:

- If the treatment is complex or involves significant risks
- The treatment involves general or regional anaesthesia
- Providing clinical care is not the primary purpose of the procedure
- There may be significant consequences to the persons employment, social or personal life
- The treatment is part of a project or programme of research (Research should have ethical approval)

Completed forms should be kept with the patient's notes. Any changes to a form made after the form has been signed by the patient, should be initialled and dated by both patient and health professional.

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.

3.0 WHEN SHOULD CONSENT BE SOUGHT?

When a patient formally gives their consent to an 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.

3.1 Single stage process

In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient is willing for the technique to be used, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given verbally.

If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals must take into consideration whether the patient has had enough chance to absorb the information necessary for them to make their decision. If the patient understands and consents, the health professional may then proceed.

3.2 Two or more stage process

In most cases where *written* consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out. This may be on just one occasion (either within primary care or in a hospital out-patient clinic), or it might be over a whole series of consultations with several different health professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (verbal) decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.

Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure and should have received a copy of the page documenting the decision-making process. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. If a form is signed before patients arrive for treatment, however, a member of the healthcare team **must** check with the patient at this point whether they have any further concerns and whether their condition has changed. This is particularly important where there has been a significant lapse of time between the form being signed and the procedure. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

While administrative arrangements will vary, it should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patient's condition.

3.3 Seeking consent for anaesthesia

Where the clinician providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

3.4 Emergencies

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.

3.5 Treatment of Children and Young People

The legal position of consent and refusal of treatment is different from that of Adults. Children refers to people aged 16 and below and Young People refers to 16-17 year olds.

Young People are presumed capable of consenting to their own medical treatment and procedures involved in the treatment. As with Adults consent needs to be valid. (See section 1.3 of this document). However, unlike Adults in certain situations the refusal of treatment can be overridden by a person with parental responsibility or the court of protection.

If a child has enough understanding and intelligence to enable them to fully understand the procedure and has the capacity to consent, then the child could be deemed "Gillick Competent" and able to consent for their own treatment. Children's capacity to consent may be affected by different factors, for example stress, mental health conditions and the complexities of the decision they are making. The same child may be considered Gillick competent to make one decision but not competent to make a different decision.

If the child is not Gillick Competent, or there are inconsistencies in their understanding, the health professional should seek consent from their parents or carers before proceeding.

In complex medical cases, such as those involving disagreements about treatment, it is recommended to seek the opinion of a colleague about a child's capacity to consent, see Care Quality Commission (2020).

Young people also have the right to seek a second opinion from another medical professional, see General Medical Council (2018)

A child under 16 who is not deemed "Gillick competent", consent can be given on their behalf by any one person who has parental responsibility or the court. The Children Act (1989) sets out who has parental, or court appointed responsibility for a child:

- Mothers automatically have parental responsibility for their children
- A father usually has parental responsibility if he is:
  - married to the child's mother
  - listed on the birth certificate (after a certain date, depending on where in the UK the child was born)
  - has a court order confirming parental responsibility
- a legally appointed guardian
- a person with a residence order concerning the child
- a local authority designated to care for the child
- a local authority or person with an emergency protection order for the child

Always check who has parental or court appointed responsibility and the person providing the consent has the capacity to consent. Refusal of treatment for a person under 16 can be overridden by the court.

Due to the complexity regarding consent in children and young people, BEMS advises that all staff responsible for the care of children within their services should familiarise themselves with the Children Act (1989), The Mental Capacity Act (2005) and The Mental Capacity Act Code of Practice (2007)

4.0 PROVISION OF INFORMATION

The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensive information about their condition and about possible treatments/investigations and their risks and benefits (including the risks/benefits of doing nothing). They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of tissue. Once a decision to have a treatment/investigation has been made, patients need information about what will happen: where to go, how long they will be in hospital, how they will feel afterwards and follow-up procedures.

