NHS
HDL (2006) 34

SCOTTISH EXECUTIVE

Health Department
Directorate of Healthcare Policy and Strategy

St Andrew's House
Regent Road
Edinburgh EH1 3DG

16 June 2006

Dear Colleague

A Good Practice Guide on Consent for Health Professionals in NHSScotland

Purpose

1. I attached a copy of *A Good Practice Guide on Consent for Health Professionals in the NHSScotland.* This replaces the previous guidance "A Guide to Consent to Examination, Investigation, Treatment or Operation", published in 1992.

Background

2. The new guidance summarises good practice on consent and takes account of several key legislative changes which impact on the safe delivery of health care, including:

- The Adults with Incapacity (Scotland) Act 2000, and
- The Mental Health (Care and Treatment) (Scotland) Act 2003.

Its purpose is to assist health professionals ensure that patients can make informed decisions about healthcare interventions.

3. The guidance, which will be reviewed and updated annually, is also available at
http://www.show.scot.nhs.uk/publicationsindex.htm
A quick reference leaflet will also be provided, as will companion guides for patients and children under the age of 16 developed by the Scottish Consumer Council's Health Rights Information project.

Action

4. Medical Directors, Directors of Nursing and Lead Allied Health Professionals are asked to ensure that the copies of the new guidance which are being sent to NHS Boards are distributed, and the best practice advice it contains implemented across their NHS Board area.

For action

Medical Directors, NHS Boards
Nursing Directors, NHS Boards
Allied Health Professionals, Leads

For information

Chief Executives, NHS Boards
Chief Executives, Special Boards
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Scottish Executive Health Department
June 2006

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Introduction

This document is a good practice guide and summary of the main issues surrounding consent and confidentiality.

Its purpose is to assist health professionals working in NHSScotland and help ensure that their patients make informed decisions about individual healthcare interventions. **It excludes situations such as obtaining consent for research, multi-disciplinary work, authorisation for post mortem examinations and retention of organs.**

Please note that its purpose is to give guidance only.
You are strongly advised to seek your own independent legal advice.

This Guide replaces *"A Guide to Consent to Examination, Investigation, Treatment or Operation"* which was published by the NHS Management Executive in 1992. Since then, there have been important changes in the way that healthcare is delivered in Scotland.

The Adults with Incapacity (Scotland) Act 2000 was introduced in stages, with Part 5 Medical Treatment and Research coming into effect in July 2002. Following that, the Mental Health (Care and Treatment) (Scotland) Act 2003 came into effect in stages from March 2004 and is now largely in force, replacing the Mental Health (Scotland) Act 1984. Both Acts provide for delivering healthcare to people who lack the ability to make treatment decisions for themselves.

During the course of examining, investigating and treating, health professionals have access to confidential healthcare information about their patients. Normally the patient's consent is required before information can be shared outwith the care team. The *NHS Code of Practice on Protecting Patient Confidentiality* published by the Scottish Executive in Autumn 2003 provides key information to assist the practitioner in this area.

Please refer to Appendix B for other important documents that the practitioner should consult with regard to obtaining informed consent.

Chapter 1 Principles of Consent

Why obtain consent?

Generally, people have the right to decide whether or not to agree to healthcare interventions, including examinations, diagnostic procedures and treatment. There are exceptions to this in the case of persons aged under 16 (see Chapter 2) and persons who have no or impaired capacity (see Chapter 3) or where compulsory treatment is authorised under the Mental Health (Care and Treatment) (Scotland) Act 2003. It is important to respect this right, to provide the requisite information about the procedure and to obtain their permission or agreement before you proceed with the intervention. This is often described as "**getting consent**."

You must also respect your patients' dignity, privacy and confidentiality. Normally, the consent of your patients is required before you disclose any information obtained in the course of their healthcare. The *NHS Code of Practice on Protecting Patient Confidentiality* published by the Scottish Executive in Autumn 2003 provides key information to assist the practitioner in this area .

Getting consent

Four general principles are central to getting consent from the patient to receiving clinical treatment or investigation. These are:

1.1 Information

People should receive enough information, supplied in a way that they can understand, before they make up their minds about the proposed examination, diagnostic procedure, treatment or anaesthesia. The information should include benefits, significant risks and the implications of any relevant options, including the option of not having the intervention. The person should be given information specific to their own circumstances. It is good practice to allow enough time for consideration and, if they wish, discussion with family and friends. If they ask questions, these must be answered honestly.

It is important to ensure that there is sufficient time sharing and considering that information, even though this may be difficult to achieve in a busy surgery or clinic. You should be aware that some people, because of their background or circumstances e.g. different language, complex communication needs, may need extra support to make an informed decision about what is right for them. Advocacy support should be considered as one possible form of such assistance.

1.2 Freedom of Choice

Patients' agreement to proceed must be given voluntarily without pressure, deceit or undue influence being used. Health professionals should ensure that patients have reached their own decisions and understand that they can change their minds if they do not wish to continue with the procedures.

1.3 Capacity

The law in Scotland presumes that people aged 16 and over have the capacity to make their own decisions. Having capacity means being able to understand and remember what is being proposed, to weigh up the relevant information, including its benefits, hazards and options, and to use this in reaching a decision. People may have enough capacity to take some healthcare decisions for themselves but may lack the capacity to decide about other, more complex, healthcare matters.

You should be aware that decisions which are unusual, unexpected or not what you would have chosen do not necessarily mean that a patient lacks capacity: instead, it may highlight the need for further information or a clearer explanation or an understanding of the person's individual circumstances. People under the age of 16 may have sufficient capacity to make healthcare decisions for themselves if given adequate support (see Chapter 2).

1.4 Ongoing process

Consent to be examined, investigated and treated is usually an ongoing process, not a single event. People can change their minds and withdraw their consent at any time. If you are in doubt, check with your patient (or their advocate) to ensure that they still wish to continue with the healthcare being offered. People may be willing to participate in some parts of the proposed treatment, but decline others.

Should consent be in writing?

Some statutes require written consent to be obtained before a procedure can be carried out. Examples of this are treatments under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 where the patient is capable of consenting to treatment (see Chapter 3), and the Human Fertilisation and Embryology Act 1990, which deals with certain fertility treatments.

It is important that the clinical practitioner is aware of the local Health Boards policy on when written consent ought to be obtained. Generally however, it is not essential that consent be given in writing. In some situations, the patient may give their consent verbally or by their actions e.g. holding out their arm to have blood taken.

Whether or not consent requires to be given in writing, it is essential that the patient understands and agrees to the healthcare intervention (children and persons who lack capacity are discussed in Chapters 2 and 3). Where consent forms are used, a signature on a form will be evidence that the patient has given consent, but if the patient does not understand the procedure, or their first language is not English or they are a British Sign Language user, the consent may not be valid.

Whatever the process, it is therefore important that you and your patient both understand what has been agreed. It is also important to document within the patient's health record the information provided verbally and outcome.

Who should ask for consent?

Where the person is over 16 and has capacity, it is usually preferable for the health professional who will be carrying out the examination, diagnostic procedure, treatment or anaesthesia to explain what is involved to the patient and obtain their agreement to proceed. However, you can seek consent on behalf of colleagues, provided that you are able to undertake the intervention or have been appropriately trained in obtaining consent for it.

The position in relation to persons under 16 and persons who have no or impaired capacity is discussed at Chapters 2 and 3.

When should this be done?

Consent must be obtained before a procedure is carried out. The timing of the obtaining of consent can also be important. Unless you are in an emergency situation (see below) you should ensure that the patient has given consent to the procedure you will be carrying out at a point in the process where the patient does not feel under pressure to comply.

It is often helpful to reinforce what you have said with printed information which the patient can keep.

What if consent is refused?

Generally, people with capacity aged over 16 have the right to say what is or is not going to happen to their bodies and may choose to refuse to have the proposed healthcare intervention (again, children and persons who have no or impaired capacity are discussed in chapters 2 and 3). Failure to respect a patient's wishes and treating that person in the absence of consent can leave health professionals open to criminal charges, civil actions and allegations of professional misconduct.

Advance statements

As a general principle of law and medical practice, treatment should only be given with the consent of the patient. A "living will" or other document (sometimes also referred to as an "advance directive" or "advance statement") which contains a person's instructions about the medical treatment he or she would or would not be prepared to accept, if he or she should subsequently lose the capacity to indicate his or her wishes directly, may be effective in law depending on the circumstances, but cannot authorise actions which would be contrary to law.

The Adults with Incapacity (Scotland) Act 2000 sets out arrangements for making decisions about (amongst other matters) welfare and health on behalf of adults who lack capacity to take decisions themselves because of mental disorder or inability to communicate. Section 1 of that Act sets out 5 principles which must be observed in relation to any intervention in the affairs of an adult or in pursuance of the AWI Act, including taking account of the past wishes of the adult where these can be ascertained. This would include taking account of past wishes expressed in an advance statement.

The Mental Health (Care and Treatment) (Scotland) Act 2003 makes some provision for advance statements. That Act requires certain persons to have regard to the wishes specified in such advance statements and where they do something that conflicts with those wishes to record that action.

What about emergencies?

In an emergency where the patient is unable to give or refuse consent, it will usually be acceptable for medical practitioners to provide medical treatment without obtaining consent where it is immediately necessary to save life or to avoid significant deterioration in the patient's health. The treatment given must be no more than the immediate situation requires however.

The division between urgent cases where treatment is necessary for the preservation of life or to prevent serious deterioration and routine matters is not always clear-cut. What underlies

the concepts of emergency and necessity is the issue of immediacy. The definition of emergency will vary slightly from specialty to specialty. There will of course be clinical situations where urgent treatment is required to save life – for example in labour wards or Accident & Emergency Departments, or when the patient is found unconscious through illness or injury. In such circumstances a decision must be taken and acted upon within seconds or minutes, if a fatality or severe damage is to be avoided. In other specialties, however, situations can take much longer to develop.

Chapter 2 Children

2.1 Children

In Scots law, when persons reach their 16th birthday, unless they lack the appropriate mental capacity, they gain the legal capacity to make decisions which have legal effect under the Age of Legal Capacity (Scotland) Act 1991.

However, even under the age of 16, a child can have the legal capacity to consent on his or her own behalf to any surgical, medical or dental treatment where in the opinion of a qualified medical practitioner attending the child, the child is capable of understanding the nature and possible consequences of the procedure or treatment (see section 2(4) of the 1991 Act).

This is a matter of clinical judgement and will depend on several things, including:

- the age of the patient
- the maturity of the patient
- the complexity of the proposed intervention
- its likely outcome
- the risks associated with it.

If the child is not capable of understanding the nature of the healthcare intervention and its consequences, then you should ask the child's parent or guardian for their consent to proceed with the intervention.

Sometimes the parent or guardian who has parental responsibility for the child is not available. If the procedure cannot be deferred until you can speak to the parent, then section 5 of the Children (Scotland) Act 1995 gives a person who has care or control of the child, but has no parental rights or responsibilities in relation to the child, the power to do what is reasonable in all the circumstances to safeguard the child's health, development and welfare.

This could include persons such as the child's father (where the parents are unmarried and even if there is no parental responsibilities agreement) or step-parent, a relative or a child minder who is looking after the child during the day. This person may consent to any surgical, medical or dental treatment or procedure where the child cannot give consent on his own behalf and it is not within the knowledge of the person that a parent of the child would refuse. **This provision does not apply to teachers and others having care and control of a child in school.**

In addition to capacity, the other requirements about sufficient information and voluntariness apply to decisions about healthcare for patients under the age of 16.

Occasionally you may be involved in the examination or treatment ordered under the Children (Scotland) Act 1995 by a Children's Hearing. A Children's Hearing may make a supervision requirement to require the child to submit to any medical examination or treatment. However, where the child has the necessary capacity then you must still obtain the child's consent or, where the child lacks that capacity, then parental consent should be obtained. The same requirements for consent apply in the context of medical examination or treatment in the course of school education.

In relation to child looked after or accommodated by a local authority the same general principles apply. If the child is capable of understanding the nature and possible consequences of the procedure or treatment no further consent is required. If a Court has made a parental responsibilities order in favour of a local authority then, if the child lacks the capacity to consent, the consent of the authority would be required.

It is good practice for you to encourage children to involve their parents in the healthcare decision-making process. Occasionally, there may be a difference of opinion between the child and the parent. Dealing with the situation professionally and tactfully may help reach an agreement. However, where the child has the capacity to make the healthcare decision in question, then the 1991 Act requires that the child's decision should be respected even if it differs from the parents' views or yours.

In some circumstances the refusal of consent by or on behalf of a child may be overridden by the courts which in terms of section 11(2) of the 1995 Act may authorise medical treatment. Any person with an interest, which could include a medical practitioner, can apply to the court which will decide the matter on the basis of the best interests of the child. The circumstances in which such an application will be appropriate are likely to be limited but could arise in a life or death situation.

2.2 Emergencies

The position set out in Chapter 1 with regard to emergencies would also apply in the case of children under 16, where the child is unable to consent (and section 2(4) of the 1991 Act discussed above cannot be relied upon). Treatment cannot be delayed until the person with parental rights or responsibilities is consulted.

Chapter 3 Adults with Impaired Capacity

The principles of consent (information, voluntariness and capacity) apply to all patients. It is important to be aware that most people suffering from a mental illness (including people with dementia) or learning disability retain the capacity to make most, or at least some, healthcare decisions for themselves. An individual's capacity to reach a decision on their healthcare will depend on the decision in question, their intellectual state at the time and the nature of their disorder.

3.1 Adults with Incapacity (Scotland) Act 2000

In Scotland, approximately 100,000 people aged 16 and over have difficulties in taking decisions for themselves because of mental disorder or a communication disorder due to a physical and/or learning disability. Part 5 of the Adults with Incapacity (Scotland) Act 2000 ("the AWI Act") dealing with medical treatment and research came into effect on 1st July 2002. Application of the AWI Act's principles and provisions should ensure that these adults receive equity of access to healthcare.

The AWI Act applies to persons aged 16 or over. It defines incapacity as being incapable of:

- acting; or
- making decisions; or
- communicating decisions; or
- understanding decisions; or
- retaining the memory of decisions,

The cause of the incapacity must be mental disorder (meaning a mental illness, personality disorder, learning disability) or inability to communicate because of a physical disability (unless that inability to communicate can be made good by human or mechanical aid). You should be aware the definition of incapacity would include unconscious adults

There are many people with a learning disability who may have varying degrees and levels of understanding and who would not in any way regard themselves as having a mental disorder.

Many people with a learning disability also have very complex health needs, including physical disability. This can affect both their understanding and the ability to communicate effectively, unless careful and planned assistance is given to help them. People with a learning disability can often achieve a level of understanding which you might not have expected, providing that information is well-presented by experienced people. Sometimes mechanical aids are also helpful here.

As above, the definition of incapacity by reference to the inability to communicate because of a physical disability does not include such a disability when it can be made good by human or mechanical aid. Again, as above, what this means in practice is taking measures such as ensuring that the adult is wearing their glasses and hearing aid or providing a quiet and distraction free environment or information in appropriate format e.g. British Sign Language, large print. If you can overcome or improve on the disability by human or mechanical support, then you should do so. You may need to involve other people, including speech and language therapists, signers or interpreters, to help bridge the communication gap.

3.2 Principles

Section 1 of the AWI Act sets out 5 principles which must be observed in relation to any intervention in the affairs of an adult or in pursuance of the AWI Act. All decisions made on behalf of an adult with incapacity must:

- benefit the adult
- take account of the adult's present and past wishes and feelings
- take into account the wishes of the nearest relative, primary carer, proxy and relevant others, where it is reasonable and practicable to do so
- restrict the adult's freedom as little as possible while achieving the desired benefit
- encourage the adult to exercise residual capacity

You should note that capacity is specific to the situation. This means that an adult may be capable of reaching a decision on some aspects of their healthcare, but incapable in terms of handling decisions about its more complex aspects.

3.3 Authority to treat

Part 5 of the AWI Act deals with medical treatment and research. Medical treatment is defined widely in Section 47 of the AWI Act as "any procedure or treatment designed to safeguard or promote physical or mental health". The AWI Act sets out what must be done to obtain the general authority to treat, including observing the principles, assessing the adult's capacity and completing the appropriate certificate (sometimes called a Section 47 certificate or a certificate of incapacity). This process will include speaking not only with the adult but also with the nearest relative, primary carer, their healthcare proxy if they have one and others, as set out in the AWI Act, where it is reasonable and practicable to do so. Several members of the healthcare team may be involved in the assessment process.

Some medical treatments are not permitted however under section 47 of the AWI Act (see further below ("exceptions")). Section 47 also cannot be used in certain cases, for example where the medical practitioner is aware that an application is pending for a relevant guardianship or intervention order or where it was reasonable and practicable for the medical practitioner to obtain the consent of the adult's guardian or welfare attorney in compliance with the AWI Act but the medical practitioner has failed to do so. See the *Code of Practice for Part 5* of the AWI Act for more information.

Section 47 also does not give authority to treat an adult in certain ways. These include the use of force or detention, unless it is immediately necessary and only for so long as is necessary in the circumstances; action which would be inconsistent with any decision by a competent court; and placing an adult in hospital for the treatment of mental disorder against his will.

When the AWI Act was originally introduced in 2002 only a medical practitioner was empowered to complete and sign the certificate of incapacity. The Act also allowed for the general authority to treat to be delegated to other members of the healthcare team so that they

can do what is necessary to safeguard or promote the physical or mental health of the adult. However, following an amendment to section 47 (1) of the Act by section 35 of the Smoking, Health and Social Care (Scotland) Act 2005 (which took effect from 19th December 2005), the following persons may now issue a certificate under section 47 giving authority to carry out medical treatment:

- a medical practitioner; or
- a dental practitioner, ophthalmic optician or registered nurse who has satisfied prescribed requirements
- any other member of a healthcare profession which the Minister may prescribe in regulations who has satisfied prescribed requirements.

Importantly, under the changes to section 47 of the AWI Act, a certificate issued by healthcare professionals other than 'medical practitioners' will only be valid within their own area of practice e.g. a dentist could only authorise dental treatment.

A further change has also been made to the duration of the incapacity certificate as a result of section 35 of the Smoking, Health and Social Care (Scotland) Act 2005. When the AWI Act was first introduced the maximum duration of the certificate was 12 months. This maximum duration has now been increased from 1 year to 3 years. This however, is dependent on the nature of the illness from which the patient is suffering. The conditions are expected **to be** prescribed in regulations later in 2006

The certificate of incapacity should be kept in the adult's healthcare record.

The AWI Act, therefore, not only enhances access to healthcare by your adult patients lacking capacity to make some or all of their decisions for themselves but also it enables you to deliver care lawfully to them.

3.4 Excepted treatments

The AWI Act contains additional safeguards for patients. Section 47 of the AWI Act cannot be used where Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003

applies, and there are additional criteria which must be satisfied before electro-convulsive therapy, sterilisation (including any medical treatment likely to lead to sterilisation as an unavoidable result), termination of pregnancy or implantation of hormones or drug treatment to reduce sexual drive can be carried out.

3.5 The Mental Health (Care and Treatment) (Scotland) Act 2003

The Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act") is now largely in force, and has replaced the Mental Health (Scotland) Act 1984. The 2003 Act establishes new arrangements for the detention, care and treatment of persons who have a mental disorder. It also refines the role and functions of the Mental Welfare Commission and establishes the Mental Health Tribunal for Scotland as the principal forum for approving and reviewing compulsory measures for the detention, care and treatment of mentally disordered persons.

The 2003 Act sets out some principles which most people performing functions under it have to consider. These include:

- the present and past wishes and feelings of the patient;
- the views of the patient's named person, carer, guardian or welfare attorney;
- the importance of the patient participating as fully as possible;
- the importance of providing the maximum benefit to the patient;
- the importance of providing appropriate services to the patient; and
- the needs and circumstances of the patient's carer.

The 2003 Act also sets out principles relating to the *way* in which the function must be discharged. These require the person discharging the function to do so in a way which, for example:

- involves the minimum restriction on the freedom of the patient that appears to be necessary in the circumstances;
- encourages equal opportunities; and
- if the patient is a child, best secures their welfare

3.6 Consent

In relation to consent, the 2003 Act updates Mental Health legislation in Scotland in two important ways. The first change lies in the area of urgent treatment in emergencies. Part X of the Mental Health Act (Scotland) Act 1984 did not give authority to treat a patient detained on a Section 24 (Emergency) Order. By contrast, Section 243 of the 2003 Act does allow for medical treatment to be given to a patient who does not consent or is incapable of consenting to that treatment even where that patient is detained because of an Emergency Detention Certificate (issued under Section 36 of the 2003 Act).

Urgent medical treatment for mental disorder can only be provided, notwithstanding the patient does not consent or is incapable of consenting, where the purpose of the treatment is to

a) save the patient's life
b) prevent serious deterioration in the patient's condition
c) alleviate serious suffering on the part of the patient
d) prevent the patient from behaving violently or from being a danger to himself or others

Section 243 however limits the circumstances in which medical treatment can be given. Other than where the purpose of giving the treatment is to save the patient's life, medical treatment will only be authorised under the section if the treatment is not likely to entail unfavourable, and irreversible, physical or psychological consequences. Where the purpose of the treatment is to alleviate serious suffering or prevent the patient from behaving violently or being a danger to himself or others, the proposed treatment must also not entail significant physical hazard to the patient.

The second important way in which the 2003 Act updates Scottish mental health legislation is through the introduction of a set of principles known as the Millan Principles which you should apply when carrying out functions under the Act. From the point of view of consent, the most relevant principles are non-discrimination, informal care and participation. The Millan Principles will have an impact on many health professionals in NHS Scotland whether or not you are working in the field of mental health.

3.7 When someone refuses examination

You may be faced with someone who refuses to be examined and you think that their refusal may be because of a mental disorder. This can be a difficult situation to deal with because it may happen without much warning and in surroundings such as the person's home or an Accident and Emergency Department. Sometimes you may become involved after the person has been taken into police custody.

If the person refuses to talk to you, or to be examined, it may be because they are seriously mentally ill and are a potential risk to themselves and to others. If so, you may have to consider whether it is appropriate to use the Mental Health (Care and Treatment) (Scotland) Act 2003. If the person is unwilling or unable to consent to examination then you may have to obtain information about the patient from other sources. This could include relatives and friends of the person, police officers or other people involved in the current situation. Part 5 of the Mental Health (Care and Treatment) (Scotland) Act 2003 describes the conditions which must be satisfied before emergency detention can take place.

QUICK REFERENCE TO KEY POINTS

A Good Practice Guide on Consent for Health Professionals in NHSScotland

(This is a good practice guide and is not intended to have any legal effect.)

KEY POINTS

When is it necessary for health professionals to obtain consent from patients?

1. Before you examine, investigate or treat patients you must have authorisation to proceed. This is often called 'getting consent'.

2. People aged 16 and over are presumed to have the capacity to make their own decisions. If you have doubts about someone's capacity, you may find it helpful to ask yourself: "Can this person understand, retain and use the information they need to make this decision?" Decisions which are unusual or unexpected do not necessarily mean that the patient lacks capacity: it may indicate a need for further information or a clearer explanation.

3. People may have the capacity to take some healthcare decisions for themselves but may lack the capacity to decide about other, more complex matters.

4. Consent is usually a process, not an event. People can change their minds and withdraw their consent at any time. If in doubt, check with your patient to ensure that they still wish to continue with the healthcare being offered.

5. In an emergency, it is acceptable for you to save life or prevent serious deterioration in someone's medical condition without obtaining consent.

Can children consent to treatment themselves?

6. Once a person reaches the age of 16, Scots law gives them the legal capacity to make decisions for themselves. However, persons under the age of 16 have the legal capacity to authorise medical or dental care where, in the opinion of the practitioner looking after him or her, he or she is capable of understanding its nature and possible consequences. If the child has capacity, the child's decision must be respected. When a child cannot understand, then a parent or an adult with parental responsibility can make the decision on their behalf.

Who is the right person to ask the patient for consent?

7. It is usually preferable for the health professional who will be carrying out the examination, investigation or treatment to obtain consent from the patient. However, you can ask on behalf of colleagues, if you are capable of performing the procedure in question or if you have been trained to seek consent for it.

What information should be provided?

8. People need sufficient information expressed in a way that they can understand before they can reach a decision. This should include the benefits and significant risks of the proposed intervention and any relevant options, including not having the intervention. The patient’s questions must be answered truthfully. If you do not know the answers, you should identify a colleague who does know and listen when they discuss the issues with the patient.

Has consent been given voluntarily?

9. Consent to proceed must be given voluntarily, without pressure, deceit or undue influence from family, health professionals or others.

Does consent have to be in writing?

10. Some statutes require written consent to be obtained before a procedure can be carried out. Where there is no statutory requirement to obtain written consent, consent can be oral or non-verbal, depending on the circumstances. A signature on a form is not in itself proof of valid authorisation. Its purpose is to record the decision and the discussions which have taken place beforehand. Your Board may have a policy setting out the circumstances in which you need to obtain the patient's consent in writing.

Refusing healthcare

11. People with capacity are entitled to refuse healthcare, even though you believe that it would be beneficial to them. However, an exception to this occurs where the treatment is for mental disorder and the patient is detained under the Mental Health Care and Treatment (Scotland) Act 2003. The 2003 Act sets out the provisions for detention and treatment under the Act and the circumstances in which a patient's consent is not required.

Adults with Incapacity

12. The Adults with Incapacity (Scotland) Act 2000 sets out a framework for regulating interventions into the property, financial affairs and personal welfare of adults with impaired capacity. It protects the interests of adults who are incapable of taking a decision because of mental disorder or because of physical disability which makes them unable to communicate. (Scottish Executive guidance is available on this Act and how it affects health professionals.)

The adult may be able to reach a healthcare decision where a relatively simple and low risk procedure is being proposed. If an adult is incapable in relation to a decision about the medical treatment in question (and it is not excepted treatment under the AWI Act), the AWI Act sets out a process to proceed with that medical treatment (see further Chapter 3 of this guidance).

What about consent to disclose healthcare information?

13. Usually, you need the patient's permission before identifiable information about them is shared with other people. However, there are some exceptions to this rule. Examples include the statutory requirement to report particular events and where a court requires disclosure. There are other clinical situations where disclosure of healthcare information may be required as a matter of public safety. Non-identifiable information can be used for audit and planning of healthcare services without the consent of the patient. See the Scottish Executive's guidance *NHS Code of Practice on Protecting Patient Confidentiality* for more information. Speak to your Caldicott Guardian or Data Protection Officer for advice.

List of Further Reading

Abortion Act 1967 -
Abortion (Scotland) Regulations 1991 –
http://www.opsi.gov.uk/si/si1991/Uksi_19910460_en_1.htm

Adults with Incapacity (Scotland) Act 2000 –
http://www.opsi.gov.uk/legislation/scotland/acts2000/20000004.htm

Adults with Incapacity (Scotland) Act 2000, Code of Practice for Persons Authorised to Carry Out Medical Treatment or Research Under Part 5 of the Act – http://www.scotland.gov.uk/Resource/Doc/1097/0000568.pdf

Age of Legal Capacity (Scotland) Act 1991 –
http://www.opsi.gov.uk/acts/acts1991/Ukpga_19910050_en_1.htm

Children (Scotland) Act 1995 –
http://www.opsi.gov.uk/acts/acts1995/Ukpga_19950036_en_1.htm

Data Protection Act 1998 - http://www.opsi.gov.uk/acts/acts1998/19980029.htm

Getting Our priorities Right, Scottish Executive, 2003 –
http://www.scotland.gov.uk/Publications/2003/02/16469/18705

Human Rights Act 1998 - http://www.opsi.gov.uk/acts/acts1998/19980042.htm

Mental Health (Care and Treatment) (Scotland) Act 2003 –
http://www.opsi.gov.uk/legislation/scotland/acts2003/20030013.htm

The NHS Code of Practice on Protecting Patient Confidentiality 2003 –
http://www.confidentiality.scot.nhs.uk/publications/6074NHSCode.pdf

Public Health (Notification of Infectious Diseases)(Scotland) Regulations 1988 –
http://www.opsi.gov.uk/si/si1988/Uksi_19881550_en_1.htm

Road Traffic Act 1988 - http://www.opsi.gov.uk/acts/acts1988/Ukpga_19880052_en_1.htm

Terrorism Act 2000 - http://www.opsi.gov.uk/acts/acts2000/20000011.htm

Websites

www.dataprotection.gov.uk/dpr/dpdoc.nsf

www.scotland.gov.uk/health/mentalhealthlaw

www.scotland.gov.uk/justice/incapacity

www.show.scot.nhs.uk/confidentiality

SCOTTISH EXECUTIVE

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Patients' Rights

- **Patients have the right to decide whether or not to agree to a health care intervention.**
- **Patients aged 16 and over are presumed to have the capacity to make their own decisions.**
- **Patients under the age of 16 have the legal capacity to authorise medical or dental care where, in the opinion of the practitioner looking after them, the patient has the capability of understanding its nature and consequences.**
- **When a child cannot understand, then a parent or an adult with parental responsibility can make the decision on their behalf.**
- **Patients (over 16) who lack the capacity to make healthcare decisions must be treated under Part 5 of the Adults with Incapacity (Scotland) Act 2000. Patients have a right to receive equity of healthcare.**
- **Patients have the right to receive verbal and written information on proposed examination, diagnostic procedure, treatment or anaesthesia.**
- **Patients have the right to make their own decisions and to understand that they can change their minds at any time.**
- **Patients have the right to be communicated with frequently about their healthcare needs and choices available. Discussions should be two-way.**

Clinician's Responsibilities

- **You must always seek the patient's authorisation to proceed with treatment. The exception to this rule is when an emergency arises – it is acceptable for you to save life or prevent serious deterioration without getting consent from the patient.**
- **The health professional that will carry out the examination, investigation or treatment is in the best position to obtain consent, however other health professionals who are expert in this healthcare intervention can seek consent on your behalf.**
- **You must provide the relevant verbal and written information to your patient at an appropriate time to allow them to make an informed decision. This should include the benefits and risks.**
- **You must get consent voluntarily from your patient: this means without pressure, deceit or undue influence from family, health professionals or others.**
- **You must make sure your patient understands what has been said. This should be verified throughout the patients treatment.**
- **You must answer any questions the patient may have about their care. If you do not have the answer seek help.**
- **You must be aware of your local hospital/health centre procedure with regard to obtaining verbal and written consent.**
- **You must record within the patients health record the verbal and written information provided to your patient, which should include alternatives.**
- **You must be aware of the NHS Code of Practice on Protecting Patient Confidentiality and seek consent from your patient when information about them may be used. Exceptions to this include: statutory requirements to report specific events, court requests, investigations of a serious crime, non-identifiable information for the use of audit and planning of healthcare services.**

Useful documents to help you carry out this process include:

- Abortion Act 1967 -
- Abortion (Scotland) Regulations 1991 –
- Adults with Incapacity (Scotland) Act 2000, Code of Practice for Persons Authorised to Carry Out Medical Treatment or Research Under Part 5
- Age of Legal Capacity (Scotland) Act 1991
- A Good Practice Guide on Consent for Health Professionals in NHSScotland.
- Children (Scotland) Act 1995
- Data Protection Act 1998
- Getting Our Priorities Right, Scottish Executive, 2003
- Mental Health (Care and Treatment) (Scotland) Act 2003
- The NHS Code of Practice on Protecting Patient Confidentiality 2003
- Public Health (Notification of Infectious Diseases) (Scotland) Regulations 1988

June 2006.

Note your useful Contacts: e.g. GMC, NMC

NHS SCOTLAND

A Good Practice Guide on Consent

Quick Check for Health Professionals