Consent in adults – core principles

Gaining consent for all medical interventions, including examinations, investigations and surgical procedures, is an integral part of healthcare and a fundamental legal and ethical obligation for all clinicians. Failure to obtain valid consent can result in criminal prosecutions, civil actions and investigation by the General Medical Council (GMC) or General Dental Council (GDC).

In a bona fide emergency, interventions can proceed where it is not possible for the patient to consent, for example where the patient is unconscious, but the intervention is needed to save their life and you cannot ascertain the patient's wishes. The treatment should be the least restrictive in terms of the patient's rights and freedoms – including future choices.

Basic considerations

The GMC has described seven principles of decision making and consent in its revised 2020 Consent guidance:

1. All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able.
2. Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient.
3. All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.
4. Doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.
5. Doctors must start from the presumption that all adult patients have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements.
6. The choice of treatment or care for patients who lack capacity must be of overall benefit to them, and decisions should be made in consultation with those who are close to them or advocating for them.
7. Patients whose right to consent is affected by law should be supported to be involved in the decision-making process, and to exercise choice if possible

For GDC registrants, the starting point is Principle 3 of Standards for the Dental Team. The concepts outlined by the GMC above and discussed throughout this note are broadly consistent with the GDC's requirements, but it is important to recognise one additional factor the GDC specifically requires practitioners to address in the context of consent discussions: the question of costs. Dental practitioners should exercise particular caution in outlining whether each of the available treatment options is available on the NHS or privately and the relative cost associated with each relevant treatment option.

While the GMC guidance is silent on the question of costs in the context of consent, it is perhaps a matter of common sense to suggest that a patient receiving private medical treatment could not provide valid consent without having a clear understanding of the costs involved.

A proportionate approach may be taken to obtaining a patient's consent. Written consent is not always necessary, although it is essential to document the key elements of what was discussed during the consent process in the patient's notes. Further, non-verbal consent may be relied on for non-invasive interventions such as examinations where an appropriate explanation is given, and the practitioner is sensitive to the patient's wishes and reactions during the activity.

Consent forms can be used as a means of documenting the consent process. Written consent is a pre-requisite for certain treatments, such as fertility treatment. It is important to remember that a consent form does not replace the need for an appropriate dialogue to help the patient understand that they have choice, based on provision of the appropriate information that might influence patient choice where a variety of options exist with the aim of reaching a shared understanding of what the patient might expect from an intervention and what the risks/benefits are of the various options.

Capacity

Adult patients are presumed to have capacity, and can only be regarded as lacking capacity to make a decision if it is clear that, having been given all appropriate help and support, they cannot understand, retain, use or weigh up the information needed to make that decision or communicate their wishes. It must not be assumed that because someone has a disability or medical condition (including mental illness) that they lack capacity to make a particular choice.

Capacity is decision-specific and therefore a patient may have capacity to consent to some interventions and not others. It is also important to bear in mind that capacity is a fluctuating concept and a patient may have capacity to make a decision on one particular occasion, but not at a later date (and vice versa). It is therefore essential that capacity assessments are revisited prior to treatment, particularly if there has been a prolonged period since the assessment was undertaken. Assessments of capacity should be fully documented in a patient's medical records and, where it is determined that a patient does not have capacity, the appropriate legal framework should be followed.

Sufficient information

The exchange of information is a central part of consent process. Patients should be given the information they need and want in a waythat is understandable to them.

In ensuring a patient is sufficiently informed, they need to be made aware of the purpose, risks, benefits and likelihood of success of the proposed intervention and any alternatives, including the option not to have any intervention. Following the case of *Montgomery v Lanarkshire Health Board* (2015), the test the Courts will apply is whether or not a patient was made aware of all material risks involved in the recommended treatment and reasonable alternatives. A material risk is one to which a reasonable person in the patient's position would attach significance.

In practice, this means that in deciding whether a particular risk should be discussed, doctors should not only consider the seriousness or probability of a risk, but also whether the patient in front of them would want to be aware of that particular risk before making a decision. The Courts will consider whether the doctor should reasonably have been aware that the particular patient would be likely to attach significance to the risk. You should therefore ensure, in sharing information, that you try andfound out what matters to be patient.

The law recognises that the doctor is entitled to withhold information regarding risks from the patient if it is reasonably considered that disclosure would cause the patient serious harm; but any decision in this regard should be carefully considered, as the bar for 'serious harm' is high and requires more than that the patient might become upset or decide to refuse treatment. In addition, the amount of information to be shared with a patient can be restricted if a patient with capacity makes clear that they do not wish to be given this information; again, this is a delicate line to tread and any decision to withhold information should be carefully justified with reference to GMC/GDC guidance and clearly recorded.

The person who takes consent must be able to provide all the necessary information to the patient and answer any questions. Therefore, it should usually be the clinician providing the intervention that seeks consent. If you choose to delegate the consenting process, you must ensure that the person to whom you delegate is suitably trained and qualified, has sufficient knowledge of the proposed intervention and reasonable alternatives and understands the risks involved in each. The consenting process remaining remains your responsibility, even if delegated.

Autonomy

The main ethical principle underlying the consent process is respect for autonomy. A patient must be able to exercise their own free will to provide valid consent. You should be aware of the possibility of a patient being susceptible to pressure from others to make a particular decision. This might be more likely in situations where a patient is experiencing abuse, is a resident in a care home, in detention, subject to compulsory treatment or otherwise vulnerable.

A patient may withdraw their consent at any time. If, during a procedure, a patient indicates that they no longer consent, the procedure should be stopped as soon as it is safe to do so.

Key points

- You should presume a patient has capacity, unless they have been appropriately assessed and found to lack capacity to make that decision.
- You should not obtain consent for an intervention you are not familiar with and you should not delegate the consenting process to someone unable to fully discuss the risks and benefits of the proposed intervention and alternatives.
- When taking consent, you should inform the patient of all material risks of the proposed intervention and reasonable alternative treatment options. You should focus on the patient's individual situation and do your best to understand what information the patient in front of you is likely to attach significance to.

- You should document the consent process, including the information that was discussed, in the patient's notes.
- Remember that completion and signing of a consent form is not a substitute for a meaningful and individualised dialogue with the patient.

Further guidance

- GMC ethical guidance: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent
- GDC *Standards for the dental team:* https://www.gdc-uk.org/professionals/standards
- MDDUS video presentation, Consent: Part one: https://www.mddus.com/training-and-cpd/training-for-members/video-presentations/consent-module-1
- MDDUS Consent- children guidance https://www.mddus.com/advice-and-support/advice-library/consent---children
- MDDUS Assessing capacity guidance https://www.mddus.com/advice-and-support/advice-library/accessing-capacity