SERVICE STANDARDS ON OBTAINING VALID CONSENT IN SEXUAL HEALTH SERVICES

July 2014

27 Sussex Place, London, NW1 4RG
www.fsrh.org.

Published by the Clinical Standards Committee
Faculty of Sexual & Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists

**Committee members in September 2014:**

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Dr Jane Dickson</td>
</tr>
<tr>
<td>Vice Chair</td>
<td>Dr Lynne Gilbert</td>
</tr>
<tr>
<td>Members</td>
<td>Dr Paula Briggs, Dr Dianna Reed, Dr Helen Munro, Dr Mayada Abu-affan</td>
</tr>
<tr>
<td>Revalidation Representative</td>
<td>Dr Louise Massey</td>
</tr>
<tr>
<td>Trainee member</td>
<td>Dr Rachel Westwick</td>
</tr>
<tr>
<td>Nurse Member</td>
<td>Mrs Michelle Jenkins</td>
</tr>
<tr>
<td>Ex-Officio:</td>
<td>Dr Asha Kasliwal</td>
</tr>
<tr>
<td>Representatives</td>
<td>Dr Louise Melvin, CEU</td>
</tr>
</tbody>
</table>

First Published: June 2007

Reviewed and updated: June 2011, July 2014

Next review date: July 2017
New to 2014 Guidelines

- References have been updated and where relevant include law specific to devolved countries where the law varies from England.
- Advice on the use of an interpreter who is not known to the patient, and assessment of capacity using the two-stage functional test has also been included.
- An Appendix summarising the 12 key points on consent: the law in England has been included.
1. **Standard Statement on Training in Seeking and Obtaining Valid Consent**

   All staff should have training and ongoing support in seeking and obtaining valid consent.

2. **Standard Statement on Process of Obtaining Valid Consent**

   All staff should understand the process of obtaining valid consent. This includes: purpose, process, assessment of capacity, provision of information and assessment of a patient’s autonomy.

3. **Standard Statement on Who Should Seek Consent**

   The clinician providing the treatment or investigation is responsible for ensuring that the patient has given valid consent before treatment begins.

4. **Standard Statement on When to Obtain Consent**

   Staff should be aware that the process of seeking consent may take place at one time, or over a series of meetings and discussions. This should be documented appropriately.

5. **Standard Statement on Method of Giving and Recording Consent**

   Valid consent may be given in a number of different ways but should be documented.

6. **Standard Statement on the Duration of a Patient’s Consent**

   Staff should be aware that valid consent to an intervention remains valid for an indefinite duration unless it is withdrawn by the patient or the patient loses capacity to consent in which case this should be clearly documented.

7. **Standard Statement on Refusal of Treatment by Adults with Capacity**

   If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment this decision must be respected, except in circumstances defined by the Mental Health Act (1983).

8. **Standard Statement on Treatment of Adults Who Lack Capacity**

   The Mental Capacity (England) Act 2005 or the Adults with Incapacity (Scotland) Act 2000 should be referred to when caring for adults who lack the capacity to make their own decisions.
9. Standard Statement on Consent to Treatment for Children and Young People

The process of obtaining valid consent to treat children and young people must be in accordance with current legislation and follow guidance from professional and employing bodies.

10. Standard Statement on Consent Policies

All services should have a written policy on seeking and obtaining valid consent.
Introduction

Consent is a person’s agreement for a health professional to provide care.

“It is a general legal and ethical principle that health professionals must obtain valid consent before starting treatment or physical investigation or providing personal care. This principle reflects a person’s right to determine what happens to his or her own body, and is a fundamental part of good practice.”

Patients have the right to dignity, privacy and confidentiality. Seeking consent is also a matter of common courtesy between health professionals and patients.

For consent to be valid, the person must:
- Be competent to make the decision
- Have enough information to take the decision
- Be free from duress.

‘Valid consent’ is obtained by the person being informed of the nature and purpose of any proposed treatment and the likely outcome(s), including any significant possible adverse outcomes, and the likely result of not proceeding with the proposed treatment, so that the person can make an informed decision. The term ‘informed consent’ should be avoided as this legally means that the person has been informed of every conceivable outcome and risk, however remote.

While there is no English statute setting out the general principles of consent, case law (‘common law’) has established that touching a person without valid consent may constitute the civil or criminal offence of battery. In Scotland, this is known as assault. Further, if doctors and other healthcare professionals fail to obtain valid consent and the person subsequently suffers harm as a result of treatment, this may be a factor in a claim of negligence against the professional involved. Poor handling of the consent process may also result in complaints from patients. Case law on consent has evolved significantly over recent years. Further legal developments may occur after this guidance has been issued, and health professionals must remember their duty to keep themselves informed of legal developments that may have a bearing on their practice. Legal advice should always be sought if there is doubt about the legal validity of a proposed intervention. While much of the case law refers specifically to doctors, the same principles will apply to other health professionals involved in examining or treating patients.

The Human Rights Act 1998 came into force in October 2000, giving further weight in the UK to the rights enshrined in the European Convention on Human Rights. In future, courts will be expected to take into account the case law of the European Court of Human Rights, as well as English case law (Scottish Common Law).

Capacity and Incapacity
In order to give valid consent a patient must have capacity. This is a legal concept and relates to the way in which the patient arrives at a decision, rather than the appropriateness of their decision.

The law in England and Wales, and in Northern Ireland, presumes that adults (persons aged 18 years and over) have the capacity to make their own decisions unless there is reason to believe otherwise. The legal position concerning consent and refusal of treatment by those under the age of 18 is different from the position of adults, in particular, where treatment is being refused. Young people aged 16 or over, but under 18, can give independent consent to their own treatment (but this can be overruled by a court order). Young people under 16 can give their own consent to treatment provided that they are judged capable of understanding what is involved; each case being judged on its own merits. The law in Scotland presumes that people aged 16 and over have the capacity to make their own decisions. In Scotland, a
young person under 16 can consent to, or refuse, any treatment if the qualified medical practitioner attending them believes that they are capable of understanding the nature and possible consequences of the treatment.

The Mental Capacity Act 2005(\url{http://www.justice.gov.uk/guidance/mental-capacity.htm}) covering England and Wales, enshrines in statute what common law suggests regarding the care of those who lack capacity to consent. It provides a statutory framework for people who may not be able to make their own decisions for example, because of a learning disability, an illness such as dementia or mental health problems. It sets out who can take decisions, in which situations, and how they should go about this. It defines incapacity as an inability to make a decision for each intervention and states “A person is unable to make a decision if s/he cannot:

- Understand information relevant to the decision
- Retain that information for as long as necessary to make that decision
- Use or weigh that information, or
- Communicate the decision.”

It goes on to state” \textit{before deciding that a person is incapable, all practical steps should be taken to assist the person to make his/her decision}”. This should include involving more specialist colleague(s). Guidance on how people should be helped to make their own decisions is given in Chapter 3 of the Mental Capacity Act (2005) Code of Practice.\textsuperscript{5}

In Scotland, the framework for regulating interventions into the property, financial affairs and personal welfare of adults with impaired capacity is set out in The Adults with Incapacity (Scotland) Act 2000.\textsuperscript{6} Guidance on this Act and how it affects health professionals is also available.\textsuperscript{7}

\textbf{Note}
This document has been produced to assist health professionals working in the field of contraception and reproductive health service provision. Consequently it has been assumed that colleagues working in these settings will not normally be involved in obtaining valid consent in the following situations:

- Removal of organs or tissue from patients who have been declared dead, whether for diagnostic, therapeutic or research purposes
- Specialised subfertility practice covered by the Human Fertilisation and Embryology Act 2008
- Organ transplantation
- Withdrawing and withholding life-prolonging treatment
- Permission to conduct a post-mortem examination.

To avoid multiple reference annotation, it should be noted that statement points not specifically referenced can be found in numerous documents already referenced.
1. **Standard Statement on Training in Seeking and Obtaining Valid Consent**

<table>
<thead>
<tr>
<th>All staff should have training and ongoing support in seeking and obtaining valid consent.</th>
</tr>
</thead>
</table>

1.1 Clinical and non-clinical staff should receive appropriate training in obtaining valid consent and keep up to date with any changes in the law.

1.2 All staff should receive training on national Child Protection procedures and be able to use local Child Protection/Safeguarding Children policies and protocols.


1.4 All staff working with young people should be familiar with the latest Department of Health Guidance on the care of under-16s.

1.5 All staff working with young people under 16 should be familiar with and use the Fraser Guidelines (or equivalent guidance) on competence.

1.6 All staff should be trained in the legal requirements of the Data Protection Act as they apply to health services.

1.6 All staff should receive Caldicott training.

All staff should be aware of the process of obtaining valid consent. This includes: purpose, process, assessment of capacity, provision of information and assessment of a patient’s autonomy.

2.1 Purpose

2.1.1 All staff should be aware that people have a fundamental legal and ethical right to determine what happens to their own bodies.

2.1.2 Valid (verbal or written) consent should be obtained before examining, starting treatment or physical investigation or providing personal care for a patient.

2.1.3 The consent of a patient is required before any disclosure of information obtained in the course of their healthcare, except in exceptional circumstances where disclosure is to protect the individual from serious harm or is in the public interest (cf. Standards on Confidentiality published by the FSRH; MedFASH Sexual Health Standards).

2.1.4 Health professionals should be aware that if they do not respect this principle, they may be liable both to legal action by the patient and action by their professional body.

2.1.5 Employing bodies should be aware that they may be liable for the actions of their staff if this principle is not respected.

2.2 Process

2.2.1 For consent to be valid the patient must:
- Be competent to take the particular decision and
- Have received sufficient information to make the particular decision and
- Not be acting under duress or undue influence from partners, family, friends, health professionals or other agencies.

2.2.2 Giving and obtaining consent is usually a process, rather than a one-off event. Patients can change their minds and withdraw their consent at any time.

2.2.3 A person may be competent to make some healthcare decisions, even if s/he is not competent to make others (i.e. consent is ‘decision-specific’). For example, a young person may not be deemed competent to consent to the provision of contraception but not necessarily to sex.
2.3 Assessment of Capacity to Consent

2.3.1 The health professional seeking to obtain valid consent must be sure that the person giving consent can understand, retain and use/weigh the information relating to the decision.

2.3.2 Adults (persons aged 18 years and over in England or aged 16 and over in Scotland) are assumed to be competent to give consent unless there is reason to believe otherwise (see Introduction regarding Capacity and Incapacity).

2.3.3 No-one can give consent to examination or treatment on behalf of an adult who is deemed unable to give consent for him/herself (see Standard 8).

2.3.4 Adults are presumed to have capacity to give or withhold consent to examination, investigation or treatment, but where any doubt exists the health professional should assess the capacity of the patient to take the decision in question.

2.3.5 The assessment of capacity and the conclusions drawn from it should be recorded in the patient’s notes.

2.3.6 An adult’s incapacity may be temporary or long-standing and in these circumstances the law permits interventions, which are necessary in the patient’s best interests.

2.3.7 Where the adult has never been competent, relatives, carers and friends may be well placed to advise on the patient’s needs and preferences. It is advisable to involve a Consultant in Learning Disability Psychiatry and the multidisciplinary team in the decision-making process, and to document their involvement (see also Standard 8).

2.3.8 Under Section 8 of the Family Law Reform Act 1969,10 young people aged 16 and 17 years are entitled to consent to their own medical treatment, and any ancillary procedures involved in that treatment, such as an anaesthetic. As for adults, consent is valid only if it is given voluntarily, by an appropriately informed patient, capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent person aged 16-17 years may in certain circumstances be overridden by either a person with parental responsibility or a court (see 9.11). This would not be the case in Scotland.

2.3.9 Young people aged under 16 who understand fully what is involved in the proposed procedure or treatment can give consent (although their parents, or someone with parental responsibility, should ideally be involved) 3,4,11 (see 9.1). In Scotland, this is covered by the Age of Legal Capacity Act 1991. (http://www.legislation.gov.uk/ukpga/1991/50/section/1)

2.3.10 Where a young person is assessed as not competent to give consent, someone with parental responsibility must give consent on the young person’s behalf (see 9.10).

2.3.11 If a competent young person consents to treatment, a parent or legal guardian cannot override that consent (see 9.1).
2.3.12 Health professionals should take all reasonable steps to facilitate communication with the patient, using interpreters or communication aids as appropriate.

2.4 **Provision of Information Prior to Obtaining Valid Consent**

2.4.1 Patients should receive evidence-led, objective information, supplied in a way that they can understand, before they give or withhold consent to the proposed examination, diagnostic procedure or treatment. Information should include:

- The nature of the intended intervention
- The purpose of the treatment
- The known risks, benefits and uncertainties of the treatment (including some quantification of risk, if known)
- The implications of not carrying out the procedure or treatment (including some quantification of risk, if known)
- The known risks, benefits and uncertainties of alternative interventions (including some quantification of risk, if known).

2.4.2 Information should be given regarding 'significant' risks (i.e. information to which any reasonable person in the same situation would attach significance).\(^{12,13}\)

2.4.3 Information about anaesthesia should be given as well as information about the procedure.\(^{14}\)

2.4.4 Patients need to know whether additional procedures are likely to be necessary as part of the procedure, and consent should be sought for any treatment to deal with problems that may arise during the primary procedure.

2.4.5 GMC guidance\(^ {15}\) and MedFASH standards\(^ {9}\) state that clinicians should do their best to find out about patients' individual needs and priorities when providing information about treatment options and that if the patient asks specific questions about the procedure and associated risks these should be answered truthfully.

2.4.6 If the health professional believes that to follow the guidance in the above paragraphs in full would have a deleterious effect on the patient’s health, the GMC guidance states that this view, and the reasons for not following the guidance should be recorded in the patient's notes. If information about the treatment that is being proposed is offered to a patient and declined, it is also good practice to record this fact in the notes.

2.4.7 Patients should be treated with courtesy and respect and their dignity should be maintained at all times. Adequate privacy should be ensured for information giving. Patients should not be given important information or asked to make decisions whilst undergoing intimate examinations.

2.4.8 Staff should seek to reinforce verbal information in a way that is appropriate and helpful to the user, for example printed or written information, pictorial or information in another media which the patient can retain.
2.5 **Assessment of a Patient’s Autonomy**

2.5.1 To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the patient either to accept or refuse treatment.

2.5.2 Health professionals must 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 procedure.

2.5.3 Health professionals should be alert to the possibility that pressure or undue influence can come from partners, family members or friends, as well as healthcare and social care professionals, and where appropriate should arrange to see the patient on their own to establish that the decision is truly that of the patient.

2.5.4 When an interpreter is needed, it is highly likely to be in the individuals best interests to use independent party, rather than a friend or relative.

2.5.5 In environments where involuntary detention may be an issue (e.g. prison, mental health settings), staff should be careful to avoid the potential for treatments to be perceived as coercive, since coercion invalidates consent.

The clinician providing the treatment or investigation is responsible for ensuring that the patient has given valid consent before treatment begins.

3.1 Where verbal, non-verbal or written consent is being sought for examination, investigation, treatment or care, the health professional carrying out the procedure should seek consent from the patient. If the task of seeking written consent is delegated to another health professional, that professional must be capable of performing the procedure in question, or have been suitably trained and qualified, have sufficient knowledge of the proposed investigation or treatment, and understands the risks involved, in order to be able to provide any information the patient may require.\(^{15}\)

3.2 The clinician performing the procedure must ensure that valid consent has been obtained before treatment begins. If the clinician delegates, he/she is still responsible for making sure that the patient has been given enough time and information to make an informed decision, and has given their consent, before starting any investigation or treatment.\(^{15}\)
4. Standard Statement on When to Obtain Consent

| Staff should be aware that the process of seeking consent may take place at one time, or over a series of meetings and discussions. This should be documented appropriately. |

All staff should be aware that:

4.1 A health professional can initiate a procedure immediately after discussing it with the patient, provided that the principles of obtaining valid consent (capacity, information and voluntariness) have been met.

4.2 For procedures where written consent is sought, health professionals must allow the patient sufficient time to absorb the information necessary for her/him to make their decision. It is good practice to seek the patient’s consent to the proposed procedure well in advance and then check again, before the procedure starts, that the patient’s consent still stands.

4.3 The timing of the process of seeking consent should be sufficiently close to the intervention for the patient to recall what they have been told about it. However, seeking consent when the patient may be feeling vulnerable is likely to be regarded as invalid.
5. **Standard Statement on Method of Giving and Recording Consent**

| Valid consent may be given in a number of different ways but should be documented. |

All staff should be aware that:

5.1 Legally, verbal and written consent are **equally** valid.

5.2 Consent may be implied (non-verbal) or expressed (verbal or written).

5.3 The form in which the patient expresses consent should be documented in the patient’s record.\textsuperscript{16}

5.4 Implied consent (non-verbal) or verbal consent is sufficient for procedures such as venepuncture, taking blood pressure, speculum examination, taking of swabs, cervical cytology, colposcopy, insertion or removal of intrauterine devices and subdermal implants.

5.5 It is good practice to obtain written consent for specific procedures such as:
   - A procedure that involves significant risks (e.g. abortion, sterilisation)
   - A procedure that involves general/regional anaesthesia or sedation
   - Pelvic examination by medical students of anaesthetised women
   - Participation in a research project or programme
   - A procedure or treatment that is being offered that is of an experimental nature\textsuperscript{17}
   - Recording and use of multimedia images
   - Disclosure of records.\textsuperscript{16,18}

5.6 For procedures involving significant risks, it is essential for health professionals to document clearly both a patient’s agreement to the intervention and the discussions that led up to this agreement, including the provision of any patient information materials.

5.7 A signature on a consent form is not proof of valid consent but is evidence of the process of consent-giving and is not a binding contract; patients may, if they wish, withdraw their consent after they have signed a form.

5.8 If consent has been validly given and documented, the lack of a completed consent form is no bar to treatment.

5.9 Completion of a consent form is in most cases **not** a legal requirement (exceptions include certain requirements of the Mental Health Act 1983 and of the Human Fertilisation and Embryology Act 2008.

5.10 A patient who has capacity to consent, but is illiterate, may be able to make a mark on a consent form to indicate that the consent-giving process has taken place. It is good practice for this mark to be witnessed by an appropriate adult, and for that fact that the patient has chosen to make their mark in this way to be recorded in the patient’s notes.

5.11 If a patient has capacity to consent, and wishes to give consent, but is physically unable to mark the form, this fact should be recorded in the notes.
5.12 Explicit consent must be sought for the presence of medical students and other clinicians in training during consultations and in operating theatres as observers and assistants, and for students performing clinical examinations. This may be given verbally and documented accordingly.

Staff should be aware that valid consent to an intervention remains valid for an indefinite duration unless it is withdrawn by the patient or the patient loses capacity to consent in which case this should be clearly documented.

All staff should be aware that:

6.1 If consent has been obtained a significant time before undertaking the intervention, it is good practice to confirm that the person who has given consent retains capacity and that the person still wishes the intervention to proceed. This applies even if no new information needs to be provided or further questions answered. A health professional involved in their care on the day should document that the patient still wishes to go ahead and has had any further questions answered.

6.2 If new information becomes available regarding the proposed intervention (e.g. new evidence of risks or new treatment options) between the time when consent was sought and when the intervention is undertaken, a health professional should inform the patient and reconfirm their consent by repeating the process of seeking consent on the basis of this new information. Similarly, if the patient’s condition has changed significantly in the intervening time it may be necessary to seek consent again, on the basis that the likely benefits and/or risks of the treatment may also have changed.

6.3 A patient with capacity is entitled to withdraw consent at any time, including during the performance of a procedure.
7. Standard Statement on Refusal of Treatment by Adults with Capacity

If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment this decision must be respected, except in circumstances defined by the Mental Health Act 1983.

All staff should be aware that:

7.1 The Mental Health Act 1983\textsuperscript{19} [Mental Health (Care and Treatment)(Scotland) Act 2003\textsuperscript{20}] sets out circumstances in which patients detained under the Act may be treated without consent for their mental disorder. It has no application to treatment for physical disorders unrelated to the mental disorder, which remains subject to the common law principles set out in Standards 2.

7.2 Patients may have an ‘advance directive’ specifying how they would like to be treated in the case of future incapacity. An advance refusal of treatment which is valid (made voluntarily by an appropriately informed person with capacity) and applicable to subsequent circumstances, in which the patient lacks capacity, is legally binding and must be respected. If there is doubt about the validity of an advance refusal a ruling should be sought from a court.


7.3 Decisions taken by a patient, which are unusual, unexpected or not what the health professional would have chosen for him/herself, do not mean that the patient lacks capacity. It may highlight the need for further information or a clearer explanation. People are entitled to make decisions based on their own religious belief or value system even if it is perceived by others to be irrational, as long as the patient understands what is entailed in their decision. However, if the decision that appears irrational is based on a misperception of reality then the patient may not be able to comprehend and make use of the relevant information and hence may lack capacity to make the decision in question.
8. Standard Statement on Treatment of Adults Who Lack Capacity

<table>
<thead>
<tr>
<th>The Mental Capacity Act 2005 or Mental Health (Care and Treatment) (Scotland) Act 2003 should be referred to when caring for adults who lack the capacity to make their own decisions.5</th>
</tr>
</thead>
</table>

8.1 Treatment can be given if it is believed by the health professional to be in the patient’s ‘best interests’. The process of reaching this decision can be recorded using Consent Form 4.21 ‘Best interests’ are not confined to best medical interest but the most appropriate therapeutic response should also be considered where relevant1.

8.2 In considering the relevant circumstances, the Act rules that the healthcare professional must take the following steps:

- Consider whether the person is likely to regain capacity and if so involve the person as fully as possible in the decision that is being made on their behalf.
- As far as possible, consider the person's past and present wishes and feelings (in particular if they have been written down) and any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question or any other relevant factors that the person would be likely to consider if they were able to do so.

8.3 As far as possible consult other people if it is appropriate to do so and take into account their views as to what would be in the best interests of the person lacking capacity, especially anyone previously named by the person lacking capacity as someone to be consulted; anyone engaging in caring for or interested in the person's welfare; any attorney appointed under a Lasting Power of Attorney or any deputy appointed by the Court of Protection to make decisions for the person.22

8.4 Independent Mental Capacity Advocates (IMCAs) are not decision-makers for the person who lacks capacity. They are there to support and represent that person and to ensure that decision-making for people who lack capacity is done appropriately and in accordance with the Mental Capacity Act 2005.23

8.5 Where there is doubt about an individual’s capacity or best interests, a court ruling should be sought. It is good practice to seek a court ruling prior to undertaking certain interventions which arouse particular concern, namely sterilisation for contraceptive purposes, medical or surgical abortion.

8.6 The Mental Capacity Act 2005 Code of Practice5 sets out a legal framework for involving people who lack the capacity to consent to taking part in research. The Act does not include clinical trials, which are covered by the Medicines for Human Use (Clinical Trial regulations)2004. (http://www.legislation.gov.uk/uksi/2004/1031/contents/made)

Similarly, consent to research is covered by the Mental Health (Care and Treatment) (Scotland) Act 2003. (http://www.legislation.gov.uk/asp/2003/13/section/279)

8.7 Capacity may need to be assessed where a person is unable to make a particular decision at a particular time because their mind or brain is affected by illness or disability. Lack of capacity may not be a permanent condition and assessment should reflect this by being both time- and decision-specific. The health professional may want to consider the “two stage functional test” in order to help them make a decision;
Stage 1. Is there an impairment of, or disturbance in the functioning of a person's mind or brain? If so,

Stage 2. Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate. Family, friends, carers or other professionals may need to be involved and the final decision documented accordingly. ²⁴

(http://www.scie.org.uk/publications/mca/assessing.asp)
9. Standard Statement on Consent to Treatment for Children and Young People

The process of obtaining valid consent to treatment for children and young people must be in accordance with current legislation and follow guidance from professional and employing bodies.\(^{11, 25, 26}\)

9.1 The legal framework on consent, confidentiality and safeguarding (child protection) is covered by the General Medical Council publication, \(0–18\) Years: Guidance for All Doctors.\(^{27}\) This document includes more detailed information covering each of the UK nations. In law; any competent young person in the UK can consent to medical treatment including contraception. Young people over 16 years of age, including those with a disability/impairment, are presumed to be competent to give consent to medical treatment unless otherwise demonstrated. For young people under the age of 16 years, however, competence to consent has to be demonstrated. A young person must have sufficient understanding and maturity to understand fully what is proposed (England, Wales and Northern Ireland) or be capable of understanding the nature and possible consequences of the treatment (Scotland).\(^6\)

9.2 In England, Wales and Northern Ireland, those under the age of 13 years are considered unable to legally consent to sexual activity.\(^{28, 29}\) In Northern Ireland, there is no statutory duty under criminal law to report to the police cases of sexual activity involving children under the age of 16 years unless the child is under 13 years or the other party is aged 18 years or over. In the Sexual Offences Scotland Act 2009\(^ {30}\) sexual activity with a male or female aged under 13 years is “rape of a young child”.

9.3 The assessment of a young person’s capacity to make a decision about contraception or medical treatment is a matter of clinical judgement guided by professional practice and local/national policy and is a legal requirement.\(^{30}\) Assumptions should not be made about an individual’s capacity to consent based on age alone or disability.\(^6, 31\)

9.4 Following the case of Gillick\(^ {32}\) in 1986, the courts have held that children and young people under 16 who have sufficient understanding and maturity to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent for treatment (Gillick Competence), in accordance with Fraser Guidance.\(^{11, 32, 33}\) In England, Wales and Northern Ireland, in order to provide contraception to young people under 16 years of age without parental consent, it is considered good practice to follow the Fraser Guidelines/criteria (Table 1).\(^7\) In Scotland, although the Fraser Guidelines are sometimes used by health professionals, they have no authority in Scottish law. The primary legislation when determining ‘competency’ is the Age of Legal Capacity (Scotland) Act 1991, whereby the only criterion is that the child understands the nature and consequence of the treatment.

9.5 A clinician should assess a young person’s competence to consent to treatment by their ability to understand information provided, to weigh up the risks and benefits and to express their own wishes.

---

**Table 1 Fraser Guidelines/criteria:**\(^4\)

1. The young person understands the professional’s advice.
2. The young person cannot be persuaded to inform their parents.
3. The young person is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment.
4. Unless the young person receives contraceptive treatment, their physical or mental health, or both, are likely to suffer.
5. The young person’s best interests require them to receive contraceptive advice or treatment with or without parental consent.

Health professionals may wish to use a checklist (e.g. Fraser Guidelines) to assess competency and risk when providing contraceptive advice or treatment to young person.
9.6 Competence to consent to treatment should be assessed and documented at each visit where relevant (e.g. for under-16-year-olds).\textsuperscript{33}

9.7 In England, Wales and Northern Ireland, unlike adults, the refusal of treatment by a competent person aged 16–17 years may in certain circumstances be over-ridden by either a person with parental responsibility or a court. This is not the case in Scotland where young people aged 16 years and over are considered competent to consent to, and refuse treatment.\textsuperscript{3,31}

9.8 As the understanding required for different interventions will vary considerably, a young person under 16 may have the capacity to consent to some interventions but not others (decision-specific consent).

9.9 Where a child or young person lacks capacity to consent, consent can be given on their behalf by anyone with parental responsibility or by the court. Those giving consent on behalf of young people must have the capacity to consent to the intervention in question, be acting voluntarily and be appropriately informed. The power to consent must be exercised according to the ‘welfare principle’. Even where a child lacks capacity to consent on their own behalf, it is good practice to involve the child as much as possible in the decision-making process.

9.10 The Children Act 1989\textsuperscript{34} sets out persons with parental responsibility. These include:

- The child’s parents if married to each other at the time of conception or birth;
- The child’s mother, but not the father if they were not married unless the father has acquired parental responsibility via a court order or a parental responsibility agreement or the couple subsequently marry;
- The child’s legally appointed guardian;
- A person in whose favour the court has made a residence order concerning the child;
- A Local Authority designated in a care order in respect of the child;
- A Local Authority or other authorised person who holds an emergency protection order in respect of the child.

Section 2(9) of the Children Act 1989 states that a person who has parental responsibility for a child “may arrange for some or all of it to be met by one or more persons acting on his behalf”. Such a person might choose to do this, for example, if a child-minder or the staff of a boarding school have regular care of the child. As only a person exercising parental responsibility can give valid consent, in the event of any doubt, specific enquiry should be made. Foster parents do not automatically have parental responsibility. This legislation is covered by the Children (Scotland) Act 1995 and Age of Legal Capacity (Scotland) Act1991.\textsuperscript{31,34}

9.11 The Adoption and Children Act 2002\textsuperscript{36} amended The Children Act 1989\textsuperscript{35} to provide that an unmarried father acquires parental responsibility where he and the child’s mother register the birth of their child together; and introduced a new special guardianship order intended to provide permanence for children for whom adoption is not appropriate.

9.12 The Civil Partnerships Act 2004\textsuperscript{37} amended The Children Act 1989\textsuperscript{35} under the section relating to “acquisition of parental responsibility by step-parent” to include civil partners as well as married partners.

9.13 Consent given by one person with parental responsibility is valid, even if another person with parental responsibility withholds consent.
9.14 Where the mother of a child is herself under 16, she will only be able to give valid consent for her child’s treatment if she herself is ‘Fraser competent’. ¹¹

9.15 Where a child or young person is a ward of court, no important step may be taken in the life of the ward without the prior consent of the court. This is likely to include more significant medical interventions.

9.16 Where a young person of 16 or 17, or a child under 16 who is deemed ‘Fraser competent, consents to treatment, this cannot be overruled, but if they refuse treatment, such a refusal can be over-ruled (except in Scotland) either by a person with parental responsibility for the child or by the court. ³⁸ This power to over-rule must be exercised on the basis that the welfare of the child/young person is paramount. As with the concept of ‘best interests’, ‘welfare’ does not just mean physical health. The psychological effect of having the decision over-ruled must also be considered. While no definitive guidance has been given as to when it is appropriate to over-rule a competent young person’s refusal, it has been suggested that this should be restricted to occasions where the child/young person is at risk of suffering “grave and irreversible mental or physical harm”. It may include a young person with capacity refusing an abortion being over-ruled by a person with parental responsibility. It is recommended that health professionals seek a court ruling prior to undertaking the intervention, particularly as the parent(s) must be provided with information about their child’s condition which the child/young person may not be willing for them to receive and this may involve a breach of confidence on the part of the clinician treating the young person (which may be justifiable where it is in the child’s best interests).

9.17 If the young person seeks advice or treatment in relation to abortion and cannot be persuaded to inform her parent(s), every effort should be made to help them find another adult (such as another family member or a specialist youth worker) to provide support. The putative father of a foetus cannot influence whether or not his partner requests an abortion (case law only).
10. **Standard Statement on Consent Policies**

**All services should have a written policy on seeking and obtaining valid consent.**

10.1 Service consent policies should be informed by, and updated in line with latest national guidance [e.g. from the Department of Health, Scottish Executive, The Welsh Office, the Department of Health, Social Services and Public Safety (Northern Ireland), GMC and other professional organisations].

http://www.dhsspsni.gov.uk/public_health_consent
http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp

10.2 Service consent policies should be in line with and endorsed by local NHS Trusts.

10.3 All staff should work to the service’s consent policy.
Further Guidance

The Department of Health has issued a range of guidance documents on consent and these should be consulted for details of the law and good practice requirements on consent. Doctors and other health professionals must also be aware of any guidance on consent issued by their own regulatory bodies (e.g. GMC, Nursing and Midwifery Council, Royal Pharmaceutical Society of Great Britain).

The following guidance documents are available from the Department of Health and can be accessed on the Internet at www.dh.gov.uk/consent.

✓ Reference Guide to Consent for Examination or Treatment’ provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the GMC where these are more stringent.


✓ Specific guidance, incorporating the law and good practice advice, is available for health professionals working with children, with people with learning disabilities and with older people.

✓ Model policy for consent to examination or treatment www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643

✓ Consent forms:
  • About the consent form 39
  • Consent Form 1 – patient agreement to investigation or treatment 40
  • Consent Form 2 – parental agreement to investigation or treatment for a child or young person 41
  • Consent Form 3 – patient/parental agreement to investigation or treatment (procedures where consciousness not impaired) 42
  • Consent Form 4 – form for adults who are unable to consent to investigation or treatment. 43

Guidance on the use of these consent forms can be found at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138297/dh_103652.pdf


The Department of Health, Social Services and Public Safety in Northern Ireland has published a Reference Guide to Consent for Examination, Treatment of Care and this may be accessed at: http://www.dhsspsni.gov.uk/public_health_consent

Guidance on consent is also produced by the General Medical Council, 15 the Royal College of Obstetricians and Gynaecologists 44 and the British Medical Association. 45
References


12. O’Mahony F, Koutoukos I, Menon V. What should we tell women preoperatively? The Obstetrician & Gynaecologist 2006;8:165–169


Further Reading


4. Sawers R, Avery, S. Consent in assisted conception. The Obstetrician and Gynaecologist 2006; 8:245–250


Appendix

12 key points on consent: the law in England

When do health professionals 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 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 over-ride 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.

Is the patients consent voluntary?

8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, 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.

Refusals of treatment

10. Competent adult patients are entitled to refuse treatment, even where 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 reference: