General Osteopathic Council

Obtaining Consent

Patients' capacity to give consent: guidance for osteopaths practising in England and Wales

Effective from 17 October 2013

Contents

1. Introduction

1.1 The law on consent is complex and varies between the different countries of the United Kingdom (UK). **This guidance applies to osteopaths practising in England and Wales**. Separate guidance is available for osteopaths practising in other parts of the UK.

1.2 This guidance expands upon that given at Standard A4 of the *Osteopathic Practice Standards* (OPS). It is an extension of the guidance given at paragraphs 11, 13 and 18, which support Standard A4. It has the same status as that guidance and should always be read in conjunction with the full guidance provided in the OPS.

1.3 Standard A4 requires you to have your patient's valid consent before you examine or treat your patient. For the consent to be valid it must be given by a patient who has the capacity to consent.

1.4 On occasion, however, you may be asked to examine or treat a patient who does not have the required mental capacity to consent. This may be because of the patient's age or illness.

1.5 The law properly provides a number of safeguards for patients who fall into this category and need medical care. This document explains this law as it relates to the practice of osteopathy in relation to:

a. examining and treating adults who may not have the capacity to consent

b. receiving consent for the examination or treatment of young people and children.

1.6 This guidance cannot cover all eventualities. You may occasionally need to supplement this guidance with full independent legal advice.

1.7 As the law may change, this guidance will be provided in an electronic form only. The current and up-to-date version will be available on the General Osteopathic Council's website, www.osteopathy.org.uk

2. Adult Patients and Capacity

2.1 The presumption of capacity

2.1.1 'Capacity' refers to the ability of your patient to understand and retain information that is relevant to his or her condition and the treatment that you are proposing.

2.1.2 It also includes the ability of the patient to weigh the various options available (including the consequences of not having treatment) and to make decisions about his or her treatment.

2.1.3 A person with capacity has the right to refuse treatment. You must respect this decision even if you believe treatment would be beneficial to that person.

2.1.4 A person with capacity may withdraw consent to treatment at any time.

2.1.5 The starting point is a presumption of capacity.

2.1.6 Patients who are aged 18 years and over are presumed to have the capacity to consent, unless it is established that they lack capacity[1].

2.2 Lack of capacity

2.2.1 The law sets out certain circumstances in which your patient is deemed to lack capacity.

2.2.2 The law[2] states that your patient will not have capacity if:

a. he or she has an impairment or disturbance (whether temporary or permanent) that affects the way their mind or brain works

b. that impairment or disturbance means that they are unable to make a decision at the time it needs to be made.

2.2.3 Your patient will be deemed to be unable to make a decision if he or she is unable to:

a. understand the information that is relevant to the decision to be made

b. retain that information

c. use or weigh that information as part of the decision making process

d. communicate their decision (whether by talking, signing or any other means).

2.2.4 The cause of the 'incapacity' must be a mental disorder or an inability to communicate because of a physical disability (unless the disability can be made good by human or mechanical aid).

2.3 Assessing capacity

2.3.1 When assessing a patient's capacity to consent, you should make your assessment on the patient's ability to make a decision about the specific intervention you are proposing.

2.3.2 Your patient may be capable of making a decision on some aspects of their healthcare, but incapable in relation to other more complex aspects.

2.3.3 Your assessment should be objective and you should bear in mind the principle that, where possible, patients should be assisted to make their own decisions about their healthcare.

[1] Section 1(2) of the *Mental Capacity Act 2005* and common law principle
[2] Sections 2 and 3 of the *Mental Capacity Act 2005*

2.3.4 Care should be taken not to underestimate the capacity of a patient with a learning disability. Many people with learning disabilities have the capacity to consent if time is spent explaining to the individual the issues in simple language, using visual aids and signing if necessary.

2.3.5 Your patient's capacity may be temporarily affected by factors such as shock, panic, confusion, fatigue, pain or medication. The patient's capacity may also be affected by illegal drugs or alcohol.

2.3.6 In these circumstances you should not assume that the patient does not have capacity. However, it may be appropriate to defer the decision until the temporary effects subside and capacity is restored.

2.3.7 Decisions by a patient that are unusual or are not what you would have chosen to do if you were the patient, do not mean that the patient lacks capacity.

2.3.8 You should ensure that your assessments, decisions and conclusions are based on all available evidence and are recorded in your patient's notes.

2.4 Treating adult patients who lack capacity

2.4.1 You may in certain circumstances, examine and treat adults who lack capacity. It is important that you comply with the law when doing so.

2.4.2 A person may be authorised to provide consent for your patient to be treated under a Lasting Power of Attorney (LPA) or as a deputy appointed by the Court of Protection, if that person is authorised in respect of personal welfare matters[3].

2.4.3 You may also examine and treat a patient who lacks capacity if it is in their best interests for you to do so[4].

2.4.4 It is important to remember that a patient's best interests are not confined to their best medical interests.

2.4.5 A patient's best interests may include their wishes and beliefs when they did have capacity; their current wishes; the patient's general wellbeing and quality of life; the patient's spiritual and religious welfare; the patient's relationship with family or other carers; and the patient's financial interests.

2.4.6 You will need to consider all relevant circumstances relating to the decision that needs to be made and you should not make assumptions about a patient's best interests based on their age, appearance, condition or any aspect of their behaviour.

