General Osteopathic Council

Obtaining Consent

Introduction

This guidance expands upon that given at Standard A4 of the *Osteopathic Practice Standards*[1]. 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 *Osteopathic Practice Standards*.

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

1. Examining and treating adults who may not have the capacity to consent.

2. Receiving consent for the examination or treatment of young people and children.

This guidance concentrates on the challenges that will be faced by osteopaths in practice. It does not, for example, explain the law on end of life decisions and it will not, therefore, cover all eventualities. You may occasionally need to supplement this guidance with full independent legal advice.

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

[1] *Osteopathic Practice Standards*. General Osteopathic Council, September 2012.

Contents

The law on consent is complex and varies between the different countries of the United Kingdom (UK). We provide an explanation of the law for each of the different countries as it relates to the following questions.

Section 1

Does your patient have the capacity to consent to the intervention you are proposing?

Having capacity means that your patient is able to understand and retain information relevant to their condition and what you are proposing. They will also be able to weigh up the relevant information, including the consequences of having or not having the proposed intervention, in order to reach a decision. If a person with capacity refuses treatment this decision must be respected, even if you believe that the treatment would be beneficial to them. A person with capacity may also withdraw their consent at any time.

1.1 Adult patients with presumed capacity

You are able to presume that some patients have the required capacity. The position is slightly different in the UK countries:

England and Wales	Northern Ireland	Scotland
Patients aged 18 years and over are presumed to have capacity to consent, unless it is established that they lack capacity[2].	Patients aged 18 years and over are presumed to have capacity to consent, unless it is established that they lack capacity[3].	Patients aged 16 years and over have the capacity to make their own decisions which have legal effect, unless they lack the appropriate mental capacity[4].

1.2 Assessing Capacity

[2] The Mental Capacity Act 2005

[3] Principle at Common Law

[4] The Age of Legal Capacity (Scotland) Act 1991

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

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.

Your patient's capacity may be temporarily affected by factors such as shock, panic, confusion, fatigue, pain or medication. In these circumstances you should not assume that the patient does not have capacity. Instead it may be appropriate to defer the decision until the temporary effects subside and capacity is restored.

Decisions which are unusual or not what you would have chosen do not mean that the patient lacks capacity; instead it may highlight the need for further information to be given to the patient.

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

The law on assessing capacity differs slightly in the UK countries:

England and Wales	Northern Ireland	Scotland
Your patient lacks capacity if: • they have an impairment or disturbance that affects the way their mind or brain works; and • that impairment or disturbance	If you have any doubts about your patient's capacity, you should assess their capacity by asking: • whether the patient is able to understand and retain information	Incapacity is defined as being incapable of: • acting[6]; • making decisions; • communicating decisions;

[6] For example, incapable of acting to safeguard or promote his interests in his personal welfare. See Edinburgh v D SLT v D 32

England and Wales	Northern Ireland	Scotland
means that they are unable to make a decision at the time it needs to be made. Your patient is unable to make a decision for themselves if they are unable to: • understand the information that is relevant to the decision; • retain that information; • use or weigh up that information as part of the decision-making process; or • communicate their decision (whether by talking, using sign language or any other means)[5].	relevant to the decision; and • whether the patient is able to use and weigh up that information in the decision-making process.	• understanding decisions; or • remembering decisions[7]. 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. The definition of incapacity includes unconscious adults.

[5] Sections 2 and 3 of the Mental Capacity Act 2005

[7] The Adults with Incapacity (Scotland) Act 2000

1.3 Adult patients who lack capacity

If your adult patient lacks capacity, no-one is able to give consent for them. It is, however, possible to examine and treat adult patients who lack capacity. You should proceed carefully and follow the safeguards that are provided by law:

