General Osteopathic Council

Obtaining Consent

Patients' capacity to give consent: guidance for osteopaths

Contents

1. Introduction **3**

2. Adult patients and capacity **4**

2.1 The presumption of capacity

2.2 Assessing capacity

2.3 Treating adult patients who lack capacity.

3. 16 and 17 year old minors **7**

4. Children aged 15 and under **8**

4.1 Assessment of capacity

4.2 Children without capacity

5. Sources of further guidance **13**

1. Introduction

The law on consent is complex and varies between the different countries of the United Kingdom (UK).

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.

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.

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. 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:

- Examining and treating adults who may not have the capacity to consent.
- Receiving consent for the examination or treatment of young people and children.

This guidance cannot 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

2. Adult Patients and Capacity

2.1 The presumption of capacity

'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.

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.

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.

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

The starting point is a presumption of capacity.

In England and Wales, and in Northern Ireland, patients who are aged 18 years and over are presumed to have capacity to consent, unless it is established that they lack capacity[1].

In Scotland, the position is slightly different. 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[2].

2.2 Assessing capacity

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

In *England and Wales*[3], your patient will not have capacity if:

a. he or she has an impairment or disturbance that affects the way their mind or brain works, and

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

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, or

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

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[1] *The Mental Capacity Act 2005* and common law principle
[2] *The Age of Legal Capacity (Scotland) Act 1991*
[3] Sections 2 and 3 of the *Mental Capacity Act 2005*

In *Scotland*, your patient will not have capacity if he or she is incapable of acting; or is incapable of making, communicating, understanding or remembering decisions[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).

The definition of incapacity in Scotland includes adults who are unconscious.

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.

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 by a patient that are unusual or are not what you would have chosen do if you were the patient, 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.

[4] *The Adults with Incapacity (Scotland) Act 2000*

2.3 Treating adult patients who lack capacity

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

In *England and Wales*, 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.

In *England and Wales*, and in *Northern Ireland*, you may also examine and treat a patient who lacks capacity if it is in their best interests for you to do so.

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

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.

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.

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

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, 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

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

    iii. (In England and Wales) anyone appointed with Lasting Power of Attorney, or

    iv. (In England and Wales) a deputy appointed by the Court of Protection.

The position is different in *Scotland.*

If you conclude that your patient lacks capacity, you cannot lawfully treat that patient unless the treatment is authorised by a Certificate of Incapacity[5].

Certificates of Incapacity can be issued by a medical practitioner, such as the patient's general practitioner or by a registered nurse (provided that the nurse has had their knowledge of the assessment of capacity certified by a Scottish further or higher education institution or by NHS Education for Scotland[6]).

A template for the Certificate can be obtained from:
http://www.scotland.gov.uk/Resource/Doc/254430/0086221.pdf

The law sets out five principles which must be observed in considering whether or not to provide treatment[7].

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:

a. be for the benefit of the patient

b. be the minimum necessary to achieve the desired benefit

c. take into account the patient's present and past wishes

d. take into account the views of the nearest relative, primary carer, proxy and relevant others, where it is reasonable and practicable to do so

e. encourage the patient to exercise residual capacity.

3. 16 and 17 year-old Minors

16 and 17 year-old minors are able to consent to medical treatment unless they lack capacity[8].

If you are treating such minors, it is important to establish whether they have capacity and you should use the same criteria as that for adult patients set out in section 2.1 above, to assess their capacity.

Even if a 16 or 17-year old patient 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[9].

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[5] Section 47 of the *Adults with Incapacity (Scotland) Act 2000*
[6] The Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Amendment Regulations SSI 2012/170
[7] Section 1 of the *Adults with Incapacity (Scotland) Act 2000*
[8] Section 4 of the *Age of Majority Act (Northern Ireland) 1969*; *The Age of Legal Capacity (Scotland) Act 1991*
[9] *The Mental Capacity Act 2005*: Code of Practice, at para. 12.13

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

Where a minor with capacity refuses treatment, this decision may be overridden by a person with parental responsibility, or by the Court.

In *Northern Ireland*, any power to override a decision made by the minor can only be exercised on the basis that the welfare of the young person is paramount.

Where a minor does not have capacity to consent, then you may be able to examine or treat them if it is in their best interests for you to do so. In determining whether or not it would be in the minor's best interests, 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

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

In *England and Wales*, and in *Northern Ireland*, 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[10].

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.

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

In *Scotland*, a child may have legal capacity to consent to treatment if, in the opinion of a qualified medical practitioner attending the child, that child is capable of understanding the nature and possible consequences of the procedure or treatment[11].

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.

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.

[10] Gillick v West Norfolk and Wisbech AHA [1986] AC 112
[11] Section 2(4) of the *Age of Legal Capacity (Scotland) Act 1991*

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 in *England and Wales* or *Northern Ireland.*

In *Scotland,* the child's decision to consent to treatment should be respected, even if it differs from the view of his or her parents.

In all UK countries, 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

Where the child lacks the capacity to consent, consent to treatment in *England* and *Wales* must be sought from a person with parental responsibility.

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, and

c. 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:

a. the child's mother

b. the child's father, if he was married to the mother at the time of birth

c. the child's legally appointed guardian

d. a person in whose favour a Court has made a residence order concerning the child

e. a local authority designated in a care order in respect of the child

f. a person who has been appointed by the Court as a guardian for a child with no parent with parental responsibility

g. 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

h. for children born on or after 6th April 2009:

    i. 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

ii. where the child's mother was 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.

In *Northern Ireland*, consent to the treatment of a child can be given on the child's behalf by any one person with parental responsibility, or by the Court.

Persons with parental responsibility include[12]:

a. the child's parents (if married to each other at the time of conception or birth)

b. for children born before 15 April 2002:

    i. the child's mother

    (If the father was not married to the mother at the time of the child's birth, the father will not have parental responsibility unless this is subsequently acquired via a court order or a parental responsibility agreement, or the couple subsequently marry).

c. for children born to unmarried parents on or after 15 April 2002:

    i. the child's parents if they jointly registered the child's birth, so that the father's name appears on the birth certificate

    ii. 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.

d. for children born on or after 6th 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:

    i. if she is registered as a parent of the child

    ii. via a parental responsibility agreement, or

    iii. by order of the Court

    iv. 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

    v. the child's legally appointed guardian.

[12] The Children (Northern Ireland) Order 1995 and *Family law Act (NI) 2001*

e. a person in whose favour the Court has made a residence order concerning the child

f. 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)

g. 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 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 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.

In *Scotland*, where the child is not capable of understanding the nature of the intervention or its consequences, consent to treatment must be sought 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.[13]

This provision does not apply to teachers and others who may have care and control of a child in school.

People who have parental responsibility include:

a. for a child born before 4 May 2006:

    i. both parents if the child's mother and father were married to each other (or got married later)

    ii. the child's mother only, if the child's mother and father are not married.

b. for children born on or after 4 May 2006:

    i. the child's mother

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

ii. the child's father, if he was married to the mother at the time of birth (or got married later)

iii. both parents provided that they have registered the child's birth together

iv. 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 parental responsibility and rights

v. Other people (such as grandparents, step-parents, aunts or uncles) if they are given parental responsibility and rights by a Court. [14]

c. for children born on or after 6 April 2009:

i. 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

ii. 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.

[14] *The Family Law (Scotland) Act 2006*

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)
- *Reference Guide for Consent to Examination or Treatment* (Welsh Assembly Government) 2008
- *A Good Practice Guide on Consent for Health Professionals in NHS Scotland* (Scottish Executive Health Department), 2006
- *Mental Capacity Act 2005* Code of Practice