CONSENT POLICY
ON HEALTHCARE ASSESSMENT, CARE &TREATMENT

Lead Manager	Clinical Risk Manager
Responsible Director	Director of Clinical and Care Governance
Approved By	Corporate Management Team
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This policy was written with the NHS Scotland Inequalities and planning directorate vision in mind and impact assessed by the Corporate Inequalities team at NHSGGC

Vision

Our vision is of a person centred NHS that eliminates discrimination and embraces diversity, is fair for all and where all people experience equality of opportunity and equity of treatment

This policy can be made available in alternative formats on request

1. Introduction

1.1. Consent is integral to clinical interactions between healthcare staff and patients.

1.2. The principles pertaining to consent in this policy are relevant to all the health and care decisions that are made with patients about mental and physical health. This includes, but is not limited to, decisions about treatments, procedures, investigations, examinations and referrals, and applies whatever the method of communication, including remote consultations as described in 'The Seven Principles of Decision Making and Consent, GMC Guidance' (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent/the-seven-principles-of-decision-making-and-consent).

1.3. All individuals (adults aged 16 and over and children/young people under 16 who have capacity and can give valid consent), with decision-making capacity, have a fundamental legal, ethical and human right to determine what happens to their own body and capacity to consent or refuse consent is assumed unless there is evidence to the contrary. No adult can give valid consent for another unless legally authorised to do so. Valid consent to treatment is therefore absolutely central in all forms of healthcare and is also a matter of common courtesy between health professionals and patients.

2. Scope

2.1. Who is the Policy intended to Benefit or Affect?

2.1.1. The policy is intended to protect the rights of patients and ensure good clinical practice https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent/the-seven-principles-of-decision-making-and-consent) is followed to ensure shared decision making for healthcare interventions so patients will receive treatments and care of most benefit to them personally.

2.2. Who are the Stakeholders?

2.2.1. The principles of the policy apply to all healthcare staff who are interacting with patients however the main stakeholders are clinical practitioners who are responsible for proposing, planning and ensuring delivery of treatments and care.

3. Aim

3.1. This policy aims to inform staff of NHS Greater Glasgow and Clyde (NHSGGC) of the principles of consent; to ensure that the ethical and legal principles relating to consent are adhered to in practice and to ensure that valid consent is obtained from patients prior to any treatment, investigation or examination. This policy is also in keeping with national guidance that has been issued for health professionals in Scotland ("A Good Practice Guide in Consent for Health Professionals in NHS Scotland") and has its basis in Scots law and relevant Scottish and UK legislation.

3.2. Consent is a patient's agreement for a health professional to provide care and treatment. **Patients may indicate consent verbally, non-verbally, or in writing.** For the consent to be valid, the patient must:

- Have capacity to make the particular decision under discussion.
- Have received sufficient information to make that decision.
- Not be acting under duress.

4. Roles and Responsibilities

4.1. It is normally the responsibility of the doctor, nurse, midwife or other health professionals providing treatment, carrying out an investigation or performing a surgical operation or other procedure to provide all the information necessary for the patient's understanding and to obtain consent. However, it is recognised that there are circumstances where this ideal is not practicable. Obtaining consent may be delegated to a person who:

- Is suitably trained and qualified in the proposed investigation or treatment OR
- Has sufficient knowledge of the proposed investigation or treatment (including understanding the risk involved)
- Acts in full accordance with both this policy statement and professional codes of conduct.

4.2. Patients should be made aware that hospitals within NHSGGC are teaching hospitals which mean that procedures can be carried out by trainee professionals who are supervised by Consultants or other fully qualified professionals such as Advanced Nurse/Allied Health Practitioners (AHP). If it is not the person carrying out the procedure (operator) that is taking consent, it is important the patient is told who and what designation of staff will be performing the procedure as patients will assume it is their own consultant.

4.3. Additionally, there are situations in which it may be regarded as standard practice for one practitioner to refer a patient to a colleague to carry out a particular procedure or investigation or aspect of treatment, e.g. referral of a patient by a surgeon for anaesthesia or interventional radiology or procedures performed by Advanced Nurse or AHP practitioners. In these circumstances, the referring practitioner (in this case, the surgeon) should explain the general need for the proposed referral, possibly using additional resources such as patient information leaflets or links to appropriate web sites provided by the 'receiving' colleague and obtain written consent on that basis.

4.4. It would be for the 'receiving' practitioner (in this case, the anaesthetist or radiologist or ANP) to provide any (further) 'specialist' information necessary to secure the patient's full understanding and valid consent.

4.5. It would be for the relevant specialist departments to decide standard practice as to those situations when further written consent was necessary.

4.6. It remains the responsibility of the person performing the procedure to ensure that:

- The patient has been given sufficient time and information to make an informed decision.
- Any additional support or alternative forms of information patients may need about the procedure to reach an informed choice, has been made available to the patient.
- That the interpreting services are utilised if there are language barriers.
- All the other requirements of this policy have been met.

5. Seeking Consent

5.1. It takes time to undertake the whole process of consent properly for every patient. Communication with the patient in a way they understand is central to "seeking consent". The patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge. Clinical Practitioners must also give consideration to, for example, people's religious, cultural and other non-medical views that may influence the decisions they make about the overall management of their care.

5.2. The shifting emphasis from the language of 'consent' to that of 'patient involvement' and 'shared decision making' reflects a move away from the traditional model of consent as a discrete requirement for invasive examinations or interventions. Shared decision making means that patients must have a voice in all aspects of their healthcare, including decisions about medication and overall management of their conditions. While informed consent for discrete interventions remains important, this

aspect forms part of a broader requirement for Clinical Practitioner to support patients to make their own decisions.

5.3. The Supreme Court ruling in Montgomery (2015) (https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf) endorsed a test for consent which requires a health care professional to take into account an individual's circumstances and preferences when explaining a treatment, and to consider what risks this particular patient would be likely to attach significance to. The Montgomery ruling fundamentally changes the balance of power between patients and Clinical Practitioner, empowering patients to take an active role in their healthcare.

5.4. It is expected that the seven principles of decision making and consent outlined in the GMC decision making and consent guidance will be adhered to at all times. The seven principles are

One
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.

Two
Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient.

Three
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.

Four
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.

Five
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.

Six
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.

Seven
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.

5.5. Health professionals must ensure that before they commence any treatment or intervention that they discuss:

- The diagnosis and prognosis
- The various treatment options, the nature of each option, what would be involved and the desired outcome (including the option of not to treat)
- The individual circumstances and preferences of the patient (Montgomery)
- The risks associated with the intervention (consider risks which are less severe but which occur frequently and risks which this patient may attach significance to (Montgomery).
- Additional procedures, including those which may become evident at a later stage.

5.6. When considering how much information to tell the patient the health professional seeking consent must take into account:

- The nature of the condition
- The complexity of the procedure
- The nature and probability of risks involved, including frequency, seriousness, permanence and consideration of the balance of risks and benefits.
- The benefits to be reasonability expected from the procedure
- The urgency of the treatment
- The patient's lifestyle, wishes or emotional state
- Whether the treatment is an innovative or novel procedure
- The inability of the practitioner to predict the results
- The irreversibly of the procedure, if that is the case
- Any variance from generally accepted standards in clinical practice

5.7. There may be exceptional circumstances in which the clinical practitioner decides not to share all relevant information with a patient straight away. In these circumstances the clinical practitioner should let the patient know there's more to discuss and make sure arrangements are made to share the information as soon as it's appropriate to do so. The clinical practitioner must make a record of the information still to be shared, the reasons for not sharing it now, and when it can be shared.