Patients and those close to them will vary in how much information they want: from those who want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. There will always be an element of clinical judgement in determining what information should be given. However, the *presumption* must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

Sources of information available:

- Clinicians may wish to consider using the patient information leaflets provided on the NHS website www.nhs.uk The information leaflets can be accessed in the Health A-Z section and then the Search by Subject for the relevant procedure or operation.

- The individual BEMS clinical services will provide specific leaflets for the patients' intended procedure or referral.

It is important to assess the patient's ability to appreciate the significance of the information and every attempt must be made to aid their understanding. This includes patients with any type of disability and not just those with language problems. Consideration should be given to the use of other communication aids for example symbols, photographs, Braille.

With the patient's agreement, the presence of a friend, relative or advocate during the discussion may be helpful. Information leaflets should be used and the assistance of other members of staff, such as specialist nurses, should be sought to help provide information.

4.1 Provision for patients whose first language is not English

BEMS is committed to ensuring that patients whose first language is not
English receive the information they need and can communicate appropriately with healthcare staff.

It is not appropriate to use children to interpret for family members who do not speak English.

BEMS has a contract with Language Line. Client Identification Number: 282820 Telephone number 0800 028 0073

4.2 Access to more detail or specialist information

Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflets. The commissioners have made the following arrangements to assist patients to obtain such information:

- Patient Advice and Liaison Service (PALS) on 01225 831717
- The NHS Website: www.nhs.uk

The treating clinician must be prepared to provide more detailed information on request.

5.0 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 and that the patient has the capacity to make the decision; 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.

5.1 Responsibility of health professionals

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

6.0 REFUSAL OF TREATMENT

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the Mental Health Act (2007). Refer to the GMC best practice guidance when patients refuse treatment: GMC Ethical Guidance. The situation for children is more complex and guidance is detailed in: Department of Health Seeking Consent: Working with Children (2001). The following paragraphs apply primarily to adults.

If, after discussion of possible treatment options, a patient refuses all treatment, this should be clearly documented in their medical records.

Where a patient has refused an 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.

If a patient consents to a 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.

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 (2007).

7.0 PROCEDURES TO FOLLOW WHEN PATIENTS LACK CAPACITY TO GIVE OR WITHHOLD CONSENT

In the case of emergency treatment, the patient's best interests take precedence. Patients seen in Out of Hours and in an Urgent Care setting will have a registered GP and as much information as possible should be obtained when possible to inform decisions. Treating those patients who lack the capacity to give or withhold consent to treatment is now governed under the Mental Capacity Act (2005). The Act goes much wider than consent to examination and treatment but for this purpose many of the provisions of the Act are based upon existing common law principles and formalise good practice into a legal obligation. Exceptions to the Act are those under 16 years of age, and if a person is detained under the Mental Health Act (2007) for compulsory treatment for mental disorder.

Staff have a legal duty to have regard to the Mental Capacity Act Code of Practice (2007) in respect of their dealings with patients who may lack capacity.

There are 5 statutory principles within the Mental Capacity Act (2005) concerning consent to treatment:

1. **Presumption of Capacity**

   A person must be assumed to have capacity unless it is established otherwise

2. **Individuals being supported to make their own Decisions**

   A person is not to be treated as unable to decide unless all practicable steps to help him/her to do so have been taken without success. This includes the use of specialist teams such as learning disabilities services, communication aids etc

3. **Unwise Decisions**

   A person is not to be treated as unable to decide merely because their decision appears unwise.

4. **Best Interests**

   Anything done for or on behalf of people without capacity **must** be in their best interests

5. **Less Restrictive Option**

   Regard must be given as to whether the purpose of the treatment can be effectively achieved in a way that is less restrictive to the person's basic rights and freedoms

The Mental Capacity Act (2005) permits medical treatment to be given to a person if they have been assessed as lacking capacity without the person's consent when it is:

1. in their best interests **and**
2. has not been refused through a valid and applicable Advanced Directive or Advance Decision **and**
3. all appropriate consultation required under the Act has taken place.