[3] Section 9(1) of the *Mental Capacity Act 2005*
[4] Section 1(5) of the *Mental Capacity Act 2005*

2.4.7 When deciding if the intervention you are proposing is in your patient's best interests, you should[5]:

a. consider whether your patient is likely to regain capacity and if so whether the decision can wait until capacity is regained

b. involve your patient as fully as possible in the decision that is being made

c. consider your patient's past and present wishes and feelings, including whether any of their beliefs and values are likely to influence the decision in question, and any other factors which the patient would be likely to consider if they were able to do so

d. as far as possible and if it is reasonable to do so, consult other people (unless the patient has previously made it clear that certain individuals should not be involved) and take into account their views as to what would be in the best interests of the patient, especially:

- anyone previously named by the patient as someone to be consulted
- anyone caring for or interested in the patient's welfare
- anyone appointed with Lasting Power of Attorney
- a deputy appointed by the Court of Protection.

3. 16 and 17 year-olds

3.1 16 and 17 year-olds are able to consent to medical treatment unless they lack capacity[6].

3.2 If you are treating a 16 or 17 year old, it is important to establish whether they have capacity and you should use the same criteria as for adult patients set out in section 2.1 above, to assess their capacity.

3.3 Even if a 16 or 17-year old does not have an impairment or disturbance, you may still need to consider whether:

a. he or she has sufficient maturity and intelligence to enable them to understand what is involved in the proposed treatment

b. a lack of maturity means that he or she feels unable to make the decision for themselves[7].

3.4 Although not a legal requirement, it is good practice to encourage the patient to involve their family in the decision they make about treatment, unless the patient specifically wants to exclude them.

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[5] Section 4 of the *Mental Capacity Act 2005*
[6] Section 8 of the *Family Reform Act 1969*
[7] The *Mental Capacity Act 2005*: *Code of Practice*, at para. 12.13

3.5 Where a 16 or 17 year old with capacity refuses treatment, this decision may be overridden by a person with parental responsibility, or by the Court.

3.6 Where a 16 or 17 year old does not have capacity to consent, you may be able to examine or treat them if it is in their best interests for you to do so.

3.7 In determining whether or not treatment is in the best interests of a 16 or 17 year old, you should follow the same criteria as set out in section 2.3 above for adult patients.

4. Children aged 15 and under

4.1 Assessment of capacity

4.1.1 Some children may be able to give their own consent to examination and treatment.

4.1.2 The test is whether the child has sufficient maturity and intelligence to enable him or her to understand what is involved in the proposed intervention or treatment[8].

4.1.3 A child may be competent to consent to some treatments or interventions but not others. This is because the level of understanding required for different treatments may vary.

4.1.4 You should therefore carefully assess the child's capacity to consent in relation to each decision that needs to be made.

4.1.5 Establishing whether or not a child has capacity to consent is a matter for your professional judgment. You will need to take into account factors such as:

a. the age and maturity of the child

b. the complexity of the proposed intervention

c. the likely outcome of the intervention

d. the risks associated with the proposed intervention.

4.1.6 Where it is established that a child has capacity, it is good practice to encourage the child to involve their family in the decision-making process.

4.1.7 Where a child with capacity has been provided with appropriate information and voluntarily gives his or her consent to treatment, that consent cannot be over-ridden by a person with parental responsibility.

[8] Gillick v West Norfolk and Wisbech AHA [1986] AC 112

4.1.8 Where a child with capacity refuses to consent to treatment, that decision may be overridden by those with parental responsibility or by a Court in certain situations. You should consider obtaining legal advice before attempting to treat a patient in such circumstances.

4.2 Children without capacity

4.2.1 Where the child lacks the capacity to consent, consent to treatment must be sought from a person with parental responsibility.

4.2.2 You should ensure that the person with parental responsibility, who is giving consent on behalf of the child:

a. has capacity to consent to the examination and/or treatment

b. is acting voluntarily

c. is appropriately informed.

4.2.3 When exercising the power to consent on behalf of a child, the child's welfare or best interests must be paramount.

4.2.4 People who have parental responsibility include[9]:

In relation to children born before 6 April 2009

- The child's mother
- The child's father, if he was married to the mother at the time of birth
- The child's father if (although not married to the mother at time of birth), he has subsequently obtained a parental responsibility order from the Court or has subsequently married the mother of their child, or if he jointly registered the birth with the child's mother (from 1 December 2003)
- The child's legally appointed guardian
- A person in whose favour a Court has made a residence order concerning the child
- A local authority designated in a care order in respect of the child
- A person who has been appointed by the Court as a guardian for a child where there is no parent with parental responsibility.

[9] See section 2 of the *Children Act 19894*

In relation to children born on or after 6th April 2009, parental responsibility may be exercised by the following persons in addition to those mentioned above

- Where the child's mother was in a civil partnership at the time of treatment for assisted reproduction, e.g. IVF, the other party to the civil partnership is to be treated as a parent of the child.

- Where the child's mother was in a same sex relationship (but not a civil partnership) at the time of the IVF, the other woman will be a legal parent if the mother consents.

4.2.5 Consent given by one person with parental responsibility is valid, even if another person with parental responsibility withholds consent.

4.2.6 However, it is recognised that important decisions should not be taken by one person with parental responsibility against the wishes of another.

4.2.7 Where persons with parental responsibility disagree as to whether a procedure is in the child's best interests, it is advisable to refer the matter to the Court.

Sources of further guidance:

- *Reference guide for consent to examination or treatment*, Second Edition (Department of Health) 2009
- *Reference guide for consent to examination or treatment* (Welsh Assembly Government) 2008
- *Mental Capacity Act 2005 Code of Practice* (also available in Welsh)
- www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility