

Supporting note

Consent to care and treatment

Purpose of note	<p>To clarify the definition of consent and the different types of consent.</p> <p>To provide signposting to information that explains when certain types of consent should be obtained and any special circumstances surrounding some types of treatment and consent.</p> <p>Please note: this supporting note should be read in conjunction with the supporting note on Resuscitation: Staffing.</p>	
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Main outcome	2: Consent to care and treatment	G
Specific prompt(s)	All prompts in consent outcome; in particular 2G and 2H	
The note may also be relevant, in part, to the following outcomes	1a - 1h 14	

This note is relevant to the following service types
All service types All population groups

Detail of the note to the essential standards
<p>It is a general principle that valid consent must be obtained for a person before starting treatment or physical investigation, or providing personal care.</p> <p>This principle reflects people's right to determine what happens to their own bodies, and is a fundamental part of good practice.</p> <p>For consent to be valid, it must be given voluntarily and freely, without pressure or undue influence being exerted on the person either to accept or refuse treatment. The consent must be given by an appropriately informed person who has the capacity to consent to the intervention in question.</p>

This could include the patient, someone with parental responsibility, the court, someone authorised under a Lasting Power of Attorney (LPA) or someone who has the authority to make treatment decisions as a court appointed deputy. (Refer to reference section for further information.)

There are situations such as in an emergency or when a person is unconscious, when consent cannot be obtained. Further guidance is available in the reference section that explains what to do in these types of situation.

Types of consent

There are different types of consent in health care and social care settings. The Department of Health (DH) and professional bodies have produced comprehensive guidance about consent. The DH guidance includes information about what consent is, the different types of consent, when consent should be obtained, by whom and in what circumstances. This note reflects some of the key points from the DH guidance.

The validity of consent does not depend on the form in which it is given.

Written consent

Written consent merely serves as evidence of consent. It is valid if it is given voluntarily and appropriate information and capacity have been satisfied. A signature on a form will not make the consent valid.

It is good practice to use forms for written consent where an intervention such as surgery is to be undertaken. Most providers' consent policies will require written consent to be obtained in these circumstances. Most professional bodies and the guidance from DH also advise this as good practice. Details of the assessment of capacity, and the conclusion reached, should be recorded in the case notes.

Verbal (explicit) and non-verbal (implied or implicit) consent

Sometimes verbal consent might be referred to as 'explicit' consent, and non-verbal may be referred to as 'implied' or 'implicit' consent.

An example of non-verbal or implied consent would be where a person, after receiving appropriate information, holds out an arm for their blood pressure to be taken or opens their mouth for their teeth or throat to be examined. However, the person must have understood what examination or treatment is intended, and why, for such consent to be valid. This could also apply for patient transport services. For example, when a person is called to get into an ambulance in order to be transported for treatment.

An example of verbal or explicit consent would be where a doctor carries out a rectal examination of a patient and tells the patient what they want to do and asks them if they agree to such an examination. If the patient agrees then this is explicit consent (verbal consent).

In all cases, staff should be aware of the different types of consent and the importance of ensuring that the person understands what is going to happen to them

and what is involved. Staff should also be aware of and understand what to do if people refuse care or treatment or when consent is not valid or is no longer valid.

Treatments requiring special types of consent

Some procedures and treatments require special consent procedures to be followed. The following are examples of when special consent should be obtained:

- a) Before a person's gametes are used for the treatment of others, or to create an embryo in vitro.
- b) Before donation from living people of solid organs, bone marrow and peripheral blood stem cells for transplantation into others.
- c) Before research is carried out.

Refer to the reference section of these notes about the Human Fertilisation and Embryology Act 2008 (HFEA) and Human Tissue authority (HTA).

Refusal of consent

If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment, this decision must be respected, except in certain circumstances as defined by the Mental Health Act 1983 (see reference section for further detail). This is the case even where this may result in the death of the person and/or the death of an unborn child, whatever the stage of the pregnancy.

Advance decisions

Outcome 2B refers to advance decisions. Please refer to the first DH link in the 'background and reference' section for information and guidance about advance decisions.

Please note, there is a separate supporting note about decisions regarding resuscitation.

Withdrawal of consent

A person with capacity is entitled to withdraw consent at any time, including during the performance of a procedure. Where a person does object during treatment, it is good practice for the practitioner, if at all possible, to stop the procedure. They should establish the person's concerns and explain the consequences of not completing the procedure.

At times, an apparent objection may in fact be a cry of pain rather than withdrawal of consent. Appropriate reassurance may enable the practitioner to continue with the person's consent. If stopping the procedure at that point would genuinely put the life of the person at risk, the practitioner may be entitled to continue until that risk no longer applies (see reference links for further detail).

