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Information paper

Consent and Physiotherapy Practice

(2nd Edition)

reference PD078

issuing function Practice & Development

date of issue April 2016

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Introduction

This guidance replaces CSP Information Paper PA60 (2005). This new and fully updated paper aims to provide professional practice guidance to members in achieving patient consent to physiotherapy in line with current law and relevant Health Department guidance.

This guidance sets out the framework upon which good clinical decision-making should be based and covers the many factors that may be considered when gaining patient consent to physiotherapy, as well as a number of specific situations and contexts that may require special thought.

The law relating to decision-making and consent, particularly for patients who lack capacity, varies across the UK. Physiotherapists need to understand the law as it applies to the country in which they work, and this guidance will highlight where there is variation in the law.

This paper is aimed at

- Working physiotherapists
- Student physiotherapists
- Physiotherapy support workers
- Those who manage physiotherapists who may need to understand the framework within which physiotherapists work.

This paper does not give clinical information, nor does it evaluate clinical literature in order to tell you what you must tell your patients as part of the consent process. This paper will however provide you with the over-arching principles which you can apply to your clinical area of practice to determine the information you discuss with your patients.

This paper addresses the main principles of consent. This paper may make reference to confidentiality where it impacts upon consent but this paper does not specifically and directly address matters of confidentiality.

This guidance is not exhaustive and you will need to use your professional judgment to apply its principles into your everyday practice. This paper does not give legal advice. If, after reading this information paper and any other documents referred to, you are unsure how to proceed you should seek legal advice.

Update to the 1st Edition.

***Montgomery v Lanarkshire Health Board* [2015] UKSC 11**

What has changed?

The Supreme Court of the United Kingdom has made ruling relating to 'informed consent' to treatment which may affect how all health professionals provide information to patients. The case of *Montgomery* has fundamentally changed the legal standard for the amount of information that ought to be provided to patients if they ask for it, in order for them to give informed consent to treatment.

The amount of information that you are required to provide to patients to allow them to make informed decisions about the care you are proposing and/or providing to them has changed to the Montgomery Standard '*what the patient wants to know'*. Previously, the Bolam standard *'what the health professional reasonably is expected to provide'* applied.

What does this mean in physiotherapy practice?

Patients are now entitled to receive any information they ask for in order to make their own decisions about their treatment. *Montgomery* means that with regard to the information and/or advice you give your patients about their physiotherapy management, the default position now is that you must provide 'what the patient wants to know'. This is regardless of your professional opinion and judgment on whether you would usually provide the information.

You must answer any question that your patient asks in relation to their physiotherapy treatment, or signpost them to someone who can answer their question if it is beyond your professional expertise, before you can be sure that they have given informed consent to the treatment you are proposing.

This might mean that you now must provide patients with information on very small and rare risks that might materialize, if they ask for it, where previously you may have decided not to provide the information as standard.

Does this mean there is now a different legal 'standard of care' for information and/or advice provided to patients compared with the 'standard of care' required for the provision of treatment?

Yes.

The standard of care for advice and/or information sharing moves to the 'Montgomery Standard'. This is 'what the patient wants to know'.

The standard of care for the provision of treatment remains the 'Bolam Standard'. This is 'what the reasonable practitioner would provide' and must be underpinned by a responsible and logical evidence base.

This paper has been amended in Sections 1 and 2 to reflect the *Montgomery* judgment, but otherwise remains unchanged from the 1st Edition.

April 2016.

SECTION 1 – PRINCIPLES OF CONSENT

What is consent?

Consent is the voluntary agreement given by a person to allow something to happen to them, and/or to be done to them, and/or to allow their participation in something. It is a fundamental right that every adult with capacity has the absolute right to determine what happens to their own body. This right is protected in law and is reflected in the Health Professions Council (HPC) standards and the CSP Code of Conduct.

Why is consent needed?

1. Defence to a claim of 'battery'.

Touching any person without their consent may be a civil offence of 'battery' and may also be the criminal offence of 'assault' or 'sexual assault', depending on the nature of the touching. If the unauthorized contact involves the use of an instrument (such as a knife or needle) and breaks the skin, then this may be any one of a range of criminal offences covered by the Offences Against the Person Act 1861.

The presence of 'consent' may be used as a defence to claims of any of the above offences. The patient's consent is essential for any assessment and/or intervention that involves touching the patient, asking them to remove items of clothing, or using any instrument or modality that involves breaking the skin (in physiotherapy for example, acupuncture, venopuncture or injection therapy).

In this context, the patient must have been told of the

- nature of the treatment and its
- purpose and agreed to this.

In this context the patient has no guarantee that the treatment will be performed by a named or specific person, but they can expect that whoever performs the treatment will be appropriately skilled and competent to perform the task in question. The patient must understand in broad terms what the

treatment will involve and which of the patient's identified problems the treatment is intended to address.