England and Wales	Northern Ireland	Scotland
An adult with capacity may appoint an attorney to look after their health and welfare decisions, in case they lack the capacity to make such decisions in the future. This would be a personal welfare Lasting Power of Attorney (LPA). The LPA must be made in the form, and meet the criteria, set out in the regulations[8], and it must be registered with the Office of Public Guardian before it can be used. Healthcare decisions made by the attorney, under an LPA, are as valid as those made by the patient. The Court of Protection can appoint a deputy to make decisions on behalf of a person who lacks capacity, or the Court itself may make an order making a decision on the patient's behalf[9]. In	You may carry out an examination or provide treatment to your patient who lacks capacity if the examination and/or treatment would be in their "best interests". "Best interests" are not confined to best medical interests, and can include the patient's: • wishes and beliefs when they did have capacity; • current wishes; • general well-being and quality of life; • spiritual and religious welfare; • relationship with family or other carers; and • financial interests.	If you conclude that your patient lacks capacity, in order to lawfully treat the patient you will require the authority conferred by a certificate of incapacity[10]. At present, osteopaths do not fall within the prescribed categories of health professionals able to issue a certificate of incapacity. Instead, a certificate should be sought from a medical practitioner (for example, the patient's GP), authorising you to carry out the treatment. A certificate may also be issued by a registered nurse, where that nurse has had their knowledge of the assessment of capacity certified by a Scottish

[8] Mental Capacity Act 2005 (Lasting Powers of Attorney, Enduring Powers of Attorney and Public Guardian Regulations 2007 and www.publicguardian.gov.uk)
[9] Mental Capacity Act 2005 and www.publicguardian.gov.uk
[10] Section 47 of the Adults with Incapacity (Scotland) Act 2000

England and Wales	Northern Ireland	Scotland
such circumstances, you may wish to seek further advice before proceeding with care. You may examine and treat your patient who lacks capacity if it is in their "best interests". "Best interests" are not confined to best medical interests, and can include the patient's: • wishes and beliefs when they did have capacity; • current wishes; • general well-being and quality of life; • spiritual and religious welfare; • relationship with family or other carers; and • financial interests. You 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	If your patient does lack capacity, it is good practice for you to involve those persons who were close to the patient in the decision. This will help you to find out the patient's preferences before their loss of capacity, unless the patient had previously made it clear that certain individuals should not be involved. You should make a clear note in your patient's records showing the basis on which you made your decision to proceed or not proceed with care.	further or higher education institute or by NHS Education for Scotland[11]. A template for the certificate is provided at Annex A. You should keep the certificate of incapacity with the patient's records. When considering whether the treatment should be undertaken, there are five principles which must be observed[12]. The principles start with the policy of 'no intervention', unless this will benefit the adult and the benefit cannot otherwise be achieved. All decisions made on behalf of a patient with incapacity should: • be for the benefit of the patient; • be the minimum necessary to achieve the desired benefit; • take into account the patient's present and past wishes; • take into account the views of the nearest relative, primary carer, proxy and relevant others, where it is reasonable and practicable to do

[11] The Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Amendment Regulations 2012/170

[12] Section 1 of the Adults with Incapacity (Scotland) Act 2000

England and Wales	Northern Ireland	Scotland
age, appearance, condition or any aspect of their behaviour. Important points to remember when deciding if the intervention you are proposing is in your patient's best interests are: • you should consider whether your patient is likely to regain capacity and if so whether the decision can wait; • you should involve your patient as fully as possible in the decision that is being made; • you should consider your patient's past and present wishes and feelings, 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; • you should, as far as possible and if it is reasonable to do so, consult other people and take into account their views as to what would be in the best interests of the patient, especially: - anyone previously named by		so; and • encourage the patient to exercise residual capacity. You should make a clear note in your patient's records showing the basis on which you made your decision to proceed or not proceed with care.

England and Wales	Northern Ireland	Scotland
the patient as someone to be consulted; - anyone caring for or interested in the patient's welfare; - anyone appointed as an LPA; or - a deputy appointed by the Court of Protection. You should make a clear note in your patient's records showing the basis on which you made your decision to proceed or not proceed with care.		

Section 2

Can young people (those aged 16 or 17) provide their own consent?