Children and young people

The legal position concerning consent and refusal of treatment by those under the age of 18 is different from the position for adults. In this supporting note 'children' refers to people aged below 16 and 'young people' refers to people aged 16–17.

Young people

In section 8 of the Family Law Reform Act 1969, people aged 16 or 17 are presumed to be capable of consenting to their own medical treatment. However, the refusal of a competent person aged 16 or 17 may, in certain circumstances, be overridden by either a person with parental responsibility or a court. If the 16/17-year-old is capable of giving their own valid consent then it is not legally necessary to obtain additional consent from a person with parental responsibility for them. However, it is good practice to involve the young person's family in the decision-making process if the young person consents to their information being shared. If they do not, or they specifically wish to exclude their family, then their family should not be involved. Refer to reference section for further guidance.

Children under 16

Children who have 'sufficient understanding and intelligence' to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention. This is sometimes described as being 'Gillick competent'. A child younger than 16 may be Gillick competent to consent to medical treatment, research, donation or any other activity that requires their consent. There is extensive guidance about children's consent and the reference section provides links to example of further guidance. There is particular guidance about treatment relating to contraception, or the child's sexual or reproductive health, and abortion.

Child or young person with capacity refusing treatment

Where a young person of 16 or 17 who could consent, or a Gillick competent child under 16 refuses treatment, it is possible that such a refusal could be overruled. Authority to overrule such decisions, except in emergencies, should normally be sought from the court. Refer to reference section for further information.

Outcome 2G - Consent regarding imaging services provided to people with no symptoms to indicate that imaging is required:

Examples of such imaging services range from ultrasound imaging scans for pregnant women, such as those providing baby keepsakes to those providing ultrasound to determine a range of conditions. For example, ovarian cysts or tumours, or a range of vascular conditions (including abdominal aortic aneurysm (AAA) and stroke).

Some providers use magnetic resonance imaging (MRI) services for organ or whole body scanning as part of a well-person clinic, or computed tomography (CT) services which might involve a whole body CT, individual or multi-organ, bone density or fat assessment.

People using services or patients will often present with no symptoms of ill-health or disease (asymptomatic), although they may present with risk factors for disease.

For consent to be valid, the 'normal' consent principles should be followed, in that the person undergoing the examination should be aware of the risks and benefits and potential implications associated with the examination. The Ionising Radiation Medical Exposure Regulations 2000 (IRMER) require that all ionising radiation examinations must be justified before being carried out.

Outcome 2H - Mental capacity

Where a person lacks the mental capacity to make a decision for themselves, any decision must be made in that person's best interests. The Mental Capacity Act (MCA) set out the duties that providers should follow, in cases when serious medical treatment decisions are made for a person who lacks mental capacity to make such a decision for themselves.

For further information, refer to the Mental Capacity Act (2005) Code of Practice and the reference section in this note for information about mental capacity. We have also published guidance on the Mental Capacity Act and the Deprivation of Liberty Safeguards on our website and intranet.

Background and references

Department of Health, Reference guide to consent for examination or treatment
Second edition:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103653.pdf Gateway reference 11911.

Department of Health, Seeking consent: working with children:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007005

Human Tissue Authority (HTA), Policy on consent for post-mortem examination and tissue retention under the Human Tissue Act 2004:

<http://www.hta.gov.uk/legislationpoliciesandcodesofpractice/policyonconsentforpost-mortemexaminationandtissuere retention.cfm>

Human Tissue Authority (HTA) Legislation, policies and codes of practice:

<http://www.hta.gov.uk/legislationpoliciesandcodesofpractice.cfm>

Human Fertilisation and Embryology Bill:

<http://www.publications.parliament.uk/pa/cm200708/cmbills/070/08070.59-65.html#j260s>

Department of Health, Requested allocation of a deceased donor organ:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114800

Department of Health: General links to consent publications:

<http://www.dh.gov.uk/en/AdvanceSearchResult/index.htm?searchTerms=consent>

Consultation response to the COMARE 12 Report: recommendations on CT scanning of asymptomatic self-referred individuals:
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_115163 (paste link into web browser)

Health Protection Agency, Health Effects of Exposure to Ultrasound and Infrasonic:
http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1265028759369

Department of Health, Mental Capacity Act (2005) Code of Practice:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

CQC staff intranet about the Mental Capacity Act and Deprivation of Liberty Safeguards: <http://intranet.cqc.local/CQCIntranet/policies--guidance/acts/mental-capacity-act-2005.aspx>

Guidance for providers about the Mental Capacity Act and Deprivation of Liberty Safeguards:
<http://www.cqc.org.uk/guidanceforprofessionals/adultsocialcare/complyingwiththeregulations/mentalcapacityact.cfm>