2. Defence to a claim of 'negligence'.

Patients may attempt to bring a negligence claim on the basis that they were not given sufficient information about the proposed treatment such that they were not able to make a proper decision about whether to proceed with the treatment suggested i.e. they did not give 'informed consent'.

Such a claim in negligence usually occurs where the patient has suffered harm as a result of the treatment. A patient must have been informed of and agreed to, not only of the

- nature and
- purpose of the treatment, but also they must be informed about
- the risks of treatment and of the
- alternatives to treatment that may exist, including the option to choose no treatment at all.
- Anything else that they ask for in relation to the treatment proposed.

What is 'informed' consent?

This means that the consent that has been given is right and proper and meets three tests:

- The patient must have the capacity[1] to give their consent
- The consent must be given voluntarily
- The patient must have been given all the information they ask for in order to make their decision.

If any one of these three requirements is not met then the consent may not be legally valid and the intervention may be unlawful and/or negligent.

[1] See Section 4

The case of Montgomery v Lanarkshire Health Board [2015] UKSC 11 is the relevant case law on informed consent in the UK.

Only when the patient has been provided with all this information, and been able to consider it and give their answer can it be said that the patient has given their 'informed consent' to treatment, or indeed their 'informed refusal' of treatment.

When should consent be obtained?

Consent should be obtained prior to assessment and/or treatment where the patient has capacity to do so. Provision in law is made to allow emergency treatment without consent due to necessity to save life. It is important to recognize that where ongoing treatment is required, the 'informed consent' of the patient is an ongoing event and not a one-off occurrence, and the presence of on-going consent to treatment should be reaffirmed. Consent should be reaffirmed if there are significant changes to

- the treatment plan, or
- the patient's condition or
- the patient reports new information to you.

What types of consent are there?

Consent may be valid in law if it is either explicit (written or oral) or implied (a behaviour of the patient that implies they agree to something happening to them e.g. rolling up a sleeve for a blood pressure check). You must consider the context and circumstances very carefully before relying on implied consent as the understanding of events may be questioned at a later stage, particularly if your actions are challenged. It is good practice to gain the explicit consent of the patient in all cases where possible and this might be in one of two forms.

- **Oral**

Oral consent (often also called verbal consent) is where the patient gives their consent by speaking to you to tell you their decision. In most cases, oral consent will be acceptable provided an adequate record of the oral consent is documented.

- **Written**

Written consent is only required by law for treatment under sections of the Mental Health Act, Human Fertilisation and Embryology Act and Human Tissue Act. However, the DH - and subsequently the CSP - recommends written consent in the following cases:

- Where treatment is complex or involves significant risk
- For treatment involving general or regional anaesthesia
- Where clinical care is not the prime aim of the intervention
- Where treatment could result in significant adverse consequences to patient's employment, social or personal life even when performed properly.

In the context of physiotherapy, good practice should be to obtain written consent for any intervention that is invasive. This might include, but is not limited to:

- injection therapy in neurological and/or MSK practice
- acupuncture
- dry-needling
- performing nerve conduction studies

Written consent should be recorded on the relevant Health Department consent forms for NHS care in each of the devolved countries, or forms that mirror Health Department requirements for non-NHS care. This ensures that all providers have a consistent approach to the recording of written consent and reduces duplication of effort.

Written consent is not a mandatory requirement for intimate examinations (PV or PR examination), although you must consider the context and circumstances of such an examination and make a professional judgment. For intimate examinations you must also give consideration to issues of privacy and chaperoning.

Who gains the consent of the patient?

If you are the physiotherapist undertaking the assessment and/or intervention, it is your responsibility to discuss this with your patient and you will gain the consent of the patient.

Delegating the consent process

You may delegate your responsibility to discuss your planned treatment of your patient to someone else within the physiotherapy team provided:

- they are suitably educated, trained and competent to do so
- they have sufficient knowledge of what you propose to offer the patient and are fully able to explain the risks, benefits, alternatives and comparisons to the patient
- they are able to answer patient questions in sufficient detail to allow the patient to make a proper decision, even though they may not be able to perform the techniques themselves
- they understand and follow the guidance in this Information Paper

If you delegate your responsibility, you are still responsible for making sure the patient has been given enough time and information to make a proper decision before you start treatment.

A doctor may ask you gain the consent of a patient for a surgical or other medical procedure. You may do this provided

- the patient is on your caseload and you also consider the patient to be your patient
- you are suitably educated, trained and competent to do so
- you have sufficient knowledge of what the doctor proposes to offer the patient and you are fully able to explain the risks, benefits, alternatives and comparisons to the patient, even though you are not able to perform the surgery and/or medical intervention yourself
- you are able to answer patient questions in sufficient detail to allow the patient to make a proper decision
- you understand and follow the guidance in this Information Paper

- you understand and follow the guidance given in the GMC Guidance Paper '*Consent: Patients and doctors making decisions together.'*[2]

Disclaimers

A healthcare professional has a duty of care to their patient. A healthcare professional cannot absolve themselves of their responsibilities to their patients to take reasonable steps to avoid injury or harm to the patient during the course of treatment.