Patients aged 16 and 17 years old are able to provide consent for their own medical treatment. The provisions providing for this are slightly different in the UK countries:

England and Wales	Northern Ireland	Scotland
Patients aged 16 and 17 are presumed to have capacity to consent to their own medical treatment, unless the contrary is evident. If a young person has an impairment or disturbance that affects the way their mind or brain works then to assess whether that young person has capacity to consent, you should use the same criteria as for adults (see guidance for adults at Section 1 for England and Wales). The Code of Practice to the Mental Capacity Act 2005 suggests that even if the young person does not have an impairment or disturbance you may still need to consider whether the	Patients aged 16 and 17 are entitled to consent to their own medical treatment and to any ancillary procedures involved in the treatment such as anaesthetic[14]. It is still important to establish whether the young person has capacity to consent and you should use the same criteria as for adults (see guidance for adults at Section 1 for Northern Ireland). If the young person does not have an impairment or disturbance you may still need to consider whether the young person has sufficient maturity and intelligence to enable them to understand what is involved in the	Patients aged 16 years and over have the capacity to make their own decisions which have legal effect, unless they lack the appropriate mental capacity.

[14] Section 4 of the Age of Majority Act (Northern Ireland) 1969

England and Wales	Northern Ireland	Scotland
young person: • has sufficient maturity and intelligence to enable them to understand what is involved in the proposed intervention (see guidance below for age 15 and under); or • if a lack of maturity means that they feel unable to make the decision for themselves[13]. If you conclude that for either reason, the young person cannot give valid consent, you should apply common law principles (see above and the Northern Ireland section for "adult patients who lack capacity"). If you conclude that the young person is capable of giving valid consent, then it is not necessary to obtain any additional consent from a person with parental responsibility. However, it is good practice to involve the young person's family in the decision-making process, unless the young person specifically wishes to exclude them.	proposed intervention (see guidance for patients age 15 and under at Section 3 for Northern Ireland). If the requirements for valid consent have been met, you are not legally obliged to obtain any additional consent from those with parental responsibility. However, it is good practice to encourage the young person to involve their family in the decision they make about their health, unless the young person specifically wants to exclude them. A refusal to treatment by a young person with capacity may be overruled by either a person with parental responsibility or a court. This power to over-rule must be exercised on the basis that the welfare of the young person is paramount.	

[13] The Mental Capacity Act 2005: Code of Practice, at para.12.13.

England and Wales	Northern Ireland	Scotland
Where a young person with capacity refuses treatment, the refusal may be overridden by a person with parental responsibility or a court. To determine who has 'parental responsibility' see guidance for a child without capacity at Section 3 for England and Wales. If you conclude that a young person does not have capacity to consent then you may still examine or treat that young person if it is in their best interests. You should follow the same steps as for adults when determining whether it is in their best interests.		

Section 3

Can a child (those aged 15 years and under) provide their own consent?

A child may be able to provide their own consent for examination and treatment. It is important that you first establish that the child is competent to consent to the specific intervention you are proposing. The child may be capable of making a decision on some aspects of their healthcare, but incapable in relation to other more complex aspects. If the child is competent, you can generally proceed with the treatment. If not, you will need consent from a parent or a person with parental responsibility.

3.1 Assessing a child's capacity

England and Wales	Northern Ireland	Scotland
Patients aged 15 years and under may be competent to consent if they have sufficient maturity and intelligence to enable them to understand what is involved in the proposed intervention[15]. A child may be competent to consent to some interventions but not others as the understanding required for different interventions will vary. You should carefully assess the child's capacity to consent in relation to each	A child aged 15 years and under may be competent to consent if they have sufficient maturity and intelligence to enable them to understand what is involved in the proposed intervention.	A patient aged 15 years and under may have legal capacity to consent to any surgical, medical or dental treatment where, in the opinion of a qualified medical practitioner attending the child, the child is capable of understanding the nature and possible consequences of the procedure or treatment[16]. Establishing whether a child has capacity to consent is a matter of your professional judgement and depends

[15] Case of: Gillick v West Norfolk and Wisbech AHA [1986] AC 112

[16] Section 2(4) of the Age of Legal Capacity (Scotland) Act 1991

England and Wales	Northern Ireland	Scotland
decision that needs to be made.		on several factors such as: • the age and maturity of the child, • the complexity of the proposed intervention, • the likely outcome of the intervention, • the risks associated with the proposed intervention.

3.2 A child with capacity

A child with capacity can provide consent for their own treatment. You are encouraged, however, to involve the child's family in decisions about their care.

England and Wales	Northern Ireland	Scotland
If you conclude that a child is to give consent voluntarily after being provided with appropriate information; that consent will be valid and cannot be overridden by a person with parental responsibility. You do not need to obtain any additional consent from a person with parental responsibility in these circumstances. However, you should encourage the child to involve their family in the decision making process.	If you conclude that a child is able to give consent voluntarily and after receiving appropriate information, that consent will be valid and there is no obligation on you to obtain any additional consent from a person with parental responsibility. However, you should encourage the child to involve their family in the decision-making process.	Where a child has capacity to give consent, that decision should be respected, even if it differs from their parents' view. It is good practice to encourage the child to involve their parents in the healthcare decision-making process. Refusal to consent by or on behalf of a child may be overridden by a court in certain limited circumstances, such as

England and Wales	Northern Ireland	Scotland
If a child with capacity refuses to give consent, it may be possible for those with parental responsibility or a court to override that decision in certain circumstance, such as where a refusal to treatment would in all probability lead to the child's death, or to severe permanent injury. You should make a clear note in your patient's records showing the basis on which you made your decision to proceed or not proceed with care.	A refusal to treatment by a child with capacity may be overruled by either a person with parental responsibility or a court. You should make a clear note in your patient's records showing the basis on which you made your decision to proceed or not proceed with care.	in a life or death situation. You should make a clear note in your patient's records showing the basis on which you made your decision to proceed or not proceed with care.

3.3 A child without capacity

If a child lacks the capacity to consent for their own treatment, you should seek valid consent from a person who has parental responsibility for the child.

England and Wales	Northern Ireland	Scotland
If you conclude that a child lacks capacity to consent, you will need to seek consent from a person with parental responsibility. You should ensure that the person with parental responsibility, who is giving consent on behalf of the child, has capacity to consent to the examination and/or treatment, is acting voluntarily and is appropriately informed. When exercising the power to consent on behalf of a child, the child's welfare or best interests must be paramount. People who have parental responsibility include: • the child's mother;	Where a child lacks capacity to consent, consent can be given on their behalf by any one person with parental responsibility or by the court. People who have parental responsibility include[17]: • the child's parents if married to each other at the time of conception or birth; • for children born before 15 April 2002 the child's mother, but not father if they were not married at the time of the child's birth unless the father has acquired parental responsibility via a court order or a parental responsibility agreement, or the couple subsequently marry; • for children born to unmarried	If a child is not capable of understanding the nature of the intervention or its consequences, you need to seek consent from a parent or guardian. If the parent or guardian who has parental responsibility is not available and the intervention cannot be deferred until you can speak to them, a person who has care and control of the child, but has no parental responsibility, has the power to do what is reasonable in all the circumstances to safeguard the child's health, development and welfare[18]. This provision does not apply to teachers and others who may have care and control of a child in school.

[17] The Children (Northern Ireland) Order 1995 and Family Law Act (NI), 2001

[18] Section 5 of the Children (Scotland) Act 1995

England and Wales	Northern Ireland	Scotland
• the child's father, if he was married to the mother at the time of birth; • 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 with no parent with parental responsibility; • unmarried fathers in particular circumstances, for example those who have obtained a parental responsibility order from the court or marry the mother of their child; • for children born on or after 6 April 2009: - 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; or - where the child's mother was	parents on or after 15 April 2002: - the child's parents if they jointly registered the child's birth, so that the father's name appears on the birth certificate. - otherwise the child's mother only, unless the father has acquired parental responsibility via a court order or a parental responsibility agreement or the couple subsequently marry; • for children born on or after 6 April 2009, where the child's mother was in a same sex relationship (but not a civil partnership) at the time of the IVF, that parent shall acquire parental responsibility for the child: - if she is registered as a parent of the child; - via a parental responsibility agreement; or - by order of the court. - a step-parent (i.e. a person who is married to or a civil partner of a child's parent) if the court makes an order that he or she has parental responsibility;	People who have parental responsibility include: • for a child born before 4 May 2006: - both parents if the child's mother and father were married to each other (or got married later). - the child's mother only, if the child's mother and father are not married. • for children born on or after 4 May 2006: - the child's mother - the child's father, if he was married to the mother at the time of birth (or got married later) - both parents provided that they have registered the child's birth together - the child's father, if he fills in a form called a Parental Responsibilities and Parental Rights Agreement (PRPRA) provided the mother agrees, or by asking the court to give them

England and Wales	Northern Ireland	Scotland
in a same sex relationship (but not a civil partnership) at the time of the IVF, if the mother consents, the other woman will be a legal parent. Consent given by one person with parental responsibility is valid, even if another person with parental responsibility withholds consent. However, it is recognised that some important decisions should not be taken by one person with parental responsibility against the wishes of another. 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 courts. You should make a clear note in your patient's records showing the basis on which you made your decision to proceed or not proceed with care.	- the child's legally appointed guardian; • a person in whose favour the court has made a residence order concerning the child; • a Health and Social Services Trust designated in a care order in respect of the child (this excludes children being looked after under Article 21 of the Children (Northern Ireland) Order 1995 who are "accommodated" in a voluntary basis and for whom the Health and Social Services Trust does not have parental responsibility); • a Health and Social Services Trust who holds an emergency protection order in respect of the child; - Article 5(8) of the Children (Northern Ireland) Order 1995 states that a person who has parental responsibility for a child "may arrange for some or all of it to be met by one or more persons acting on his behalf". Such a person might	parental responsibility and rights. - Other people (such as grandparents, step-parents, aunts or uncles) if they are given parental responsibility and rights by a court[19]. • for children born on or after 6 April 2009: - 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; or - where the child's mother was in a same sex relationship (but not a civil partnership) at the time of IVF, if the woman is registered as a parent of the child she will have parental responsibility. You should make a clear note in your

[19] The Family Law (Scotland) Act 2006

England and Wales	Northern Ireland	Scotland
	choose to do this, for example, if a childminder, private foster carer or the staff of a school with a boarding department have regular care of his/her child. As only a person exercising parental responsibility can give valid consent, in the event of any doubt specific enquiry should be made. Grandparents, step-parents and foster carers do not automatically have parental responsibility unless they have acquired this by a court order. You should make a clear note in your patient's records showing the basis on which you made your decision to proceed or not proceed with care.	patient's records showing the basis on which you made your decision to proceed or not proceed with care.

Sources of further guidance:

- Reference Guide to Consent for Examination or Treatment, Second Edition (Department of Health) 2009: England and Wales
- Mental Capacity Act 2005 Code of Practice: England and Wales
- Reference Guide for Consent to Examination or Treatment (Welsh Assembly Government): Wales
- Reference Guide to Consent for Examination, Treatment or Care, March 2003 (Department of Health, Social Services & Public Safety NI): Northern Ireland
- A Good Practice Guide on Consent for Health Professionals in NHS Scotland (Scottish Executive Health Department), 2006: Scotland

Annex A

Template Certificate of Incapacity. For use in Scotland only.

I …… (name)
Of…… (address)
*am the medical practitioner primarily responsible for the medical treatment of; or
*and a person who is *a dental practitioner/an ophthalmic optician/a registered nurse and who satisfies such requirements as are prescribed by the Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 and who is primarily responsible for medical treatment of the kind in question of
…… (name)
…… (address)
……/……/…… (date of birth)
for whom the *guardian/welfare attorney/person appointed by intervention order/nearest relative/carer
is ……

I have examined the patient named above on ……/……/…… (date). I am of the opinion that *he/she is incapable within the meaning of the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act) in relation to a decision about the following medical treatment:
……
……
Because of (nature of incapacity)……
……

This incapacity is likely to continue for …… months

* I therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist from ……/……/…… (date of examination) until ……/……/……, being a period which does not exceed one year from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me; or

* I am of the opinion that that (a) *he/she is suffering from *a severe or profound learning disability/dementia/a severe neurological disorder: and (b) *what he/she is suffering from is unlikely to improve within the meaning of the Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Medical Certificates) (Scotland) Regulations 2007/100 and therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist until ……/……/…… being a period which does not exceed three years from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me.

*delete as appropriate