

Position responsible: Medical Director
Approved by: CGC

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Related Documents SOP 1.12 Photography at Scene

Further information See Section 10 in this policy

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1.0 Background

- 1.1 Consent represents a patient's agreement for a person acting in a healthcare capacity to provide care. The act of 'obtaining consent' is better thought of as 'joint decision-making': the patient and health care provider come to an agreement on the best way forward, based on the patient's values and preferences and the health care provider's clinical knowledge. A great deal of guidance exists regarding the legal and ethical principles surrounding this 'joint decision-making' process. This policy aims to summarise the available guidance as it applies to the situations faced by Magpas clinicians.
- 1.2 All patients have a fundamental right to determine what happens to their own bodies. Valid consent to examination, treatment and transport is therefore absolutely central to all forms of healthcare.
- 1.3 Seeking consent is also a matter of common courtesy between Health Care Professionals and Patients (Department of Health and Social Care – 'Good Practice in Consent' Implementation Guide, November 2001).
- 1.4 The context of consent can take many different forms, ranging from the active request of a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a Health Care Professional's advice.
- 1.5 This policy reflects the key recommendations outlined in the Department of Health and Social Care guide to consent for examination or treatment second edition 2009 which can be accessed on the gov.uk website:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653_1.pdf
- 1.6 The Department of Health and Social Care has issued a number of guidance documents on consent, and these should be consulted for advice on the current law and good practice requirements in seeking consent.
 - *Reference guide to consent for examination or treatment second edition 2009* provides a comprehensive summary of the current law on consent and capacity, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent.

- *12 key points: the law in England* has been distributed widely to health professionals working in England and summarises those aspects of the law on consent which arise on a daily basis and is attached in Appendix 1.

1.7 The UK Resuscitation Council (UK) is the authoritative body which publishes guidelines to assist those attempting resuscitation and outlines current good practice of resuscitation.

- *The legal status of those who attempt resuscitation* very clearly outlines details of claim for trespass or negligence, liability by Health Care Professionals, 'Non-Professional' First-Aiders such as Community First Responders and training agencies and minimisation or avoidance of liability

1.8 *The Mental Capacity Act 2005* is on the statute books and came into force in 2007.

2.0 Objectives

2.1 The objective of this policy is to ensure that all patients attended by Magpas clinicians are enabled to provide consent for the procedures they undergo if appropriate or feasible. For the consent to be valid the patient must:

- Be competent (ie have capacity) to take the particular decision they are asked to make [if considered to lack capacity to consent – see appendix 2] and
- Have received sufficient information to take a decision and
- Not be acting under duress.

2.2 It will provide guidance on situations when consent is required and the considerations that must be taken into account when a patient's consent to treatment is sought.

2.3 It sets out whose responsibility it is to obtain consent in a variety of situations.

3.0 Definitions

3.1 Capacity in the legal context of obtaining consent is a person's ability to make a decision, which may have legal consequences for that person, or for other people.

3.2 Presence of capacity/competence is pivotal in balancing the right to autonomy in decision making and the right to protection from harm.

3.3 Capacity must be presumed until the contrary is proven and a two-step assessment of capacity/competence is helpful (see appendix 2).

3.4 If a patient's choice of decision appears irrational or does not correlate with clinician's view of what is in the patient's best interests, this is not evidence in itself that the patient lacks capacity/competence.

4.0 Obtaining Consent

- 4.1 Patients' consent will be obtained in a consistent and responsible way wherever appropriate or feasible, in accordance with Department of Health and Social Care Guidelines, Care Quality Commission guidance and guidance from medical and health professional bodies and in a manner acceptable to Magpas.
- 4.2 In pre-hospital emergencies where life is at risk and the patient lacks capacity to give or withhold consent (sometimes referred to as the incompetent adult), consent by way of discussing treatment options and confirmation that the patient wishes to go ahead, is clearly not feasible. Magpas clinicians may provide treatment to anyone who needs it, provided the treatment is limited to what is immediately necessary to save life or avoid significant deterioration in the patient's health and is considered to be in the best interests of the patient. It would be unreasonable to postpone immediately necessary treatment or transport until the patient could be in a position to consider consent. This is recognised in Common Law as the 'doctrine of necessity'. It is the legal basis for the provision of immediately necessary pre-hospital emergency care by Magpas clinicians to acutely physically or mentally incapacitated patients, regardless of their age. In the words of the House of Lords: 'doubt should be resolved in favour of the preservation of life'.
- 4.3 No one can give consent on behalf of an incompetent adult. However, such patients may still be treated if the treatment would be in their 'best interests' such as
- Where the patient is unconscious and cannot indicate his or her wishes but requires life-saving procedures
 - Where the patient is incapable of giving consent by reason of mental disorder or learning disability but requires treatment for a physical disorder [NB: the presence of a mental disorder or a learning disability does not in itself imply incapacity, nor does detention under the Mental Health Act 2007]. Each patient's capability for giving consent must be judged individually in light of the decision required and the mental state of the patient at the time
- 4.3.1 If treatment has been refused in advance in a valid and applicable Living Will, the law makes it clear that these advance decisions are legally binding and clinicians should follow the directive once the patient lacks capacity. This overrules any personal welfare Lasting Power of Attorney (LPA) and the 'best interests' provision.
- 4.4 Deprivation of Liberty Safeguards are unlikely to apply to taking patients to hospital even if there is an expectation that patients may be deprived of liberty once there.
- 4.5 Consent must be specific as capacity is contextual such that a patient may have capacity to make one decision but not all decisions, and this will change over time.

5.0 Responsibilities of clinicians

- 5.1 The 'doctrine of necessity' does not absolve Magpas clinicians of their legal and ethical responsibilities to patients. This policy and the related documents should be read with the understanding that the aim is always to obtain valid consent wherever it is possible to do so. Indeed, a Magpas healthcare professional who does not respect this principle may be liable

to legal action by the patient and, for healthcare professionals, action their professional body. Magpas itself may also be liable for the actions of clinicians.

- 5.2 Magpas team members shall ensure that they obtain consent from their patients whenever feasible.
- 5.3 Frequently clinical team members are attending patients with immediate life-threats or who have sustained time-critical injuries: the amount of detailed information prior to obtaining verbal consent may have to be severely limited on a risk-benefit assessment. This decision requires thorough clinical judgement and agreement of both Magpas clinicians, and should be documented retrospectively on the patient report form. If there is any doubt regarding either the validity of the consent or the need to provide life-saving treatment in those that cannot consent, the Duty Advice Doctor should be contacted.

6.0 The Requirements of Providing Information to Patients Regarding Consent

- 6.1 The provision of information is central to the consent process.
- 6.2 Information provided should include details of treatment involved, benefits and risks, immediate and long-term implications of not having treatment, what alternatives might be available and who will be administering the treatment.
- 6.3 The amount and depth of information provided by the pre-hospital care providers will always involve a degree of clinical judgement depending on the urgency and seriousness of the patient's condition.
- 6.4 For time-critical, life-saving interventions, such as CPR or pre-hospital anaesthesia, giving verbal information may be irrelevant or may be limited to a bare minimum.
- 6.5 Where the patient makes it clear (verbally or non-verbally) that they do not wish to be given information or very limited information only, this should be documented.

7.0 Documenting the Process of Consent

- 7.1 Consent can be written, oral or non-verbal. The pre-hospital emergency care environment does not lend itself to the use of written consent forms as used in other aspects of hospital based emergency care.
- 7.2 In pre-hospital care, written consent is usually documented when treatment is refused eg patient's refusal to travel to attend hospital.
- 7.3 In life-threatening emergencies which are time-critical, consent is often implied by patients who have capacity by allowing examination and treatment to be performed (e.g. stretching out arm for intravenous access or for taking blood pressure).
- 7.4 In patients who lack capacity and if there are no valid advance directives, consent is presumed using the principles of acting in the 'best interest'.

- 7.5. It is not usually necessary to document a patient's consent to routine and low risk procedures such as administering oxygen via facemask.
- 7.5.1 However if there is any reason to believe that the consent may be disputed later or if the procedure is of a particular concern to the patient (for example if they have declined, or become very distressed about similar care in the past) it is considered good practice to document that consent had been sought and obtained in writing on the patient report form.
- 7.6 Occasionally there will not be a consensus on whether a particular treatment is in a patient's best interests or whether the 'doctrine of necessity' applies. Where the consequences of having, or not having, the treatment is potentially serious, the 'doctrine of necessity' should be followed and contemporaneous notes made. Where possible, advice from the on-call Duty Advice Doctor or the receiving Emergency Department senior clinician should also be sought.

8.0 Additional policy statements in respect of patient who 'lack capacity' and children

- 8.1 A child or young person under age 16 may have capacity to decide to be treated, depending on their ability to understand what is involved in their pre-hospital care.
- 8.2 The child or young person under age 16 and those with parental responsibility (not all parents have automatically parental responsibility for their children, e.g. unmarried fathers), must be provided with valid, relevant, accurate, up-to-date and well-presented information that is appropriate to their level of understanding before they are asked to decide whether to consent to examination or treatment.
- 8.3 However refusal of treatment by a child or young person under the age of 16 does not carry the same weight in English law as agreement to treatment. A person under the age of 18 can be treated by pre-hospital care providers even if they have refused consent to treatment if that treatment is considered to be in their best interest.

9.0 Clinical photography and digital or conventional video recording

- 9.1 The policy on photography at the scene is to be strictly followed by the Magpas team. It is detailed in SOP 1.12 Photography at the Scene which forms part of this policy.

10.0 References

- 10.1 Department of Health and Social Care, Reference Guide to consent for examination or treatment, second edition 2009 www.dh.gov.uk
- 10.2 Department of Health and Social Care, Good practice in consent implementation guide: consent to examination or treatment, November 2001 www.dh.gov.uk
- 10.3 General Medical Council, Consent: Patients and doctors making decisions together, 2008 http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp

- 10.4 Assessment of Mental Capacity: guidance for doctors and lawyers, 2nd edition, 2004 published by the British Medical Association and the Law Society
- 10.5 The Mental Capacity Act 2005 www.opsi.gov.uk/ACTS
- 10.6 Medical Protection Society guidance 'Mental Capacity Act 2005', <http://www.medicalprotection.org/uk/resources/england-factsheets-by-topic/mental-capacity>
- 10.7 Resuscitation Council (UK), The Legal status of those who attempt resuscitation, October 2000 <http://www.resus.org.uk>
- 10.8 Magpas SOP 1.12 Photography at the scene

Appendix 1 - 12 key points on consent: the law in England

When do carers need consent from patients?

- 1 Before you examine, treat or care for competent adult patients you must obtain their consent.
- 2 Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: "can this patient understand and weigh up the information needed to make this decision?" Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.
- 3 Patients may be competent to make some health care decisions, even if they are not competent to make others.
- 4 Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

Can children give consent for themselves?

- 5 Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, someone with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent cannot override that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent?

- 6 It is always best for the person actually treating the patient to seek the patient's consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

What information should be provided?

- 7 Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.
- 8 Consent must be given voluntarily: not under any form of duress or undue influence from carers, family or friends.

Does it matter how the patient gives consent?

- 9 No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient's decision, and also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.

Refusal of treatment

- 10 Competent adult patients are entitled to refuse treatment, even when it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the fetus.

Adults who are not competent to give consent

- 11 No one can give consent on behalf of an incompetent adult. However, you may still treat such a patient if the treatment would be in their best interests. 'Best interests' go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.
- 12 If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'advance refusal'), and those circumstances arise, you must abide by that refusal.

This summary cannot cover all situations. For more detail, consult the *Reference guide to consent for examination or treatment*, available from the NHS Response Line 08701 555 455 and at www.doh.gov.uk/consent.

Appendix 2 – Assessment of capacity

The starting assumption should always be that a person has capacity. The Act details a two stage test of capacity:

Stage 1	Does the person have an impairment or disturbance in the functioning of their mind or brain eg concussion, alcohol abuse, conditions associated with mental illness?
Stage 2	Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

To be able to make a decision a person should be able to:

- Understanding the decision to be made and information provided about the decision
- Retain the information for long enough to make the decision
- Weigh up the pros and cons of the information and making the decision
- Communicate their decision