In some circumstances organisations may use disclaimers that relate to personal property and/or possessions but it is inappropriate to use any form of disclaimer that suggests that a health professional cannot be held responsible for any physical injury or harm that may arise to a patient during the course of treatment.

[2] General Medical Council. Consent - Patients and doctors making decisions together. London. 2008.

SECTION 2 – INFORMATION SHARING AND EXCHANGE

Sharing Information with patient and discussing treatment options

The existence of a duty of care between a patient and their health-care professional is taken in law to exist – it does not need to be proved, and the healthcare professional cannot absolve themselves of this duty under any circumstances.

You must provide the patient will any information they need, and also ask for, in order for them to give informed consent[3].

Good decision-making on your behalf will require you to ensure that you have shared and exchanged information with your patient. When sharing information with patients you should tailor your approach according to

- Their needs, wishes and preferences
- Their level of knowledge and understanding of their condition and its treatment
- The nature of their condition
- The nature and level of the risks associated with the intervention and/or treatment
- What they ask for

You should not make assumptions about:

- The type of information a patient might want or need
- The type of information the patient might consider significant
- The level of knowledge or understanding a patient may have about what is proposed
- The choices a patient might choose to make and that these might be different to your own choice if you were having the treatment

[3] Montgomery v Lanarkshire Health Board [2015] UKSC 11

You must give patients information they ask for, or need about:

- The assessment that they will undergo and what this might involve
- Their diagnosis and/or prognosis, where you are able to provide this information
- Any uncertainly over diagnosis and/or prognosis including the option or need for further diagnostic tests, where you are able to provide this information
- Options for treating or managing the condition, including the options that no treatment is necessary or that a patient can choose not to have treatment
- The purpose of any intervention and/or treatment and what it will involve in broad terms
- The potential risks, benefits, side-effects and likelihood of success for each treatment option to be considered
- Any alternative or comparative treatment that may be available for the condition, even if these treatments cannot be offered by yourself and/or your hospital
- The person, or wider team members, who may be responsible for and involved in the patient's care, and whether pre-registration students may be involved
- The patient's right to refuse to take part in teaching or research or to allow students to treat them
- their options to seek a further opinion from a colleague and/or to be reviewed by a doctor if indicated
- any bills and/or costs that the patient will have to pay

You should discuss these issues with your patient in a way that you feel is appropriate, you should listen to your patient's concerns, ask for and respect their views, and give your patient time to consider your discussions and ask questions.

You must make it clear that the patient can change their mind about a decision at any time.

The manner in which you discuss a patient's condition and treatment with them is important. You should:

- ensure that information is provided to patients in a way that is intelligible to them, in a place and manner where they are best able to understand and retain the information
- give unwelcome, unexpected or distressing information in an accurate, clear and considerate manner
- involve other members of the healthcare team in your discussions where appropriate and especially if the patient asks for it

You should give information to patients in a balanced way. Where the evidence for the options under consideration is not equally balanced, you should inform the patients of all options and may offer your opinion as to the preferred option. You must not put pressure on the patient to accept your advice. The patient may choose any option for treatment, including refusal of treatment, even if such a decision results in a deterioration of their condition, or even their death.

You may support and enhance your discussions with patients with written material such as patient information leaflets, or other material. Where you decide to use this, or the patient requests it, you must ensure that the information provided is accurate and up to date, and presented in a way that is appropriate to the patient's needs.

Who is involved in treating the patient?

You should inform the patient of your professional role i.e. "physiotherapist". This is particularly important if you do not wear a uniform, your uniform is generic, you work so closely with other professionals that you could be confused for one of them and/or your job title does not include the word 'physiotherapist'.

You must be working within the overall scope of the physiotherapy profession in order for your CSP PLI to be in force[4]. The overall scope of the physiotherapy profession is very broad. If you have any concern that you are acting outside the scope of the profession, contact the CSP www.csp.org.uk.

[4] Subject to the terms of the policy. See PD027-Insurance and Physiotherapy Practice (Sept 2011) available from www.csp.org.uk

You should inform the patient if any other health-professionals are to be involved in the care of the patient, especially if you are delegating aspects of your patient's treatment to them.

Discussing risks, benefits, side-effects and complications

You must provide your patient with any information they ask for. There is no checklist of what must be disclosed. You may not need to discuss every possible eventuality with your patient. However you should discuss certain types of event with your patient and you must discuss an issue if the patient asks about it.

- '**significant events'**

  You must tell your patient about any risk where such disclosure is obviously necessary for the patient to make a decision. You must also tell the patient of any risk that is so clear and obvious such that no other reasonable professional would fail to tell the patient about it.