Normally, no one can consent to treatment on behalf of another adult however there are now two exceptions to this under The Mental Capacity Act (2005):

1. Where the patient (aged 18 and over) has appointed a Personal Welfare Lasting Power of Attorney (LPA) when they had the capacity to do so in order to consent to or refuse treatment. A Personal Welfare LPA does not have these powers if:

   - the patient has capacity to make the decision, or
   - the patient has made a valid and applicable Advance Decision which specifies the proposed treatment and their refusal

   However, where the patient made a Personal Welfare LPA **after** the Advance Decision and has given the Attorney the right to consent to or refuse the treatment then the Attorney can choose **not** to follow the Advance Decision. **NOTE,** decisions relating to life sustaining treatment have special rules and must be authorised explicitly. The Personal Welfare LPA does not have these rights if the patient is detained under the Mental Health Act (2007) and the treatment relates to the mental disorder.

2. A Court of Protection appointed Deputy who may have been appointed by the Court of Protection to make ongoing decisions relating to a patient's welfare who lacks capacity, (excluding decisions relating to life sustaining treatment).

The Court of Protection can also be approached to determine the validity of an LPA or Advance Decision if there are disputes or any doubts.

Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented on the medical record along with the assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's best interests, details of any consultation with family members or carers close to the patient and Personal Welfare LPA/Court of Protection Appointed Deputy if appointed or IMCA consultation (see below). For all interventions, this information should be entered in the patient's notes.

7.1 Advocacy – Independent Mental Capacity Advocates (IMCA)

The IMCA service was created under the Mental Capacity Act (2005) to aid important decision making about serious medical treatment or long-term accommodation changes. The IMCA is a legal safeguard for people who lack capacity and are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. An IMCA must be instructed if:

- The patient is aged 16 years or over
- The patient is to have '***serious medical treatment'***
- The patient is to be in hospital for more than 28 days, or in a care home for more than 8 weeks
- The local authority is to arrange for the patient to be accommodated for more than 8 weeks

Serious medical treatment is defined in the Mental Capacity Act (2005) as treatment which involves giving new treatment, stopping treatment that has already started or withholding treatment that could be offered in circumstances where:

- if a single treatment is proposed there is a fine balance between the likely benefits and the burdens to the patient and the risks involved
- a decision between a choice of treatments is finely balanced, or
- what is proposed is likely to have serious consequences for the patient

The IMCA service for Bath & North East Somerset is accessed via The South West Advocacy Network (SWAN):

- Telephone 03333 447928
- https://swanadvocacy.org.uk/services/advocacy-services/

The IMCA website had details of all IMCA services on their website: https://www.scie.org.uk/mca/imca/find

The IMCA service is available during office hours only and not at weekends or bank holidays. This is because urgent/emergency treatment can be actioned without the need to instruct an IMCA. If further serious medical treatment will be required, an IMCA referral should be made at the earliest opportunity.

Occasionally, there will not be a consensus on whether a 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. See Appendix C for details of how to do this.

8.0 CLINICAL PHOTOGRAPHY AND CONVENTIONAL OR DIGITAL VIDEO RECORDINGS

Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as x-rays, is implicit in the patient's consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.

Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient. If you wish to use such a recording for education, publication or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to control future use of the material once it has been placed in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.

Photographic and video recordings, made for treating or assessing a patient and from which there is no possibility that the patient might be recognised, may be used within the clinical setting for education or research purposes without express consent from the patient, as long as this policy is well publicised. However, express consent must be sought for any form of publication.

If you wish to make a photographic or video recording of a patient specifically for education, publication or research purposes, you must first seek their written consent (or where appropriate that of a person with parental responsibility) to make the recording, and then seek their consent to use it. Patients must know that they are free to stop the

recording at any time and that they are entitled to view it if they wish, before deciding whether to give consent to its use. If the patient decides that they are not happy for any recording to be used, it must be destroyed. Patients can ask BEMS to stop using their images at any time, in which case it will not be used in future publications. As with recordings made with therapeutic intent, patients must receive full information on the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain.

Recording telephone consultations may be required specifically for quality assurance and monitoring purposes in line with Key Performance Standards as set by the Clinical Commissioning Group. It will not be possible to obtain written consent for this purpose. However, information that the call is being recorded will be included in the initial telephone message created by the cloud-based telephone management service Sesui.

The situation may sometimes arise where you wish to make a recording specifically for education, publication or research purposes, but the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, you should seek the agreement of someone close to the patient. You must not make any use of the recording, which might be against the interests of the patient. You should also not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

9.0 TRAINING

All clinicians should understand the laws around consent and capacity. All clinical staff are to attend the local Mental Capacity Act and Deprivation of Liberty training.

9.1 Staff

It is the individual health professional's responsibility to adhere to BEMS Consent to Examination and Treatment Policy and to gain consent from patients prior to examination or treatment in line with this Policy.

All clinicians and administrators must adhere to this policy at all times when dealing with patient and surgery enquiries.

Staff should notify the BEMS office should they believe this policy has been breached.

10.0 REFERENCES

The Policy recognises and takes account of the following:

Mental Health Act (2007): https://www.legislation.gov.uk/ukpga/2007/12/contents
Mental Capacity Act (2005): https://www.legislation.gov.uk/ukpga/2005/9/contents
Mental Capacity Act Code of Practice (2007):
https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
The Human Rights Act (1998): https://www.legislation.gov.uk/ukpga/1998/42/contents

Disability Discrimination Act (1995):
https://www.legislation.gov.uk/ukpga/1995/50/contents
Equality Act (2010): https://www.legislation.gov.uk/ukpga/2010/15/contents
Human Fertilisation and Embryology Act (2008):
https://www.legislation.gov.uk/ukpga/2008/22/contents
Human Tissue Act (2004): https://www.legislation.gov.uk/ukpga/2004/30/contents
Organ Donation (Deemed Consent) Act (2019):
https://www.legislation.gov.uk/ukpga/2019/7
NHS Resolution Risk Management Policy and Procedure (2020):
https://resolution.nhs.uk/wp-content/uploads/2020/12/CG04-Risk-Management-Policy-and-Procedure.pdf
Department of Health Seeking Consent: working with children (2001):
https://dera.ioe.ac.uk/9286/1/dh_4067204.pdf
Department of Health Reference Guide to Consent for examination or treatment (Second Edition, 2009):
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf
Human Tissue Authority Post Mortem Examination Code of Practice (2017):
https://content.hta.gov.uk/sites/default/files/2020-11/Code%20B.pdf
General Medical Council Decision making and consent (2020): https://www.gmc-uk.org/-/media/documents/updated-decision-making-and-consent-guidance_pdf-84160128.pdf
Bath, Swindon and Wiltshire Clinical Commissioning Group Respect policy (2021):
https://www.bswccg.nhs.uk/docs-reports/policies-and-governance/2286-bsw-respect-policy/file
NICE Shared Decision Making (2021):
https://www.nice.org.uk/guidance/ng197
Care Quality Commission Regulation 11: Need for consent:
https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-11-need-consent
The Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 (Regulation 11):
https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/11
National Institute for Health and Care Excellence Shared Decision Making:
https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making

11.0 **REVIEW**

This policy will be reviewed at least 3 yearly or more frequently and in respect of new guidance.

APPENDIX A

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 treating the patient to seek the patient's consent. However, you may seek consent on behalf of colleagues if you can perform 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 enough 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 increasingly the discussions that have taken place. It has

been agreed that BEMS doctors will record consent on any case note where they feel complied consent to treat has not been given as most work is urgent in the out of hours setting.

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 foetus.

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.

This summary cannot cover all situations. For more detail, consult the Reference guide to consent for examination or treatment (second edition):
https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition

APPENDIX B

HOW TO SEEK A LEGAL ADVICE

Health professionals who wish to access legal support, should in the first instance contact their Medial Union such as the MPS.

APPENDIX C

Seeking Consent: Remembering the Patient's Perspective