Osteopathic Practice Committee
2 October 2014
Consent Scenarios

Classification	Public
Purpose	For discussion
Issue	Feedback from the Registrant Focus Group held in Autumn 2013 indicated that registrants would find it helpful to have some practical scenarios to accompany the guidance document *Obtaining Consent-Patient's capacity to give Consent*, which was published by the Council in October 2013. Consent is also a key part of developing continuing fitness to practise model and we are developing e-learning in relation to consent. These pieces of work complement each other.
Recommendation	To note the amended consent scenarios at Annex B.
Financial and resourcing implications	None
Equality and diversity implications	None
Communications implications	None
Annexes	A. Extract from Standard A4, *Osteopathic Practice Standards* B. Amended Consent Scenarios
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Background

1. In October 2013, following a recommendation from the Osteopathic Practice Committee, Council approved guidance on consent for registrants: *Obtaining Consent-Patient's Capacity to Obtain Consent*. Separate guidance was produced for England and Wales, Scotland and Northern Ireland.

2. The guidance underpins Standard A4 of the *Osteopathic Practice Standards*. A copy of the relevant part of Standard A4 is enclosed at Annex A, for ease of reference.

3. As part of the consultation process, the Executive held a focus group with registrants on 30 September 2013. The focus group was attended by 13 registered osteopaths. Six were male and seven were female. The registrants' experience of practice ranged from two years to 28 years. Eight of the group had experience of treating children and six of the group had experience of treating persons with mental health issues.

4. The feedback from the focus group was to the effect that registrants would find it very helpful if the GOsC produced both "information on the law" as well as practical guidance in the form of scenarios.

5. Issues which the registrant focus group thought might usefully be included in more practical guidance, included:

   a. Whether it was appropriate for an osteopath to charge an examination/ consultation fee for determining the issue of capacity (the person paying the fee might not necessarily be the prospective patient).

   b. The practical steps that should be taken before the examination to determine if a patient had capacity. This includes matters such as who should attend the consultation, the role/involvement of that person in decision making, and what information should be sought from patients or carers before hand.

      "These are things that you might need because it is a child. We might need a consent form from his parents or guardians or if it is somebody with diminished capacity, then we might need a consent form from a healthcare professional or somebody like that. That might be worth putting in the guidance just to help us out."

   c. Dealing with inebriated patients and patients with dementia.

6. Separately, in October 2013, the Council published its draft Continuing Fitness to Practise Framework. Since then, the executive has been working on draft guidance and case studies to support osteopaths to undertake CPD in the required areas, which include consent.

7. The development of the scenarios in this paper is therefore timely, as they provide further options for osteopaths to undertake CPD in consent in a simple, straightforward, yet useful way and to complement the pilot e-learning that we have already published in this area. Once agreed, the scenarios can be added into the draft CPD Guidelines before publication at the end of the year.

8. The consent scenarios at Annex B aim to flesh out the legal principles covered in *Obtaining Consent-Patient's Capacity to Give Consent*, and to deal with the particular areas identified by the registrant focus group.

Previous consideration by the Osteopathic Practice Committee

9. A first draft of the individual scenarios was considered by the Osteopathic Practice Committee at its meeting on 25 June 2014.

10. Members discussed the nature and purpose of the consent scenarios. A range of views on the merits and perceived flaws of the individual scenarios were expressed. It was noted that emerging best practice amongst the health care regulators was to provide registrants with a range of learning materials in different formats, which included scenarios and e-based learning packages. It was also noted that people had different learning styles and preferred to receive information in different ways. Feedback from the Pathfinder Groups have indicated strongly that scenarios were a useful learning tool.

11. It was acknowledged that consent is a particularly complex area for registrants and that learning materials on this topic would be a valuable addition.

12. However, it was agreed that any scenarios should strike the right tone with the profession and should reflect actual clinical practice as far as possible. It was suggested that shorter scenarios dealing with particular points of the Guidance issued by the GOsC, or the law on capacity to consent, might be preferable to longer all-inclusive scenarios. The importance of recording decisions taken in relation to consent should also be reflected in the scenarios.

13. The registrant members, Jonathan Hearsay and Haidar Ramadan, agreed to help the Executive rework the scenarios in the light of the points made by the Committee.

14. On 11 September 2014, the registrant members met at Osteopathy House to consider the scenarios. The members were provided with extracts of the minutes of the focus group which had made the original recommendation; the consent guidance for each UK jurisdiction; the draft minutes of the meeting on 25 June 2014; and the draft scenarios. The registrant members went back to the key issues of the consent guidance which the scenarios were intended to address, and worked through each scenario in turn.

15. A key concern was to ensure that the language and tone of the draft scenarios was appropriate and that the scenarios reflected actual clinical practice.

16. The amended scenarios are at Annex B. All three registrant members on the Committee are now satisfied with the scenarios as amended, and the Executive is most grateful to all the registrant members for their input and assistance in finalising the scenarios.

17. The scenarios will be published to provide examples of the sorts of considerations that can arise when considering consent issues and will be used to support registrants in complying with the GOsC Guidance in this area. The scenarios will also be used within our Continuing Fitness to Practice Guidance as part of the resources to support osteopaths.

Recommendation: to note the amended consent scenarios at Annex B.

***Extract of the Osteopathic Practice Standards* – Standard A4**

A4 You must receive valid consent before examination and treatment.

1. For consent to be valid, it must be given:

    1.1. Voluntarily.
    1.2. By an appropriately informed person.
    1.3. With the capacity to consent to the intervention in question.

2. The patient needs to understand the nature, purpose and risks of the examination or treatment proposed. The patient must then be free to either accept or refuse the proposed examination or treatment. Some patients may need time to reflect on what you have proposed before they give their consent to it.

3. Gaining consent is a fundamental part of your practice and is both an ethical and legal requirement. If you examine or treat a patient without their consent, you may face criminal, civil or GOsC proceedings.

4. Where your diagnostic examination and treatment are carried out simultaneously, consent may be best obtained by explaining your approach, describing the types of treatment methods you might like to use and setting the parameters within which you will work. If the patient consents to you proceeding on this basis, you may do so. If the patient expresses concern that you are going outside the agreed treatment plan, you must stop the treatment.

5. Before relying on a patient's consent, you should consider whether they have been given the information they want or need, and how well they understand the details and implications of what is proposed. This is more important than how their consent is expressed or recorded.

6. Patients can give consent orally or in writing, or they may imply consent by complying with the proposed examination or treatment, for example, or by getting ready for the assessment or care.

7. The validity of consent does not depend on the form in which it is given. Written consent may serve as evidence of consent but if the elements of voluntariness, appropriate information and capacity have not been satisfied, a signature on a form will not by itself make the consent valid.

8. It is particularly important to ensure that your patient understands and consents to the proposed examination or treatment of any intimate area before it is administered. Intimate areas include the groin, pubis, perineum, breast and anus, but this list is not exhaustive. Some patients may regard other areas of their body as ‘intimate’.

9. Valid consent does not always have to be in writing. However, if you are proposing a vaginal or rectal examination or technique, written consent should be obtained. You should ask the patient to provide their valid consent in writing, by signing a consent form. This form should be placed in the patient's records. You may also ask patients to provide their consent in writing for other procedures.

10. The law recognises that some patients – because of illness or mental capacity – are not competent to give consent for an examination or treatment. This is because they may not be able to absorb or weigh up the information and make an informed decision.

11. When an adult lacks mental capacity, decisions about their treatment must be taken in their best interests and in accordance with relevant legislation. Further details on the relevant legislation are provided in the GOsC guidance document *Obtaining Consent.*

12. You should involve children and young people as much as possible in discussions about their care, even if they are not able to make decisions on their own.

13. Before you examine or treat a child or young person, you should ensure that you have valid consent. Obtaining consent for treatment to be given to a child or young person is a complex issue: the guidance given below is a summary only and provides advice on the more common scenarios that present in practice. Further details are provided in the GOsC guidance document *Obtaining Consent*. Note that in the summary below a 'child' is a person under the age of 16 years and a 'young person' is a person aged 16 or 17 years.

14. A child may have the capacity to consent, depending on their maturity and ability to understand what is involved. You will need to use your professional judgement in assessing the capacity of each patient under 16 years. You are strongly advised, wherever possible, to involve the child's parent when seeking consent.

15. If a child with capacity gives their consent to treatment, a parent cannot override that consent.

16. If a child lacks the capacity to consent, you should ask for their parent's consent to treatment.

17. A young person can be treated as an adult and can be presumed to have the ability to make decisions about their own care. Nevertheless, you will need to use your professional judgement to assess whether the young person in fact has the maturity and ability to understand what is involved in the treatment you are proposing for them because, as with adults, consent must be valid (see A4, paragraph 1).

18. The position in relation to young people who lack capacity differs across the UK. In England, Wales and Northern Ireland parents may, in some circumstances, be able to give consent to treatment for their 16 or 17 year old son or daughter without capacity, while in Scotland young people without capacity are treated in the same way as adults who lack capacity. Further details are provided in the GOsC guidance document *Obtaining Consent.*

19. If a young person with capacity gives consent to treatment, that consent cannot be overridden by parents.

20. If a child or young person with capacity refuses treatment, that refusal may, in certain circumstances, be overridden. The need to override refusal of osteopathic treatment is likely to be rare, however, and in such an event you should refer to the GOsC guidance document *Obtaining Consent* and/or seek legal advice.

Obtaining Consent-Capacity to Consent – practical information

Introduction

1. This document has been designed to accompany the guidance set out in *Obtaining Consent-Patient's Capacity to Give Consent*.

2. The intention is to provide practical information to registrants on how they might deal with issues about a patient's capacity to give consent which arises within a clinical setting.

3. Obtaining consent is a fundamental requirement for the provision of osteopathic treatment.

4. As such, it is the registrant's responsibility to ensure that they comply with Standard A4 of the Osteopathic Practice Standards and that they are aware of the legal requirements for obtaining consent in the UK country in which they are practicing.

Scenario 1

Mr. Caddenet, a patient that is known to you, has made an appointment with you this afternoon for his new-born. When you gave him a reminder call this morning, he told you that his son's colic was "depriving both of us of sleep and driving us mad."

Twenty minutes after the appointment time, the bell rings and a distraught lady that is unknown to you staggers into your consultation room carrying a baby in a baby carrier. She wipes her nose and says "Phil couldn't make it."

You explain that you will need to take a case history from her and examine the baby. The lady hands you the baby and slumps in a chair at the side of the room. Still wearing her sunglasses, she says "all I know is that he's had colic since day one. It's got to stop. Please just do whatever it takes to sort the problem out."

You ask the lady to fill in a baby questionnaire and consent form. As you collect the forms, you notice that her hands are shaking. She signs the consent form without reading it but says she is too tired to fill in the questionnaire. She then asks if you mind if she goes to the toilet while you examine the baby.

Halfway through your examination, the lady reappears. Her mood is noticeably different. She is a lot more talkative and, indeed, rather loud. You explain the treatment that you intend to provide. The lady seems rather distant. "No problem", she says. "I've already signed the form."

What are the issues?

Your patient is an infant and therefore does not have legal capacity to consent to any treatment.

Who is the lady? Does she have the right to provide consent on behalf of the child?

Even if she does have the right to provide consent, is she able to do so in her current condition?

Might the lady's capacity to provide consent be temporarily affected by issues such as a lack of sleep, drugs or alcohol?

Having signed the forms before understanding what treatment is proposed and the potential risks, is the consent provided by the lady valid?

If the lady is not in a fit state for you to obtain a complete case history, is it appropriate to proceed to examination of the baby, or the formulation of a treatment plan?

What does the guidance say?

Where a child lacks capacity to consent, consent must be sought from a person with parental responsibility[1].

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.

The child's welfare or best interests must be paramount.

How should I deal with the situation?

Ask for the lady's identification, and seek clarification about whether or not she has parental responsibility for the child.

Contact Mr. Caddenet to clarify the lady's involvement with the baby.

Establish whether the lady is intoxicated or otherwise incapacitated.

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[1] See the guidance for the relevant UK country for a list of persons who may exercise parental responsibility in a particular jurisdiction.

Seek clarification about whether or not the lady really understands the treatment that you are intending to provide, and the potential risks of such treatment.

If in doubt, suggest that she return on another occasion.

Obtain a full case history before proceeding to examination or treatment.

If this is not possible, suggest that the lady returns on another occasion.

If you have concerns for the safety of the child, consider:

a. contacting Mr. Caddenet and asking him to come and collect the child

b. contacting social services or the police.

Prior to the appointment, it would be have been useful to explain to Mr. Caddenet that you would need to see documents confirming parental responsibility for the child, before you could undertake any examination or treatment.

Always remember to record your actions and conclusions (with reasons) as to a patient's capacity to consent, in the osteopathic treatment records.

Scenario 2

Mr. Lorenc, a gentleman who has moved to the UK recently, comes to see you. He is a senior citizen presenting with severe arthritis and aching neck pain.

You find the process of taking a history from Mr. Lorenc rather difficult. Mr. Lorenc seems to take quite a while to respond to any questions that you ask him, and when he does reply, he speaks very slowly.

You ask Mr. Lorenc to remove some of his clothing and when he takes off his hat, you realize that he is wearing a hearing aid. As you continue with your examination, Mr. Lorenc becomes increasingly erratic. He repeats some answers several times, and at times appears a little disorientated.

Slowly and carefully, you explain the treatment that you intend to provide and ask Mr. Lorenc whether he is happy to go ahead. Mr. Lorenc nods and smiles happily.

You begin the treatment.

Five minutes later, Mr. Lorenc asks you what he is doing in your office.

What are the issues?

Does Mr. Lorenc have capacity to consent, in the sense of being able to:

a. understand and retain information that is relevant to his condition and the treatment proposed

b. weigh the various options available (including the consequences of not having treatment)

c. communicate his decision (whether by talking, signing or any other means)

Does Mr. Lorenc have a good understanding of English? Is an interpreter required?

Is Mr. Lorenc's hearing aid working properly?

Is Mr. Lorenc suffering from some impairment (whether temporary or permanent) which affects the way his mind or brain works, and which means that he is unable to make a decision?

What does the guidance say?

The starting point is a presumption of capacity.

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.

In the rest of the UK, the test is slightly different. A patient will be deemed to lack capacity if he is not able to understand and retain information; weigh the treatment options; or communicate his decision.

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

The patient may be capable of making a decision on some aspects of their healthcare, but not others.

In some circumstances, you may be able to examine and treat a patient who lacks capacity, if it is their best interests to do so. The guidance sets out more detail on what matters should be taken into account in determining a patient's best interests.

In Scotland, patients who lack capacity may only be treated if such treatment is authorised by a Certificate of Incapacity issued by a doctor[2]. In addition, the law in Scotland establishes a number of statutory principles which must be observed before deciding whether or not treatment should be provided to a patient who lacks capacity[3].

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

How should I deal with the situation?

Seek to establish whether there are any difficulties arising from the hearing aid (is it on the correct setting?) or from language barriers.

If ability to understand English is an issue, consider asking Mr. Lorenc whether he would prefer to come back, accompanied by someone who can act as an interpreter.

Consider the use of more simple language, visual aids and signing.

If you assess Mr. Lorenc as lacking in consent, you may wish to discontinue any treatment and consider referring him to another healthcare practitioner.

You should be cautious in deciding to treat a patient who lacks capacity, and in deciding who is best placed to make a decision on what is in the patient's best interests.

Consider asking Mr. Lorenc to allow you to make direct contact with his GP, others involved in his medical care, and family members.

Consider seeking legal advice or advice from your professional body.

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[2] Section 47 of the Adults with Incapacity (Scotland) Act 2000
[3] Section 1 of the Adults with Incapacity (Scotland) Act 2000

Always remember to record your actions and conclusions (with reasons) as to a patient's capacity to consent, in the osteopathic treatment records.

Scenario 3

You receive a telephone call from Ms. Black. She says her son Steven has hurt his back playing rugby and the doctor has suggested that she should take him to an osteopath.

Ms. Black turns up at the appointment and insists on being present during your consultation with Steven. She has a habit of speaking before Steven can, and intervening to answer questions that you ask him, on his behalf.

While you are examining Steven, Ms. Black explains that she is not actually Steven's birth mother. However, her civil partner (who is Steven's birth mother) had to go to work today, and so Ms. Black has come instead.

After making your diagnosis, you explain the treatment that you intend to provide to Steven, and the potential risks of such treatment. Ms. Black felt that the risks of manipulation were too great and expressed her concerns. Ms. Black declines treatment on Steven's behalf.

The next day, Steven turns up alone. He says he doesn't care what anybody else thinks, he's looked up HVT on Google briefly and fast-forwarded through a video he found on YouTube, and it all seems ok. In any event, he is very keen to get back to playing rugby as quickly as possible, and so wants to go ahead with the treatment.

What are the Issues?

How old is Steven? Has he reached the legal age at which consent can be given?[4]

If not, does Ms. Black have parental responsibility and is she able to provide consent on his behalf?[5]

If Steven has capacity, can his wishes be overridden by Ms. Black?

What does the Guidance say?

Young persons over the age of 16 are able to consent to medical treatment unless they lack capacity.

Children under the age of 16 may be able to consent if they have sufficient maturity and intelligence to enable them to understand what is involved in the proposed intervention or treatment.

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[4] Young persons aged 16 years and above can consent to treatment unless they lack capacity. See section 8 of the Family Reform Act 1969, England and Wales; section 1 of the Age of Legal Capacity Act (Scotland) 1991; and section 4 of the Age of Majority Act (Northern Ireland) 1969.

[5] See footnote 1 above.

However, in Scotland, a doctor must certify that the child is capable of understanding the nature and possible consequences of the procedure or treatment, before any treatment can be undertaken[6].

The level of understanding required for different treatments may vary.

Establishing whether a child has capacity to consent is a matter of professional judgment. This will involve consideration of issues 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.

The criteria for capacity are the same as that for assessing capacity in adults.

It is good practice to encourage patients who are under 17 years of age to involve their family in decisions about their treatment.

In England and Wales, and in Northern Ireland, where a young person 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.

However, where a young person with capacity refuses consent to treatment, that decision may be over-ridden by a person with parental responsibility or by a Court in certain circumstances.

The legal position is less clear in Scotland, and you should seek legal advice.

How should I deal with the situation?

Prior to the appointment, it would be have been useful to explain to Ms. Black that you would need to see documents confirming parental responsibility for the child, before you could undertake any examination or treatment.

Where parental responsibility is claimed by a civil partner who is not a birth parent, the date of the child's birth will be a factor in determining whether or not the civil partner does indeed have parental responsibility.

It is important that you clarify the issue of parental responsibility at the outset of the consultation.

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

Consider asking Ms. Black to wait outside while you consult with your patient. Or make it clear to her, that it is important for you to obtain answers and information directly from your patient.

You may wish to consider inviting Steven, Steven's birth mother and her civil partner to another appointment to discuss your proposed treatment plan and the risks of treatment.

In these circumstances, it might be appropriate to charge a fee for your time.

Only consider treating Steven if you are satisfied that he has capacity to consent and that his consent is fully informed and valid. In these circumstances, you should explain to him that it would be helpful to keep his parents informed of the situation, whilst acknowledging the confidentiality of the patient-osteopath relationship.

Consider obtaining legal advice or advice from your professional association.

Always remember to record your actions and conclusions (with reasons) as to a patient's capacity to consent, in the osteopathic treatment records.