  In broad terms, this means you should tell the patient if something carries a greater than 10% risk[5] of having a consequence for the patient, but this figure is not absolute and the law is clear that ' *in determining what to tell the patient, the professional has to take into account all relevant factors."*[6]

  You must inform your patient what the 'significant event' encompasses in reality. Your duty to inform a patient about 'significant' events is not fully discharged until you have made the patient aware that fewer or no 'significant events' are associated with an alternative option.

- '**material events'**

Something is 'material' if it is something that a person relies on to make a decision and/or is likely to have a particular impact on them. 'Materiality' depends on the likelihood of the risk occurring, the seriousness of the effect if the risk did occur, and the character of the risk.

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[5] Sidaway v Board of Governors of the Bethlem Royal Hospital [1985] AC 871
[6] Pearce V United Bristol Healthcare NHS Trust [1998] EWCA Civ 865

In practice, 'material' factors are likely to be those that have a significant impact on a person's economic and/or financial circumstances, or close and/or significant relationships, or their own physical and/or mental health. A risk might also be considered 'material' if your failure to disclose it to the patient means the patient is unable to make a proper decision.

You must not make any assumption about a patient's understanding of risk, or apply your interpretation of risk to what you share with the patient. A risk that you, as the professional, consider may be minor may be considered by the patient to be 'serious'.

For example, you may regard drowsiness after treatment to be minor, but a patient who has to drive back to work, or needs to be alert for an important event straight after treatment may consider that risk serious and so should be informed of that risk. You must discuss these issues with your patient.

You must keep up to date with developments in your areas of practice, such that you are aware of the current evidence of risks involved in the treatment proposed, at the time the patient seeks such information.

Discussing Comparative and Alternative treatment options.

You should discuss with your patient those options that may have *fewer* or *no risks* associated with them than the primary option you are considering[7] for your particular patient in their individual circumstances. Where such information might be relied on by patient to make a proper decision, the balance should lie towards discussions with the patient rather than withholding information.

Answering Patient Questions

You should answer patients questions honestly and in a balanced manner, and must answer as fully and in as much detail as the patient wishes. Where you are unable to answer a patient's specific questions you should endeavor to find the answer from a more experienced colleague.

[7] Birch v UCL Hospital NHS Foundation Trust [2008] EWHC 2237 (QB)

You may also wish to consider the circumstances whereby it may be that no definitive answer to a patient's question is yet known to medical science.

Reasons for not discussing information with patients

Some patients may say they do not want to receive detailed information about their condition. You should seek to find out why the patient does not want to receive detailed information. Where possible you should explain that is important that the patient understands the options that are available to them and what treatment will involve.

You must not withhold information from patients that is necessary for them to make a proper decision for any reason, including when a friend, relative or carer asks you to, unless you believe that sharing the information would cause the patient serious harm. Believing that the patient may become upset and refuse treatment is not a reason to withhold information.

Involving others in decision-making discussions with patients

No-one else can make a decision on behalf on an adult who has the capacity to make their own decisions. Patients detained under the

- Mental Health Act 1983 (England and Wales)
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Mental Health (Northern Ireland) Order 1986

for a mental health condition may still have the capacity to make a proper decision about any physical condition they may also have.

If the patient gives you express permission to do so, you may involve other people, such as relatives, friends and/or carers, in your discussions with your patient. You should get the patient's permission in writing if circumstances might arise where the involvement of others in treatment decisions might later be challenged or disputed.

It may be difficult to give patients as much information, or support in decision-making decisions, as you – or they – would like. Where appropriate, you should consider the role of other members of the healthcare team, and what other sources of information and/or support might be available to the patient.

You may wish to provide your patients with patient-information leaflets or signpost them to advocacy services or relevant support groups.

You should ensure that patients with additional needs or disabilities are supported to make their own decisions where they have the capacity to do so.

Presenting information to patients

You may use accurate written information or other visual aids to discuss treatment with your patients, where they can help the patient understand the information and make a more informed decision.

You may use patient information leaflets (PIL). If you provide a PIL you must ensure the information contained within it is accurate and up to date at the time you give it to the patient. Where several versions of the document may exist, and where the document forms the basis upon which the patient makes a decision, you must record the edition and/or version number of the document provided to the patient in the clinical records. In this way, if the information provided to a specific patient needs to be reviewed, there will be a clear record of what was provided.

In **Wales** you will need to comply with requirements under the Welsh Language Act 1993 and Welsh Language Measure 2011. Health Boards will be operating the Welsh Language Scheme and you will need to adhere to guidance in relation to provision of information through the medium of Welsh.

Giving patients time to consider and reflect

A patient's decision must be voluntary. Some patients may want a 'cooling-off' period in order to consider the information you have shared with them, or to seek further information, before making their decision.

You should not pressure patients in to receiving a proposed treatment immediately if they are not absolutely clear that they wish to proceed. You should discuss with the patient how much time they need to consider their decision, whilst also informing them if a delay in making a decision might cause their condition to deteriorate and/or create other consequences.

Respecting patient's decisions

If a patient refuses to agree to your planned treatment, and they have capacity, you should accept that refusal of treatment even if you think their decision is wrong, irrational or made without reason at all. You should also seek to discuss with the patient their reasons for refusing treatment and seek to explore if those reasons can be resolved.

It may be appropriate to discuss the patient's refusal of your treatment with other members of the healthcare team directly involved in the patient's care, particularly if refusing physiotherapy treatment may have some effect on care being delivered by other professionals. It is good practice to gain the agreement of the patient should you need to do this, but you are not required to have explicit consent. See separate Department of Health guidance for more detailed information[8].

A patient's decision must be voluntary. Patients may be influenced by employers, insurers, relatives or others to accept (or decline) a particular treatment. You must be aware of situations and circumstances in which patients may be particularly vulnerable to undue influence and seek to ensure that the decisions made are the free choice of the patient.

If a patient makes an informed decision to refuse treatment you should document the patient's decision carefully in the records. The patient may change their mind and accept future treatment at any time.

[8] Department of Health. Confidentiality – NHS Code of Conduct. London. November 2003.

SECTION 3: DOCUMENTING CONSENT

Consent Forms

Written consent is only required by law for treatment under sections of the Mental Health Act 1983, Human Fertilisation and Embryology Act 1990 and Human Tissue Act 2004 (organ transplantation etc) and equivalent devolved legislation.

Written consent should be recorded on the relevant Health Department consent forms for NHS care in each of the devolved countries, or forms that mirror Health Department requirements for non-NHS care. This ensures that all providers have a consistent approach to the recording of written consent and reduces duplication of effort.

There should be no need for physiotherapy departments to design their own consent forms for physiotherapy procedures where an organisation already has consent forms in place.

Duration of consent

There is no set time period until consent 'expires'. In general, valid consent remains indefinitely until the patient withdraws it. However, before you start treatment you should reconfirm consent if

- A significant time has passed between consent being given and the intervention being given
- New information becomes available about the proposed intervention
- The patient's circumstances change and/or the patient provides new information

Recording refusal of treatment

If a patient refuses to agree to your planned treatment, and they have capacity, you should accept that refusal of treatment even if you think their decision is wrong, irrational or made without reason at all.

It may be appropriate to discuss the patient's refusal of your treatment with other members of the healthcare team directly involved in the patient's care, particularly if refusing physiotherapy treatment may have some effect on care being delivered by other professionals.

If a patient makes an informed decision to refuse treatment you should document the patient's decision carefully in the records. The patient may change their mind and accept future treatment at any time.

Recording Consent

You should use a Health Department approved consent form for the relevant devolved country (or equivalent for non-NHS environments) for procedures where written consent is required. A copy of this consent form should be retained in the patient's records.

If you enclose a generic information sheet into the clinical record with a consent form you also record that the sheet was suitable for the patients needs and/or annotate the generic sheet with topics that were additionally discussed.

In addition the process of physiotherapy management can be an ongoing process, with your interventions varying according to objective findings and the wishes of the patient. Throughout your treatment sessions you should discuss with your patients how treatment during the session may progress and allow them the opportunity to discuss matters with you if necessary. You should record the key points raised if necessary in the clinical record.

Consent, if disputed, may be considered on the basis of the content of the individual patient record and whether it shows that appropriate examination and reasoning took place together with an adequate discussion of the risks, benefits, outcomes and alternatives of treatment.

SECTION 4: CAPACITY TO GIVE CONSENT

The respective Health Departments in each of the Home Countries provide detailed and comprehensive guidance on all matters of consent for specific patient groups and you should refer to this guidance for your particular country. For example:

England:

Reference Guide to Consent for Examination or Treatment. Department of Health. London. (2009).

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

Scotland:

A Good Practice Guide on Consent for Health Professionals in NHS Scotland. Scottish Executive Health Department. (2006)

http://www.sehd.scot.nhs.uk/mels/HDL2006_34.pdf

Wales:

Reference Guide for Consent to Examination or Treatment. Welsh Assembly Government. (2008).

http://www.nhswalesgovernance.com/display/Home.aspx?a=243&s=2&m=153&d=0&p=0

Northern Ireland:

Reference Guide to Consent for Examination, Treatment or Care. Department of Health, Social Services and Public Safety Northern Ireland. (2003)

http://www.dhsspsni.gov.uk/consent-referenceguide.pdf

The relevant Health Departments and other agencies also provide national policy and guidance on specific issues e.g. *Safeguarding* and this will over-arch any local polices that may be in place.

The purpose of this section is to give a brief overview of the subject. You should consult your employer's policies and procedures for the specific application of guidance that applies to your unique setting.

If you are unsure of how to proceed after reading Health Department, CSP, employer and other agency guidance, you should consider the need to obtain specific legal advice.

