General Osteopathic Council

Obtaining Consent

Patients' capacity to give consent: guidance for osteopaths practising in Northern Ireland

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1. Introduction

1.1 The law on consent is complex and varies between the different countries of the United Kingdom (UK). **This guidance is for osteopaths practising in Northern Ireland**. There is separate guidance 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 and

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 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 In Northern Ireland, the position is governed by common law principles which require an assessment of whether a patient is able to understand and retain information that is relevant to the decision on treatment; and whether the patient is able to use and weigh up that information as part of the decision-making process.

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.

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. Instead 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.

[1] The *Mental Capacity Act 2005* and common law principle

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 Provided that you follow the safeguards provided by the law, you may in certain circumstances examine and treat adults who lack capacity.

2.4.2 You may examine and treat a patient who lacks capacity if it is in their best interests for you to do so.

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

2.4.4 A patient's best interests may include the patient's 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.

2.4.5 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.

2.4.6 When deciding if the intervention you are proposing is in your patient's best interests, you should:

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, and 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:

i. anyone previously named by the patient as someone to be consulted and

ii. anyone caring for or interested in the patient's welfare.

3. 16 and 17 year-olds

3.1 16 and 17 year-olds are able to consent to medical treatment unless they lack capacity[2].

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 or

b. a lack of maturity means that he or she feels unable to make the decision for themselves[3].

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.

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 However, any power to override a decision made by a 16 or 17 year old can only be exercised on the basis that the welfare of the young person is paramount.

3.7 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.

3.8 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[4].

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.

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[2] Section 4 of the *Age of Majority Act (Northern Ireland) 1969*;
[3] The *Mental Capacity Act 2005*: Code of Practice, at para. 12.13
[4] Gillick v West Norfolk and Wisbech AHA [1986] AC 112

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 and

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.

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.

4.2 Children without capacity

4.2.1 Where the child lacks the capacity to consent, consent to the treatment of a child can be given on the child's behalf by any person with parental responsibility, or by the Court.

4.2.2 Persons with parental responsibility include[5]:

Children born to parents married at time of conception or birth	The child's parents.
Children born to unmarried parents before 15 April 2002	The child's mother. The child's father *only if* parental responsibility is subsequently acquired via a court order or a parental responsibility agreement, or the couple subsequently marry.

[5] Articles 5 and 7 of the *Children (Northern Ireland) Order 1995* and section 1 of the *Family law Act (NI) 2001*

Children born to unmarried 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. The child's mother. The child's father *only if* parental responsibility is subsequently acquired via a court order or a parental responsibility agreement, or the couple subsequently marry.
Children born on or after 6 April 2009	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. 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[6]). A Health and Social Services Trust which holds an emergency protection order in respect of the child.
Children born on or after 6 April 2009 by IVF	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: a) if she is registered as a parent of the child b) via a parental responsibility agreement or c) by order of the Court.

4.2.3 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[7].

4.2.4 Such a person might choose to do this, for example, if a child-minder, private foster carer or the staff of a school with a boarding department have regular care of the child.

4.2.5 Only a person with parental responsibility can give valid consent. If you are in any doubt, you should make specific inquiries.

4.2.6 Grandparents, step-parents and foster carers do not automatically have parental responsibility unless they have acquired this by a court order.

[6] This excludes children being looked after under Article 21 of the *Children (Northern Ireland) Order 1995* who are "accommodated" on a voluntary basis and for whom the Health and Social Services Trust does not have parental responsibility.
[7] Article 5(8) of *the Children (Northern Ireland) Order 1995.*

5. Sources of further guidance:

- *Reference guide to consent for examination or treatment*, Second Edition (Department of Health) 2009
- *Reference Guide to Consent for Examination, Treatment or Care*, March 2003 (Department of Health, Social Services & Public Safety, Northern Ireland)
- www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility