

CHARTFIELD SURGERY

CONSENT TO CARE AND TREATMENT POLICY

OUTCOME 1 & 2

Introduction

Respect for Chartfield's patients' autonomy is expressed in consent law; to impose care or treatment on people without respecting their wishes and right to self-determination is not only unethical, but also illegal.

Key Principles:

I. The patient must be competent

Mental capacity is decision-specific. Assessment of a person's capacity should be based on his/her ability to understand, retain and weigh in the balance the information relevant to a particular decision. The person must also be able to communicate the decision. A patient who is unable to make a decision about a complex proposal is not necessarily incapable of making any decisions at all, and may be perfectly able to consent where the issues are simpler. The starting point in the case of adults is always to presume that the patient has capacity until it is shown otherwise.

II. The patient must have sufficient information to make a choice

Without adequate information, patients are unable to make decisions about their treatment. The information provided should, for example, include: an explanation of the investigation, diagnosis or treatment; an explanation of the probabilities of success, or the risk of failure; or harm associated with options for treatment. The patient should be given time to ask questions. The GMC and the courts expect patients to be given all information material to their decision, with the proviso that it would not cause the patient serious harm.

III. The patient must be able to give their consent freely

Pressuring patients into consenting to treatment invalidates the consent. To ensure that consent is freely given, patients should, where possible, be given time to consider their options before deciding to proceed with a proposed treatment. Be

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aware, too, that patients' friends and relatives may also try to exert their influence and that this can be subtle but nevertheless powerful.

IV. Patients who lack capacity

Patients who lack capacity should not be denied necessary treatment simply because they are unable to consent to it. The principle of proxy decision making on behalf of children is well established in General Practice. The Mental Capacity Act 2005 has provisions allowing for the appointment of proxy decision makers for incapacitated adults.

In the absence of a proxy decision maker, either because there isn't one or because the proxy cannot be reached before emergency treatment is required, the principle of necessity justifies treatment of an incompetent patient without consent. In all these circumstances any decision that is taken on behalf of an incompetent patient must be taken in his or her **best interests**.

V. Verbal or written consent?

There are very few occasions where the law specifically requires written consent. In the main, a verbal consent is just as valid as written consent. Consent is a process – it results **from open dialogue**, not primarily from getting a signature on a form.

Completed consent forms provide some evidence that consent was obtained, but mean little beyond that – it is important to realise that they do not constitute proof that the consent was valid. If there is any dispute over whether valid consent was obtained, the key issue will not be whether the patient signed a form or not, but whether they were given all the information they needed to make a considered decision. It is, therefore, crucial that the essential elements of discussions with the patient are documented in the medical record and that the EMIS code indicating consent was obtained is added.

The notes **do not need to be exhaustive**, but should state the nature of the proposed procedure or treatment and itemise the risks, benefits and alternatives brought to the attention of the patient. Any particular fears or concerns raised by the patient should also be noted.

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Some NHS trusts require consent forms to be completed as a matter of policy, but this does not alter the fundamental **requirement to give patients all the information they need and want before seeking consent to treatment.**

VI. Failure to obtain valid consent

A significant proportion of clinical negligence claims are settled simply because valid consent was not obtained. In theory, where harm has befallen the patient and consent was not obtained, this could also give rise to claims for assault or battery and, in extreme cases, criminal charges, but fortunately this is exceptionally rare. Should a clinician have doubts about consent they should always seek advice from the practice manager or supervising clinician.