Presumption of Capacity

Unless determined otherwise you must assume that every adult, and 16-17 year old, has the capacity to make their own decision about treatment. Some children will also be able to make their own decisions and consent to treatment.

Capacity is based on a person being able to

- Understand the information being given to them
- Retain the information
- Weigh up the information in order to make a decision

You must not assume that a patient lacks capacity to make their own decisions based on age, disability, behavior, medical condition, mental health status, beliefs, communication abilities, or the fact that the patient makes a decision you disagree with.

A patient may have the capacity to make some decisions, but not others, depending on the complexity and implications of the condition and/or proposed treatment. This may be particularly so in children, who even at a young age may have the capacity to make their own decisions about simple treatment and yet would require the parent/ person with parental responsibility to make decisions in regard to more complex treatment.

The presence of a **mental health** condition does not automatically mean that a patient does not have capacity to make decisions about treatment for their **physical** conditions.

Patients with learning disabilities and/or communication difficulties may have the capacity to make their own decisions but may not be able to convey their wishes to you. You should discuss the most appropriate means of communication with a speech and language therapist.

Adults with capacity

An adult with capacity has the absolute right to consent to, or refuse, treatment. All adults (18+) are presumed to have capacity unless proved otherwise. The right of every adult to make their own decision is enshrined in law[9] where it is stated

'…every adult has the right to decide whether or not he will accept medical treatment, even if a refusal may lead to permanent injury to his health or even lead to his death. Furthermore, it does not matter if the reasons for refusing treatment are rational, irrational, unknown or even non-existent.'

16-17 year olds with capacity

All 16-17 year olds with capacity are permitted by law[10] to give their own consent to medical, dental and surgical treatment. Those patients who are 16 or over on the date they attend for treatment do not need parental consent for physiotherapy. You should not share confidential information about 16-17 year olds with their parents, or others, unless you have specific permission to do so and/or you are legally obliged to.

It is good practice to seek to ensure that young people involve their families in their treatment decisions, if they agree to information being shared. However, if a 16-17 year old specifically refuses to allow you to share information you should respect their decision.

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[9] Re T (Adult: Refusal of Treatment) [1993] Fam 95 (CA)
[10] Family Law Reform Act (1969)

To establish if a 16 or 17 year old has the capacity to consent to their treatment, the same criteria as for adults should be used. If a 16 or 17 year old with capacity refuses treatment, in certain circumstances the parent or the Court can over-rule the refusal of treatment.[11]

The issue of chaperoning is separate from the issue of consent and will depend on the nature of the treatment, your professional relationship and communication skills with your patient and what your practice policy is. The CSP issues separate guidance on Chaperoning.

Children with capacity

Children under 16 years of age may give their consent to treatment provided that they can:

- Understand the information being given to them
- Retain the information
- Weigh up the information in order to make a decision

A child who has the capacity to make their own decisions may be referred to as 'Gillick Competent' after the legal case that established that children could make their own decisions in certain circumstances[12].

If a child is deemed to have the capacity to make their own voluntary decisions, it is not necessary to obtain additional consent from the parent/person with parental responsibility. However, it is good practice to persuade the child to inform their parent, unless this would be against the child's best interests.

You must be aware that consent must be voluntary to be valid, and if you feel the child is under undue influence from another person, then you must consider if the child has given their own consent and whether it is valid. If a child is deemed to have the capacity to make their own decisions, a parent/person with parental responsibility cannot override a child's valid consent to treatment.

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[11] Re W (A minor) (Medical Treatment) [1992] 4 All ER 627
[12] Gillick v West Norfolk and Wisbech AHA [1986] AC 112

A parent/ person with parental responsibility may be able to override a child's refusal of treatment. You should consider the context and reasons why a child may be unwilling to proceed with treatment and seek further advice as necessary.

Children who lack capacity

If the child does not have the capacity to give their own consent e.g. they are too young or do not understand fully what is involved, then a parent/ person with parental responsibility, or the Court, may give consent on the child's behalf.

Adults who lack capacity due to physical conditions - Mental Capacity Act.

Making treatment decisions for adults (16+ years old) who lack capacity due to **physical** conditions is governed as follows:

- England and Wales: Mental Capacity Act 2005
- Scotland: Adults with Incapacity (Scotland) Act 2000
- Northern Ireland : common law duty to act in 'best interests'.

In England, Wales and Scotland, the legislation sets out the criteria and procedures to be followed when a patient lacks the capacity to make their own decisions, or where a health professional believes a patient might lack capacity, and grants legal authority to certain designated other people to make decisions on the patient's behalf, in the patient's 'best interests' if the patient is found to lack capacity.

If you believe that an adult lacks the capacity to make their own decisions about their treatment you should raise your concerns with the doctors involved in the patient's care. They will take account of the advice contained within the **Codes of Practice** that support the relevant legislation with regard to making a '**best interests decision**' and an assessment of capacity will be made.

If you and/or the doctors caring for a patient remain unsure of a patient's capacity then you must seek formal legal advice and if necessary approach a court to determine capacity, before proceeding with treatment.

The respective (In)Capacity Acts only relate to **physical** conditions, and invoking these Acts does not confer any right to treat **mental health** conditions without consent.

If a patient treated under the Mental Capacity Act concurrently has a mental health condition that requires treatment, they may have the capacity to consent to treatment for that mental health condition. If you believe that they also lack the capacity to make their own decision about treatment for the **mental health** condition, then the Mental Health Act must be invoked before you can treat the mental health condition without consent.

Adults who lack capacity due to mental health conditions -Mental Health Act and Deprivation of Liberty Safeguards (DOLS).

Making treatment decisions for adults (16+ years old) who lack capacity due to **mental health** conditions is governed as follows:

- England and Wales: The Mental Health Act 1983 (as amended by The Mental Health Act 2007),
- Scotland: The Mental Health (Care and Treatment) (Scotland) Act 2003,
- Northern Ireland: Mental Health (Northern Ireland) Order 1986

These Acts provide the statutory framework for the compulsory treatment without consent for patients with **mental health** conditions.

These Mental Health acts only relate to **mental health** conditions, and detention of a patient under any Mental Health Act does not confer any right to treat **physical** conditions without consent.

If a patient who is detained under any Mental Health Act concurrently has a physical condition that requires treatment, they may have the capacity to consent to treatment for that physical condition. If you believe that they also lack the capacity to make their own decision about treatment for the **physical** condition, then the relevant Mental Capacity Act must be invoked before you can treat the physical condition without consent.

Vulnerable Adults

If you have concerns about the welfare of an adult who lacks capacity or is otherwise vulnerable, you have a duty to consider what action you must take to protect that adult. You should follow your local and/or national polices.

- England: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882
- Wales: http://wales.gov.uk/topics/health/socialcare/vulnerableadults/?lang=en
- Scotland: http://www.scotland.gov.uk/Topics/Health
- Northern Ireland: http://www.nhssb.n-i.nhs.uk/publications/social_services/Safeguarding_Vulnerable_Adults.pdf

Vulnerable Children / Young People

If you have concerns about the welfare of a child, or whether a parent/person with parental responsibility is acting in the best interests of a child, you have a duty to consider what action you must take to protect that child.

You should know who your employer's Child Protection and/or Safeguarding Children officer is and what your employer's policy is. If you are not employed you should know who the local authority Child Protection and/or Safeguarding Children officer is.

- England

The Department for Education and DH both have links to comprehensive guidance.

Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (March 2010). Department for Education

https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007781

- Scotland:

http://scotland.gov.uk/Topics/People/Young-People/children-families/17834

- Wales:

http://new.wales.gov.uk/topics/childrenyoungpeople/health/protection/procedures/?lang=en

- Northern Ireland:

http://www.dhsspsni.gov.uk/index/hss/child_care/child_protection/child_protection_publications.htm

Planning Ahead: Lasting Power of Attorney

The Mental Capacity Act allows a named individual, known as an 'attorney', to consent to treatment on behalf of another person in an arrangement known as a 'lasting power of attorney (LPOA).

The LPOA must be in writing, signed by the patient when they have capacity, and will take force when the patient loses capacity. The attorney may make decisions based on the patient's best interests and the decision they believe the patient may have made for themselves if they had retained capacity.

If there is a conflict between an attorney and the patient's doctors, then the Court of Protection is consulted for a legal decision.

Planning Ahead: Advance Decisions

The Mental Capacity Act also allows for 'advance decisions' to be made by a patient about the treatment they wish to receive, or not receive, if they lost capacity. Advance decisions can only be made by people over 18 years of age, and must be made when the person has full capacity.

Advance Decisions should be in writing, witnessed and signed. They only have effect once the person has lost capacity. There are special rules with regard to advance decisions that relate to refusing life-saving treatment.

It is important to recognize that an advance decision cannot cover all eventualities. A patient's functional and cognitive abilities, age, racial and ethnic backgrounds, and desire to avoid burdening loved ones may influence attitudes and definitions regarding autonomy. Moreover, if a patient has appointed a Lasting Power of Attorney (LPOA), this may be in conflict with any advance decision.

An advance decision may be legally binding depending on the full circumstances and situation, so if a patient tells you they have an advance directive, you should ask the patient what the advance decision contains and you should seek further advice from your Trust/employer's legal teams about the circumstances in which it may be invoked.

SECTION 5: SPECIAL CIRCUMSTANCES FOR CONSIDERATION

Using video recordings / photographs / mobile phone photos

The use of video recordings and photographs of patients is covered in detail by the Department of Health document

Good Practice in Consent Implementation Guide: Consent to examination or treatment - Chapter 8 *Clinical Photography and conventional or digital video recordings.* http://www.dh.gov.uk/assetRoot/04/01/90/61/04019061.pdf>.

You will need the written consent of your patient to make any video or photographic recordings. If you intend to use the recordings for any purpose other than being stored as part of the clinical record you must inform the patient where, how, when and why any recording will be used.

The patient has a right to withdraw consent at any time, but must be informed at the time of giving consent, that if the footage is placed on any web-based platform it may be impossible to remove the footage if consent is later withdrawn.

Once made any video recording/ photograph of the patient is subject to the terms of the Data Protection Act 1998 in terms of its release to third parties and subsequent use in any Court Proceedings.

Photographs and recordings of staff (updated April 2018)

Sometimes patients may wish to record, either openly or covertly, their consultation and/or treatment with you as a record of events for their personal use, including sharing unedited on social media platforms. Patients do not need to get your permission but common courtesy is that you should be told about this beforehand in most cases. Patients are allowed to do this and you cannot refuse to be recorded.

NHS Protect (2016) *Patients recording NHS staff in health and social care settings.* London. NHS Protect. http://www.proceduresonline.com/barnet/fs/files/patient_record_nhs.pdf

Social networking media (updated 2018)

Patients may sometimes wish to post their experiences of physiotherapy onto their social network platform. Patients do not need your permission to do this and you cannot refuse to allow the content to be shared. You should be familiar with your organization's policy with regard to the use of social media in this way and act accordingly.

You should also be familiar with the terms and conditions of the specific social networking site in question. Many will have 'implied consent' for items being posted. If you categorically do not consent to images / references of you being posted, you should be able to contact the social media provider directly and ask for items and/or images involving to be removed.

Where recordings are shared and/or broadcast as a means of harassing or intimidating staff, or are modified and broadcast in a way that is not connected to the consultation this may not be considered as a recording for private use and may be an offence.

NHS Protect (2016) *Patients recording NHS staff in health and social care settings.* London. NHS Protect. http://www.proceduresonline.com/barnet/fs/files/patient_record_nhs.pdf

Using patients as models/participants in educational events

You may wish to ask one of your patients to be a model and/or participant for and educational event such as a conference or study day.

In such circumstances, because the purpose of the patient's participation is education and/or research, your patients must give **written** consent if they agree to take part in such activities.

You must ensure that your patient has the capacity to understand the nature of their participation, weigh up the information and make a free choice as to whether to agree to the invitation.

It is not good practice to invite patients with cognitive impairments that may affect their capacity to make a voluntary decision to be participants in educational events.

Patients have the right to refuse to act as a model in practical classes/demonstrations and the right to withdraw from a practical (or part of a practical) at any time.

Using colleagues as models for professional skills development (including student consent.)

You may be asked to take part in practical skills development with your colleagues and this may involve being a model to allow a colleague to practice a technique or part of a technique on you.

In these circumstances you are not a 'patient' who is 'consenting to treatment', but under the Health & Safety At Work Act both you and/or your employer/HEI have a duty to consider carefully your participation in any activity that may have an impact on your own health and safety and/or well-being in the workplace.

You may not need written consent, but you should ascertain that your colleague is willing to act as a model for you and you should satisfy yourself that they are suitable to act as a model for you. If you are asked to be a model for a colleague you have the right to refuse to act as a model in practical classes/demonstrations and the right to withdraw from a practical (or part of a practical) at any time.

The CSP provides further information in its publication QA6-Guidelines for Good Practice: Student Consent. (April 2005).

The Use of Interpreters including Child Interpreters

Where patients do not use English as their first language, they may require the services of an interpreter to enable them to fully participate in their

treatment. You should follow your employer/organization's policies and procedures for using interpreters. If you are unable to access an interpreter for your patients, this is a governance issue for the organization and you should raise the issue through the appropriate governance procedures.

It is not good practice to use any family member as an interpreter for your patient and the CSP does not recommend this. Family members may not be trained as interpreters, and may not be willing and/or able to accurately translate what you wish to convey to the patient. In addition, there may be a variety of cultural competence issues and sensitivities that are best addressed by a professional interpreter.

The CSP recommends that child interpreters are **not** used. As a physiotherapist you have a duty to consider the welfare, protection and capacity issues of the child themselves and understand that even in exceptional circumstances it may not be in the best interests of the child for them to be used as an interpreter

The younger the child, and/or the more sensitive and/or distressing the information you need to convey, the more difficult it is to justify the use of child interpreters. If in any doubt, you should consider rescheduling the patient's appointment until an appropriate interpreter can be found. You may need to address access to interpreters through your organization's governance structures.

Consent and Public Interest Disclosures

The law makes provision for certain information to be disclosed without consent where it is in the public interest to do so. You should seek advice before making a public interest disclosure.

Further information is provided by the DH:

Confidentiality: NHS Code of Practice - supplementary guidance: public interest disclosures (November 2010)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122012