5.8. The clinical practitioner should not withhold information a patient needs to make a decision for any other reason, including if someone close to the patient asks them to. In very exceptional circumstances it may be felt that sharing information with a patient would cause them serious harm and, if so, it may be appropriate to withhold it. In this context 'serious harm' means more than that the patient might become upset, decide to refuse treatment, or choose an alternative. This is a limited exception and clinical

practitioners should seek advice from a senior colleague if they are considering withholding information from a patient.

5.9. The term “risk” can refer to any adverse outcome, including those which some clinical practitioners would describe as “side effects” or “complications”. Although a practitioner may not need to tell the patient about every possible consequence of an intervention, a patient might reasonably take the view that a ‘significant risk’ is one that he/she would wish to take into account in deciding whether or not to consent to the proposed procedure. The practitioner is expected to take this into consideration.

5.10. Such significant risks include, but are not limited to, loss of life, loss of limb function, brain damage, paralysis, haemorrhage, allergic reactions, nerve injury, blood clots.

5.11. From a frequency point of view, a 1 in 100 risk is definitely significant – a 1 in 10,000 risk might be, particularly if the consequences are devastating. If a patient asks about a specific risk, e.g. death, a truthful answer must be provided.

5.12. Consent may not be required under special circumstances:-

- In an emergency situation where treatment is urgently required in order to save life, or alleviate pain and/or suffering where the patient is unconscious and cannot indicate their wishes. In these circumstances, the intervention must be no more than the immediate situation requires (depending on the emergency nature of the situation Clinical Practitioners should involve relatives/carers/civil partners where/when appropriate).
- Where there is statutory power requiring the examination of the patient. However an explanation should be offered and the patient’s co-operation should nevertheless be sought.
- In certain circumstances where a court decides that a specific treatment is in a child’s best interest.
- Where treatment is authorised under part 16 of the Mental Health (Care and Treatment) Scotland Act 2003. (See section 12).
- Where treatment is authorised under part 5 of the Adults with Incapacity (Scotland) Act 2000. (See section 13).

5.13. Students: It is good practice to gain verbal consent for a patient to be treated by a student. This can be documented in the records. A patient has the right to decline and to be treated by a qualified practitioner. A patient also has the right to decline being observed by a student. They should be reassured that their decision will in no way affect their treatment.

5.14. Screening: (which may involve testing) healthy or asymptomatic people to detect genetic pre-dispositions or early signs of debilitating or life threatening conditions can have serious implications. Screening therefore requires consent. The clinical practitioner should explain clearly the purpose of the screening; the likelihood of positive/negative findings and false positive/negative results; the uncertainties and risks; any significant implications for the particular condition; follow up plans, including availability of counselling and support services.

5.15. Police: Occasionally the police may request that samples collected from patients in the course of their clinical care be handed over to them as part of an investigation or request access to patient records. In general, this should not be done without the consent of the patient. Only the Procurator Fiscal has the authority to access medical records.

5.16. A summary of the consent process can be found in Appendix A

6. Provision of Information

6.1. The provision of information is central to the consent process. The presumption is that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes it clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

6.2. Leaflets and other materials (e.g. audio-visual), informing patients about their condition and the treatment being offered must be available to patients in a format and in a way they can interpret and understand well before proposed treatment. Any written patient information should follow NHSGGC local and other national guidance standards (minimum of 14pt sans serif typeface). It would be good practice to record the date/issue number of written information as there can be significant differences between different versions. Where possible and dependant on individual circumstances/needs, information may need to be provided in alternative languages or via interpreters. Additional interpreting services support must also be arranged for people with sensory impairment such as Deaf or Deafblind or for people with learning disabilities or literacy problems. Further information can be found in the Clear to All Toolkit http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/AIP/AIT/Pages/default.aspx

6.3. The clinical practitioner should make a record of the information provided for each patient, including the key points of any discussions that are held, on the appropriate section of the clinical record or on the consent form. It is important to document discussion of the merits and burdens of alternative treatment options, including doing nothing. The patient must be explicitly

informed if the recommended treatment is at variance from generally accepted standard treatments.

6.4. The Clinical Practitioner should record the date/issue number of written information provided as there can be significant differences between different versions.

7. Documenting Consent

7.1. It is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussions that led up to that agreement. This will be done either using a consent form or through documenting in the patient's case record if they have given verbal consent. If the patient is unable to write (for whatever reason), and has full capacity the health professional should document on the consent form the patient has authorised treatment and sign this alongside a witness signature.

7.2. A signature, (or patient identification mark for patients with literacy problems) on a form is evidence that the patient has given consent but is not proof of valid consent. It is rarely a legal requirement to obtain written consent (except within certain legislation such as the Human Fertilisation and Embryology Act 1990 and treatment under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003). Consent does not equate with a signature (or mark); it is not a binding contract and the patient may, if they wish, withdraw consent at any time. Where it is not an emergency situation and where the patient has the capacity to give consent, this policy requires that practitioners **must** get express **written consent** for:

- any procedure that is complex, or involves significant risks or side effects.
- any procedure to be carried out under general anaesthesia, sedation or utilising nerve blockage or regional anaesthesia beyond that provided topically or by simple infiltration (written consent not required for the anaesthesia, just the procedure that requires it).
- any procedure to be undertaken in theatres/endoscopy units.
- any procedure which could be considered new, novel or experimental (treatment involving research requires a specific form approved by an Research Ethics Committee).
- any procedure where providing clinical care is not the primary purpose of the investigation or examination such as photography and/or video/audio recording.
- any situation where there are implications for 'third parties'.

7.3. There is a standard NHSGGC consent form (Appendix B). The Clinical Governance Support Unit will support the development of additional high

volume procedure specific consent forms with the intention of standardising information regarding risks of treatment and maximising the time spent with the patient. The procedure specific consent forms must be in accordance with this policy and follow the Accessible to All principles and approved by this policy lead.

7.4. In addition, written consent must be obtained as required by the NHSGGC Policy on Photography and Video Recording of Patients. See the link below for a copy of the form used within NHSGGC

http://www.staffnet.ggc.scot.nhs.uk/Corporate%20Services/eHealth/PoliciesandProcedures/Non%20Clinical%20Policies/Documents/Photography%20and%20Video%20Recording%20of%20Patients%20for%20Clinical%20and%20Service%20Use.pdf

7.5. It is good practice to document consent discussions even where there is no requirement for written consent. NHSGGC have adopted the use of 4 BRAN (Benefits, Risks, Alternatives Nothing) questions to encourage patients to ask about their treatment or procedure. Appendix C illustrates the questions from the 'It's Okay to Ask' The questions have been updated in 2020 Realistic Medicine Annual report. These are

- What are the benefits of my treatment?
- What are the risks of my treatment?
- Any alternative treatments I can try?
- What if I do nothing?

https://www.realisticmedicine.scot/annual-report-2020-2021-recover-restore-renew/#:~:text=The%20Chief%20Medical%20Officer%20has%20today%20published%20his,good%20practice%20and%20innovation%20over%20the%20last%20year.

7.6. The patient only consents to what has been proposed being carried out. Additional or alternative procedures require further consent. The desire to spare a patient a second anaesthetic is not sufficient justification for dispensing with this rule.

7.7. It should be noted that evidence of good communication with patients is far more important than the completion of a consent form. Patients should be given opportunity to raise questions. Staff should also be familiar with how to access sources of Interpreting, Advocacy and other support agencies should additional assistance be required by patients, to enable good communication.

7.8. All circumstances where valid consent is not obtained must be recorded in the patient's case notes and appropriate documentation completed,

particularly for cases involving anaesthesia and surgery or where the treatment carries substantial or unusual risk.

7.9. Legislation for Ionising Radiation (IRMER regulations) states that prior to any procedure requiring radiation, sufficient information must be known about the patient to ensure the exposure is justified. This would include the pregnancy status of the patient which is always asked by Radiology staff before exposure. However, if a patient is unconscious when the Radiographer is called to theatre, they are unable to ask the patient therefore the question must be asked before surgery. This could be done as part of the consent process or the pre-operative checklist. If there was an immediate risk to life the procedure would go ahead as an emergency.

7.10. All writing on consent forms by Clinical Practitioners must be:

.1. Legible
.2. Unambiguous
.3. Contain no abbreviations

- Signed and dated by the patient and health professional.
- If the patient has full capacity and is unable to sign the consent form the Clinical Practitioner should document on the consent form the patient has authorised treatment and sign this alongside a witness signature

7.11. Consent forms will be audited on a regular basis to ensure they conform to agreed standards. This should form part of each Sector/Directorates Clinical Governance Workplan. Audit tools are available on the Consent page on Staffnet (http://www.staffnet.ggc.scot.nhs.uk/Corporate%20Services/Clinical%20Governance/Key%20Information/Pages/ConsenttoTreatmentPage.aspx.)

7.12. Completed consent forms will be kept with the patient's case record. Any changes made to a form, made after the patient has signed, will be initialled and dated by both patient and health professional.

7.13. It is not usually necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if the consent may be disputed later, or if the procedure is of particular concern to the patient it would be helpful to do so.

7.14. If an error is detected on the consent form before the patient has been given any sedative pre-medication, then the clinical practitioner performing the treatment/operation must be informed and the form should be changed or rewritten to ensure the correct details. The patient is given an explanation of the error and is asked to confirm a changed form or sign the new form.

7.15. If an error is detected after the pre-medication is given, the clinical practitioner performing the treatment/operation must be informed and there should be a discussion involving the other relevant healthcare professionals such as the anaesthetist and the theatre nursing staff.

7.16. A decision on whether to proceed is taken primarily by the operator who has responsibility for the procedure and should consider the following factors:

- What is the nature of the error – is it a minor documentation error or is there confusion regarding the understanding of the patient and what is about to be performed?
- Can it be established that patient agreement has been achieved but the form not completed.
- Can it be established if the patient's judgement is affected by the sedation.
- What is the urgency of the procedure and the risk related to delay / cancel.
- Is there enough relevant information to be sure that the correct procedure will be performed in line with the patient's wishes e.g.

    - medical notes
    - out patient letters info
    - x-ray / scan results / images
    - familiarity with patient
    - site marking

7.17. If it is decided to proceed, the operator should take responsibility to change the details written on the consent form and should sign and date any alterations.

7.18. It should be recorded in the nursing records that the form was incorrect, the operator was informed and a decision to continue following review of information has been made.

7.19. It may be decided to wait until the sedative has worn off before confirming patient agreement. Each case must be considered individually as a dynamic risk assessment is required for decision making. There should be agreement from the team involved as to how to proceed. Ultimately the operator has the authority and responsibility for ensuring adequate consent.

7.20. Any concerns should be documented and all errors detected in the consent process reported as clinical incidents.

7.21. Pre-operative marking has a significant role in promoting correct site surgery. All operations in which there is a possibility of mistaking the correct location of surgery will follow a procedure to ensure the correct site is identified and marked. This includes the specific side e.g. right knee or the specific anatomical location e.g. index finger right hand.

7.22. All patients requiring surgery or a procedure requiring written consent should have a valid consent form which includes in the operation description the side / site of the procedure written out in full. The only exception would be for critically ill patients where patient agreement is not possible and a delay maybe life threatening

7.23. Patient's health records must be available when completing the consent form and when marking the site.

8. Timing of Consent

8.1. Whilst there is no recognised absolute minimum period of time which should elapse between information provision, consent and procedure, it is appropriate for there to be sufficient time for the patient to reflect. This is particularly necessary where the information provided is complex and/or the risks are significant. In such cases, more than one session may be necessary to inform the patient adequately.

8.2. Timing will often depend on the degree of urgency of the procedure. In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. In many such cases consent will be verbal and would be recorded in the clinical record as soon as possible

8.3. In the case of complex procedures requiring written consent, if a significant time has elapsed between consent and procedure, or similarly, if there has been significant change in the patient's condition, the existing consent form should be reviewed. It is good practice to confirm with the patient immediately prior to the procedure that they haven't had a "change of mind" and that there is continuing consent. Although there is no expiry time for a consent form, it is good practice to confirm with the patient that they still want to proceed if the consent was taken longer than 3 months before the procedure is performed.

8.4. For elective surgery, consent should be obtained at an outpatient clinic at the time the patient is placed on the waiting list. The information the patient needs to make informed consent should be given at this time, thus allowing an opportunity for reflection by the patient and if necessary, they may seek additional information or change their mind. The patient's

agreement to undergo the treatment based on the information provided should then be recorded by the completion of the consent form.

8.5. In situations where patients are asked to consent to an elective procedure on the same day that it will be undertaken, they should have been provided with appropriate information in advance of their appointment/procedure to enable them to give informed consent to what is being proposed.

8.6. For some procedures such as endoscopy, postal consent is sent to the patient in advance along with information regarding the procedure. This allows the patient time to consider the information before the appointment as there may not have been an opportunity for out-patient consultation. On admission the consent form is checked and the patient should be asked if they have any questions and provided with the opportunity to speak with the Endoscopist regarding any questions if required. The Endoscopist must satisfy themselves that the patient is aware of the procedure, risks associated with the procedure and will countersign the consent form that the patient has previously signed.

8.7. Key points:

- In an emergency consent may have to be directly before the procedure.
- For elective cases time should be given between provision of information and procedure to allow time to reflect.
- Consent is best taken at outpatient clinics.
- If 3 months or longer has elapsed between consent and procedure it is good practice to confirm there is continuing consent.

9. Refusal of Treatment / Examination

9.1. Refusal of consent must be one of the patient's options, and this must be made clear when discussing the proposed treatment with the patient. All individuals (adults aged 16 and over and children and younger people who can give valid consent) who have decision-making capacity are entitled to refuse any treatment at any time leading up to or during the treatment process even when it is clinically believed that this would clearly benefit their health. If consent is withdrawn in these circumstances, no further treatment can be given unless and until the patient reconsiders. A patient's refusal to consent, with the reason for refusal, must be fully documented in the case note. It is also important to explain the consequences of not proceeding and to document this in the case record.

9.2. Where a patient has refused a particular intervention, practitioners must ensure that they continue to provide any other appropriate care to which the patient has consented. Practitioners should also ensure that the patient

realises that they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

9.3. If a patient consents to a particular procedure but refuses certain aspects of the intervention, the practitioner must explain to the patient the possible consequences of their partial refusal. If the practitioner genuinely believes that the procedure cannot be safely carried out under the patients stipulated conditions, he/she is not obliged to perform it. The practitioner must, however, continue to provide any other appropriate care.

9.4. This re- assessment should be recorded in detail in the patient's case record.

9.5. Clinical Practitioners should take into account **Advance Statements**[1], which are documents composed when the patient has sufficient decision-making capacity. Decision-making capacity is based on 3 elements:

- A capacity to understand and communicate
- A capacity to reason and deliberate
- Possession of a broad set of values and goals

9.6. Advance Statements describe how patients would like to be treated should they lack decision-making capacity at some future time. The BMA guidance states that "an unambiguous and informed advance refusal is as valid as a contemporaneous decision" (BMA, 1995). These are a duly **witnessed** written statement provided by the patient or a witnessed verbal statement which is recorded in the patient's case record. An advance refusal of consent is legally binding providing that the patient is an adult who had decision-making capacity when the Advance Statement was made. The statement must be clearly applicable to the treatment option proposed and the patient's present circumstances and there must be no reason to believe that the patient has changed their mind (BMA, 2001).

9.7. Similarly, clinical practitioners should take into account the provisions outlined in an anticipatory care plan. While not legally binding, the preferences documented in such plans should influence clinical decision making, particularly so in regard to treatment escalation / limitation decisions when a patient is approaching the end of life

9.8. Patients subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 may also have an Advance Statement ***specifically in respect to treatment of Mental Disorder***. This is a written statement witnessed by a person of the prescribed class:

[1] This should be construed to mean all forms of advance directive or statement about treatment.

- Doctor
- Registered Nurse
- Social Worker
- Clinical Psychologist
- Occupational Therapist
- Solicitor
- Social service worker

9.9. The witness is confirming that, in their opinion, the person understands what they have written and its possible consequences and that the person does not appear to be acting under duress. They do not require to be involved with the writing of the Advance Statement, nor do they have to agree with its contents.

9.10. Clinical Practitioners should also note exactly what the patient's consent entails. Patients have the right to specify limitations to treatments or examinations and there are no circumstances under which procedures undertaken can exceed that consent.

9.11. If a patient refuses blood or blood products on religious or other grounds this must be clearly documented. A Jehovah's Witness will use an Advance Decision document. The specific protocol for refusal of blood products can be accessed:

http://www.staffnet.ggc.scot.nhs.uk/Acute/Diagnostics/All%20Laboratory%20Medicine/BloodTransfusion/Documents/GG_C%20Transfusion%20related%20Policies/Refusal_of_Blood_GGC_Final_April%202015%20Intranet%20copy%20updated%2023-06-16.pdf

9.12. A woman has a right to refuse a caesarean section even when it might benefit her foetus. All Obstetric practitioners must be familiar with and abide by guidance from the Royal College of Obstetricians & Gynaecologists on this topic.

9.13. When a parent refuses consent to urgent or lifesaving treatment for a child lacking capacity, and the Consultant has a written supporting opinion from a medical colleague (usually another Consultant, not their own junior) that the patient's life is in danger if the treatment is withheld, but the Consultant does not wish to proceed with consent, consent may be obtained from a Court of Session judge, if time permits. The need to treat should be discussed in the presence of a witness. The Consultant should record the discussion in the case notes and ask the witness to countersign.

9.14. When patients are detained under the statutory powers of the Mental Health (Care and Treatment) (Scotland) Act 2003, practitioners must

ensure that they know the conditions and safeguards needed for providing treatment and care without consent

10. Capacity

10.1. The law in Scotland generally presumes that adults (aged 16 or over) legally have capacity to make personal decisions and manage their own affairs. That is, the patient is able to:

- understand in simple language what the medical treatment is, its purpose and nature and why it is being proposed
- understand its principle benefits, risks and alternatives
- understand in broad terms what will be the consequences of not receiving the proposed treatment
- retain the information long enough to make an effective decision, and
- make a free choice

10.2. For capable adults, only the patient may provide consent. Whilst it is good practice to keep relatives, carers or people nominated by the patient, appropriately informed (with the patient's consent), only the patient may give or refuse consent.

10.3. Mental disorder does not necessarily make a patient incapable of giving or refusing consent. Capacity to consent should be assessed in relation to the particular patient, at the particular time, as regards the particular treatment proposed. Temporary factors can remove or reduce capacity, e.g. altered consciousness, confusion, shock, fatigue, pain, drugs. However, a practitioner would need to be satisfied that such factors were operating to such a degree that the ability to decide was absent before concluding that a patient lacked capacity.

10.4. In addition, capacity in any person may vary with:

- Time
- The patient's mood
- Influence of drugs or alcohol
- Distractions
- Time allowed to consider and decide their response
- Level of familiarity with surroundings
- The way information is presented
- The presence of infection or other physical complaints.

11. Adults with Incapacity

11.1. The "Adults with Incapacity (Scotland) Act 2000" provides a framework for decisions to be made on behalf of incapable adults. Part 5 of the Act,

which came into effect in July 2002, and was updated in January 2008, relates to medical treatment and provides authority for a healthcare professional who has primary responsibility to treat an incapable adult on the issuing of a Certificate of Incapacity (section 47). The aim of the Act is to protect the rights and interests of adults who are incapable of managing their own affairs.

11.2. A Code of Practice has been published for persons authorised to carry out medical treatment or research under Part 5 of the Act. For treatment of adults with incapacity, the more detailed guidance contained in this Code of Practice must be used in conjunction with this policy on consent. There is a flow chart for guidance in the pad of medical treatment certificates in Appendix D and an example of the form in Appendix E. Guidance is available via https://www.gov.scot/collections/adults-with-incapacity-forms-and-guidance/

11.3. Any intervention must:

- Benefit the adult – The authorising doctor must be satisfied that the intervention will benefit the adult and that such a benefit cannot reasonably be achieved without the intervention
- Minimum intervention - The intervention should be the least restrictive option in relation to the freedom of the adult, consistent with the purpose of the intervention
- Take account of the adult's wishes both past and present if these can be ascertained
- Minimise the restriction of the adult's freedom while achieving the desired benefit
- Encourage the adult to use existing skills or develop new skills
- Take account of the views of relevant others as far as it is reasonable and practicable to do so. These include

    - The nearest relative and primary carer of the adult (this may not always be the same person)
    - Any person whom a sheriff has directed should be consulted
    - Any other person appearing to have an interest in the welfare of the adult or the intervention proposed where these views have been made known to the person responsible
    - Any guardian, continuing attorney, welfare attorney or other proxy of the adult who has powers relating to the proposed intervention

11.4. The Act requires that even where a proxy has been appointed, a certificate under Section 47 (1) should be completed.

11.5. A proxy may be a guardian, a welfare attorney or a person authorised under an intervention order. It will be desirable for any proxy to make

himself or herself known during the admission process of a patient into hospital and produce the appropriate paperwork outlining the powers and a registration certificate from the Office of the Public Guardian. If the existence of a proxy with powers to consent to treatment on behalf of the adult is suspected but not known, it would be good practice for the medical practitioner to check with the adult's close relatives.

11.6. A public register held by the Office of the Public Guardian can be accessed in exceptional circumstances over the telephone by a Doctor or Social Worker if a patient is waiting for treatment. In all other cases a request can be made to the office, and on payment of a fee the register can be searched and information provided via link https://www.publicguardian-scotland.gov.uk/general/contact-us

11.7. The local authority social work department may also have this information. The details of any proxy with welfare powers appointed prior to the Act will be unknown to the Public Guardian. Proxy decision-makers cannot consent to certain irreversible or hazardous treatments regulated under Section 48 (2) of the Act. However, their views should be taken into account when considering treatment for the adult.

11.8. Section 50 of the Act envisages that a proxy with welfare powers should be given the opportunity to consent to the proposed medical treatment wherever reasonable and practicable. Situations may arise where even after discussion proxy decision-makers will not always agree with the medical treatment proposed by the doctor in charge of the case. Others close to the adult may also disagree with the doctor, and indeed with the decision of the proxy. Section 50 of the Act sets out a procedure for resolving such disagreements.

11.9. The Adults with Incapacity Act contains additional safeguards for patients. Section 47 of the Adults with Incapacity Act cannot be used where Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 applies, and there are additional criteria which must be satisfied before electro-convulsive therapy, sterilisation (including any medical treatment likely to lead to sterilisation as an unavoidable result), termination of pregnancy or implantation of hormones or drug treatment to reduce sexual drive can be carried out. Detailed guidance is provided in the Adults with Incapacity (Scotland) Act 2000, Part 5 of the Code of Practice.

11.10. Incapacity is not an "all or nothing" concept - it is to be judged in relation to particular decisions. A person may be legally capable of some decisions and actions and not capable of others.

11.11. For the purposes of the Act "incapable" means incapable by reasons of mental disorder, or inability to communicate* because of physical disability

and in relation to a particular matter is incapable of at least one of the following: An adult who lacks capacity is defined as being incapable of:

- Acting; or
- Making decisions; or
- Communicating decisions; or
- Understanding decisions; or
- Retaining memory of decisions

11.12. In adults who lack capacity due to inability to communicate due to a physical disability, all steps must be taken to assess the extent of communication problems. The Act clearly states that a person shall not fall within the definition of incapacity if the lack can be made good by human or mechanical aids to communication. So any practitioner assessing capacity must make every effort to utilise appropriate specialists; such as Speech & Language Therapists or Psychologists or communication aids to overcome perceived barriers to Communication. There is further information on NHS Inform https://www.nhsinform.scot/care-support-and-rights/health-rights/communication/communication-and-involving-you

11.13. Lack of decision-making capacity as regards healthcare treatment is verified by an assessment of the adult and that assessment follows the principles described in the Act.

11.14. The Mental Welfare Commission for Scotland provides guidance on the issue of memory in the Good Practice Guide: The Adults with Incapacity Act in general hospitals 9. Their stated view is that (p2) ".....the person must be able to retain information for long enough to make a decision. We believe he/she must:

- remember the decision; and/ or
- make the same decision consistently given the same information; and/or
- agree with a record of that decision

11.15. When assessing capacity, it is unlikely that a decision can be reached instantaneously. It will be important to talk to other health care professionals, relatives and carers before making a decision. It may be necessary to utilise the skills of speech and language therapists, interpreter or signer to help with communication.

11.16. The clinical practitioner primarily responsible for providing the proposed treatment or authorised healthcare practitioner determines that the adult lacks capacity to give or refuse consent, they will complete a Certificate of Incapacity under Section 47 of the Act which clearly states the reason for the lack of capacity. This replaces a consent form. If the consultant is not

present and it is important to avoid delay in treatment, the medical practitioner primarily responsible will be the doctor who is in attendance and to whom it is delegated to give treatment in the absence of the consultant. This should be a fully registered medical practitioner competent in the terms of the intervention proposed and with an understanding of the provisions of the Act

11.17. A certificate of Incapacity under Section 47 must be completed for patients who are incapable of consenting to treatment.

11.18. Under subsection 47 (5) (as amended), the certificate of incapacity has to be in a prescribed form and must specify the period during which the authority remains valid, being a period which:

> The person who issues the certificate for the medical treatment of the adult considers appropriate to the condition or circumstances of the adult; but does not exceed one year; unless the Adults with Incapacity (Conditions and Circumstances Applicable to the Three Year Medical Treatment Certificates) (Scotland) Regulations 2007 (as outlined below) are met.

11.19. The maximum duration of 3 years is dependent on the nature of the illness from which the patient is suffering particularly where the level of incapacity may vary or recovery may be anticipated. A certificate of 3 years would only be appropriate where, in the view of the practitioner who issues the certificate, a patient was suffering from at least one of the following conditions:

- Severe or profound learning disability, or
- Severe dementia, or
- Severe neurological disorder,
- which causes the adult to lack capacity in respect of decisions about medical treatment as defined in Section 47 of the Act (as amended) and which is unlikely to improve and for which no curative treatment is available.

11.20. It is good clinical practice however to review the capacity of the patient on a regular basis and where a treatment plan exists, could be reviewed annually. Where a practitioner would normally review and seek fresh agreement from a competent patient that may well be the appropriate point at which to review and re-certify in relation to a patient, the same principle should apply.

11.21. To demonstrate that the practitioner has fulfilled the requirements of Section 47 (3) of the Act (as amended), it is good practice to record such instructions, approval or agreement in the patient's medical record.

11.22. Four matters must be considered before completing the certificate of incapacity:

- A medical practitioner primarily responsible for the medical treatment of the adult may issue a certificate in respect of any medical treatment, whereas any other healthcare professional authorised to issue a certificate may only do so for the kind of treatment for which they are responsible.

- The practitioner must be satisfied that the adult is incapable in relation to a decision about the treatment in question.

- If the person issuing the certificate is aware of the existence of a proxy with welfare powers, that person should, where it is reasonable and practicable to do so, obtain the consent of that proxy.

- The proposal for treatment must be consistent with the general principles laid down in Section 1 of the Act.

11.23. It would be unreasonable, impractical and unnecessary to issue a separate certificate of incapacity for every health care intervention in some people. For example, an adult with dementia in a nursing home may have multiple physical and mental health care needs in addition to a requirement for fundamental procedures to ensure for example nutrition, hydration, and elimination. On the other hand, a single certificate of incapacity is entirely appropriate when an adult requires a single procedure such as an operation.

11.24. The Act specifies, under Section 47 (2) (as amended), that "the person who by virtue of subsection (1) has issued a certificate for the purposes of that subsection shall have authority to do what is reasonable in the circumstances, in relation to the medical treatment, to safeguard or promote the physical or mental health of the adult". This would cover not only the operation but also post-operative medical care and pain relief. It is therefore clear that the certificate of incapacity, as designed, will provide an effective and workable means for managing single healthcare interventions but requires careful completion for a person who needs multiple interventions. A possible way to complete the certificate would be by reference to a treatment plan.

11.25. If after issuing a certificate, the medical practitioner responsible for the treatment of the adult is of the opinion that the condition or circumstances of the adult has changed, the medical practitioner may:

- revoke the certificate

- issue a new certificate specifying a period not exceeding one year or if, in the opinion of that person, the Adults with Incapacity (Conditions and Circumstances Applicable to the Three Year Medical Treatment Certificates)(Scotland) Regulations 2017, are met, three years.

12. Mental Health (Care and Treatment (Scotland) Act 2003

12.1. Where a patient who is subject to compulsory powers due to mental disorder, requires treatment for that mental disorder, the treatment is regulated by Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Informal patients, i.e. *those not subject to any form of compulsory power*, will have the same rights as any other capable adult to give or refuse consent to any proposed treatment intervention.

12.2. 'Mental disorder' is defined as one or more of the following categories:

- Mental illness
- Learning disability
- Personality disorder

12.3. The Mental Health (Care and Treatment) (Scotland) Act 2003 provisions only cover treatment for mental disorder; any patient not capable of giving or refusing consent to treatment offered for a physical disorder would be covered by the Adults with Incapacity (Scotland) Act 2000, which is described in section 6.

12.4. There is a legal requirement to observe the Principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 for all patients treated under its provisions. (See Appendix F) Further information regarding consent to treatment options can be obtained in NHS Greater Glasgow and Clyde's Psychiatric Emergency Plan (PEP)

12.5. Part 16 of the 2003 Act provides a general authority to treat individuals where they are subject to an order that authorises treatment under that part of the Act.

12.6. Patients subject to compulsory powers have additional rights and safeguards under Part 16 of the Act in relation to specified treatments these are:

- Treatments over a period of time
- ECT and other treatments
- Neurosurgery

12.7. For these treatments:

- Consent must be provided in writing by the patient or;
- Where a patient has capacity refuses to consent or if the patient lacks capacity to consent, a second opinion for the proposed treatment must be given by a Designated Medical Practitioner appointed by the Mental Welfare Commission before treatment can commence.

12.8. For further detail please consult the code of practice https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-1/pages/11/

13. Children and Young people

13.1. This section summarises consent (or refusal) to treatment for children and young people. The policy is detailed in Appendix D and should always be referred to when dealing with this age group

13.2. Scottish law (as described in the Age of Legal Capacity (Scotland) Act 1991) allows that "a person under the age of 16 years shall have legal capacity to consent on his own behalf….where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment." There is no minimum age stipulated to this direction.

13.3. A single consent, given by a child assessed as having capacity, will be adequate for a whole course of treatment e.g. orthodontic where the child may often attend unaccompanied.

13.4. A parent (See Appendix G for the definition of a parent) or legal guardian may only consent to medical treatment if the child lacks decision-making capacity.

13.5. The health professional should assess the capacity of the child or young person to consent and ask the appropriate person to sign the consent form, making a full note of the factors taken into account. Parents cannot override the consent of a competent child or young person nor can the responsibility for signing a consent form be passed to a parent from a competent child or young person. Where there is doubt about a child or young person's competency please see Appendix G. The welfare of the young person is paramount.

13.6. In cases where more than one person has parental responsibility, consent by any one such person is sufficient, irrespective of the refusal of any other individual.

13.7. In emergency situations, proceeding without the consent of the person with parental responsibility is possible but see the guidance in Appendix F

13.8. The obligation to provide age-appropriate information remains unaltered regardless of who signs the form.

13.9. When the child or young person has independently sought advice, efforts should be made to encourage the child that their parents should be informed, except in circumstances where it is not in the child's best interest to do so. Children and young people (12 years plus) with capacity and where there is no reason to believe there is a child protection issue, should have the same rights to confidentiality and consent as adults.

13.10. Where a mother is under 16 years of age, please see Appendix G.

14. Post-Mortem, Tissue and Organs

14.1. Human Tissue (Authorisation) (Scotland) Act 2019 updates the concept of 'authorisation' and in so embodies the principle that people can expect the wishes they express during life about what should happen to their bodies after death are fulfilled. The 2019 Act includes post mortem examinations and those instructed by the Procurator Fiscal. Clinical Practitioners are expected to adopt the hospital post mortem examination standards published by NHS Quality Improvement Scotland in 2002. Arrangements for the retention of Tissues and Organs at Post-Mortem Examination, whether directed by the Procurator Fiscal or carried out at an NHS Organisation are requested with the agreement of relatives, or identified Civil Partners. Clinical Practitioners are expected to adopt the Royal College of Pathologists' Guidelines (March 2000). NHS Education Scotland have produced a TURAS module to update clinical practitioners on the changes in the act https://learn.nes.nhs.scot/40597/human-tissue-authorisation-scotland-act-2019/introducing-the-human-tissue-authorisation-scotland-act-2019-slides

14.2. In addition to respecting peoples differing religious and cultural beliefs in relation to the above, Clinical Practitioners should have available a supply of the College's leaflet "Examination of the body after death" in order that the consent relatives/civil partners give is fully informed. NHS Quality Improvement Scotland have published Post Mortem examination information leaflets.

14.3. Relatives' agreement is not required for Procurator Fiscal examinations, but relatives should be provided with an information leaflet (which is available in alternate formats and languages), explaining the legal necessity, in certain circumstances, to retain tissues or organs and of their rights to the material when the examination has been completed. The

Procurator Fiscal cannot authorise the removal of organs and tissues for research or teaching purposes and if such material is required, the additional separate agreement of relatives/civil partners of the deceased must be sought specifically.

14.4. For hospital post-mortem examinations performed with nearest relatives' authorisation:

- A senior qualified medical practitioner, preferably a consultant, who was primarily responsible for the patient during their last illness, will seek authorisation to the post-mortem examination from the nearest relative(s).
- Specific authorisation must be obtained if the primary purpose of retention of organs or tissues is specifically for teaching, training or for research.
- Written authorisation must be obtained for the retention of whole organs in all cases. The prospect of distressing relatives is not a valid reason for not seeking their agreement.
- Consent (authorisation) for the use of surplus tissue from the living.

14.5. The Human Tissue (Scotland) Act 2006 does not deal with the use of tissue for research from the living. The Human Tissue Act 2004, applies to England, Wales and Northern Ireland and is implemented by the Human Tissue Authority (HTA). Scotland has no legislative framework or licensing authority for collection and storage of tissues for research from the living. Following the Bristol and Royal Liverpool Children's Inquiries, consent (authorisation) was made the central plank of any clinical governance policy involving the use of tissues for research. It is recognised that it is an individual's right to be given the opportunity to consent (authorise) and donate their surplus tissue for research. It is best practice to offer all patients the opportunity to consent to the use of their surplus (or left over tissue) for use in teaching or medical research. The generic consent form and the stand alone electronic Surplus Tissue Authorisation (e-STA form) reflects this. All such patients need to be provided with suitable information in a form/language they can understand. A patient information leaflet is available via the Board intranet and should be used where appropriate during consent processes.

15. Photography and Video Recordings

15.1. The generic consent form should only be used for photography and video where the recordings are implicit to the procedure (such as endoscopy or retinal screening). It may also be used for theatre and day surgery cases.

Recordings consented in this way form part of the patient health record; if there is no possibility that the patient might be recognised, they can also be used within the clinical setting for education or research purposes. In all other circumstances, a specific consent to photography form should be used: this provides more detailed information on the levels of consent available to the patient. It should be noted that express consent must be sought for any form of publication.

15.2. Healthcare professionals who are required to make recordings must comply, and where necessary, be registered in accordance with the NHSGGC Policy on Photography and Video Recording of Patients.

15.3. The health professional must explain clearly the purpose and possible future use of any photographs (including digital pictures) and videos, whether for a treatment aid, medical record or as a tool for teaching, audit or research. Only then can written consent be sought for the recording/photograph to be made. The use of a consent form is mandatory in keeping with the above Policy.

15.4. A specific certificate of incapacity must cover adults who lack decision-making capacity in relation to recording of their images and protocols established must be followed.

15.5. The photograph/video becomes part of the patient health record and thus complies with the Data Protection Act (1998).

15.6. All recordings must be logged and stored appropriately. In the case of digital photographs, the files must not be manipulated in any way before storage, except where specific consent has been obtained. Please refer to the NHSGGC Policy on Photography and Video Recording of Patients for further information on storage

15.7. Photography without consent may be prescribed under certain circumstances, such as suspected non-accidental injury of a child where parental consent has been refused, and where the recording of injuries is of benefit to the patient. Consultant authority is required in these cases and should be recorded.

15.8. Patients have the right to withdraw consent for use of their images at any time.

16. Disclosure of Personal Information

16.1. Clinical Practitioners should take all reasonable measures under their control to comply with current legislation, codes of practice and other relevant guidance regarding information security. This includes:

- The Data Protection Act 2018
- The Caldicott standards
- NHSGGC Information sharing protocol with local authorities

Further guidance should be sought through these specific policy documents.

17. Research

17.1. The Research Governance Framework for NHSGGC outlines in more detail good practice with any form of research. Informed consent is at the heart of ethical research in health. Ethics committees and all those involved in a research study must ensure that there are appropriate arrangements for obtaining consent.

17.2. Adults who are assessed as lacking decision-making capacity to give valid consent (this must be supported by a certificate of incapacity) can only participate in research under the following circumstances:

- Similar research cannot be carried out on capable adults
- The purpose is to obtain knowledge of causes, diagnosis, treatment or care of the adult's incapacity
- There is likely to be a real and direct benefit to the adult or to improve the scientific understanding of the adult's condition or provide benefit to those suffering from the same form of incapacity in the long term.
- They do not express unwillingness to participate
- There is no or minimal foreseeable risk or discomfort
- Consent is obtained from any welfare guardian, welfare power of attorney or, in the absence of these, the nearest relative (which include civil partnerships) Approval cannot be given by local ethics committees and must be sought from the national ethics committee set up under Adults with Incapacity (Scotland) Act 2000.

17.3. The same legal principles apply when seeking consent from patients for research purposes as when seeking consent for investigations or treatment. The health professional should explain:

- The nature of the trial or audit
- All known side effects
- The patient does not have to take part
- The patient can withdraw at any time

17.4. Parents may give consent for their child to be entered into a trial where the evidence is that the trial therapy is at least as beneficial to the patient as the standard therapy. Research which is not of direct benefit to the child

may be lawful (with consent from a person with parental responsibility) if it is not against the interests of the child.

17.5. It is not always possible to gain consent from patients when conducting a specific audit project. Therefore it is good practice to make patients aware on admission that their records may be used for the purposes of audit.

18. Obtaining Legal Advice

18.1. Case law in this area continues to evolve, particularly in the areas of Human Rights, Adults with Incapacity and other Mental Health legislation. It may be prudent therefore to obtain legal advice in some circumstances e.g. where there is uncertainty about a patient's capacity, which cannot be resolved by following the direction of Adults with Incapacity legislation. This can be sought through the Central Legal Office via a member of the senior management team within each specialty 24 hours a day.

19. Implementation & Monitoring this policy

19.1. This policy will be implemented through the General Management structures within the organisation. It will be the responsibility of the Sectors/Directorates/Partnerships to audit policy compliance.

19.2. Requests for variances, i.e. specific consent forms should be through the Director of Clinical and Care Governance

19.3. Monitoring the policy will be through the governance structures

20. References

Advice on consent issues can be sought through the Clinical Risk Managers clinical.risk@ggc.scot.nhs.uk or through the legislation Nurse Advisor andrea.kilburn@ggc.scot.nhs.uk

A Good Practice Guide on Consent for Health Professionals in NHS Scotland Scottish Executive Health Department, June 2006

SPSO Informed consent, Learning from Complaints (March 2017) https://www.spso.org.uk/sites/spso/files/csa/InformedConsent_SPSOMarch2017.pdf

Realising Realistic Medicine: Chief Medical Officer for Scotland annual report 2015-2016 https://www.gov.scot/publications/chief-medical-officer-scotland-annual-report-2015-16-realising-realistic-9781786526731/

The Royal College of Surgeons, Consent: Supported decision making – A guide to Good Practice https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/consent/

General Medical Council Decision Making and Consent 2020 https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent

British Dental Association British Dental Association (bda.org)
British Medical Association (2020) https://www.bma.org.uk/advice-and-support/ethics/seeking-consent/seeking-patient-consent-toolkit

HCPC Standards of conduct, performance and ethics (2016)
https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/

Obtaining Valid Consent: Clinical Governance Advice no.6 Royal College of Obstetricians and Gynaecologists (2015)
https://www.rcog.org.uk/globalassets/documents/guidelines/clinical-governance-advice/cga6.pdf

RCN Guidance - Principles of consent (2017)
https://www.rcn.org.uk/professional-development/publications/PUB-006047

The Code: Professional Standards of Practice and Behaviour Nurses and Midwives Nursing & midwifery Council The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council (nmc.org.uk) (Specifically Sections – 2.3, 2.5, 4.1, 4.2 and 4.3)

National Education for Scotland (NES) Think Capacity, Think Consent Learning Module

Clear to All Toolkit
http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/AIP/AIT/Pages/default.aspx

Adults with Incapacity (Scotland) Act 2000: Code of Practice for Persons Authorised to Carry Out Medical Treatment or Research Under Part 5 of the Act (2nd Edition)
The Scottish Government, January 2008
http://www.scotland.gov.uk/resource/doc/1097/0061528.pdf

British Medical Association (2020) Advance Statements about medical treatment – code of practice. London https://www.bma.org.uk/media/2566/bma-advance-care-plan-patient-information-leaflet-june-2020.pdf

Age of Legal Capacity (Scotland) Act 1991
https://www.legislation.gov.uk/ukpga/1991/50/contents

General Medical Council, Mental Capacity Decision support tool (2016)
https://www.gmc-uk.org/ethical-guidance/learning-materials/mental-capacity-tool

Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice.
https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-1/pages/11/

The Mental welfare Commission (2018) Good Practice Guide
https://www.mwcscot.org.uk/sites/default/files/2019-06/consent_to_treatment_2018.pdf

The Mental welfare Commission, Good Practice Guides
https://www.mwcscot.org.uk/publications?theme=75

Mental Health (Care and Treatment) (Scotland) Act 2015
https://www.legislation.gov.uk/asp/2015/9/contents/enacted

Post Mortem adult leaflet http://www.pathology.scot.nhs.uk/wp-content/uploads/sites/9/adult_further_information_leaflet.pdf

https://www.nhsinform.scot/media/1503/when-someone-has-died-2016.pdf

Royal College of Pathologists (May 2019) Guidelines for the retention of tissues and organs at post-mortem https://www.rcpath.org/uploads/assets/4b6fdd98-eeaa-4f94-bb8ee9fc10217250/G174-Guidelines-on-autopsy-practice-Postoperative-deaths.pdf

Human Tissue Authorisation Scotland 2019
https://www.legislation.gov.uk/asp/2019/11/enacted

https://learn.nes.nhs.scot/40597/human-tissue-authorisation-scotland-act-2019/introducing-the-human-tissue-authorisation-scotland-act-2019-slides

MEL (2000) 21 Retention of Tissues and Organs at Post-Mortem Examination
https://www.scot.nhs.uk/sehd/mels/2000_21.html

Children (Scotland) Act 1995 https://www.legislation.gov.uk/ukpga/1995/36/contents

Human Rights Act (1998) https://www.legislation.gov.uk/ukpga/1998/42/contents

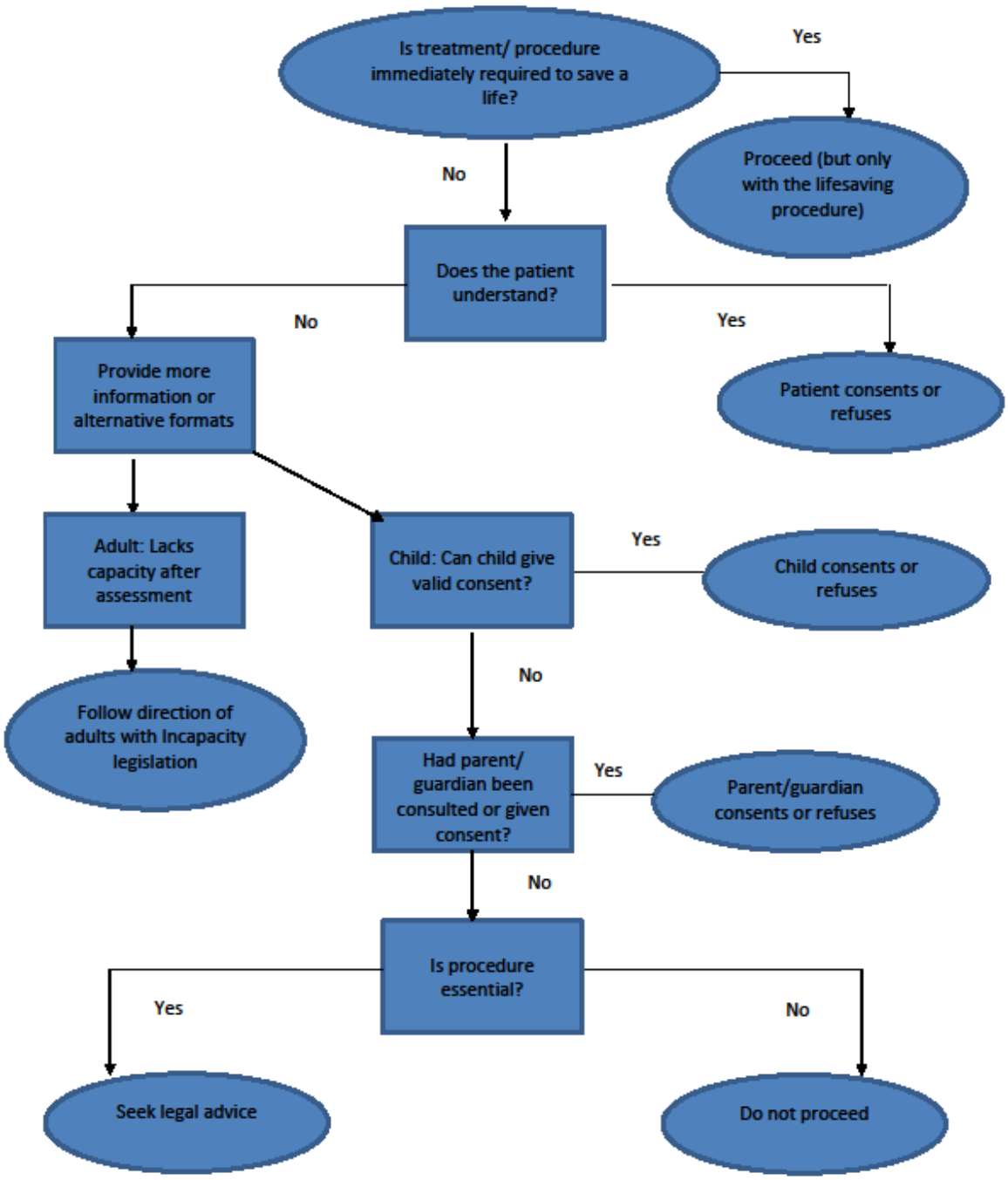
Data Protection Act Data Protection Act 2018 (legislation.gov.uk)

National Education for Scotland (NES) Think Capacity, Think Consent Learning Module 2013

Making and Using Visual and Audio Recordings of Patients, General Medical Council, May 2011
http://www.gmc-uk.org/guidance/ethical_guidance/making_audiovisual.asp

Appendix A

Consent Process



Appendix B - NHSGGC Generic Consent Form

Patient Agreement to Investigation or Treatment

Consent Form

NHS Greater Glasgow and Clyde

Patient details (or pre-printed label)	
Hospital / clinic / GP practice	
Patient's surname / family name	
Patient's first name	
Date of birth	Gender Male ☐ Female ☐
CHI number	
Special requirements (e.g. other language / communication method)	

Statement for practitioner (to be filled in by practitioner with appropriate knowledge of proposed procedure)
Describe proposed operation, investigation or other treatment. **Where appropriate specify site or side (write in full).**
Specific risks / complications Please detail any specific risk/complications related to the procedure that were discussed.
I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above). I have explained who will be doing the procedure if not myself.
Signature of practitioner
Name / Designation (print)
Date

Statement to be completed by patient / parent*
(*parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- The procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- Who will be performing my procedure on the day
- That any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

I have been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion**.

I agree

- to the administration of an anaesthetic or to sedation if required,
- to the procedure named on this form,
- to the emergency administration of blood or blood products.

Additionally you have to agree or disagree to the following	**Agree**	**Disagree**
to photographic images and video recordings being held in records, and made available for teaching, audit and ethically-approved research purposes, to improve the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

Patient / parent agreement to treatment

Signature	Date
Name (print)	

Patient refusal for blood products

Please sign here if you refuse to consent to the emergency administration of blood or blood products, **even if this results in death**.

Signature	Date
Signature of practitioner	Date

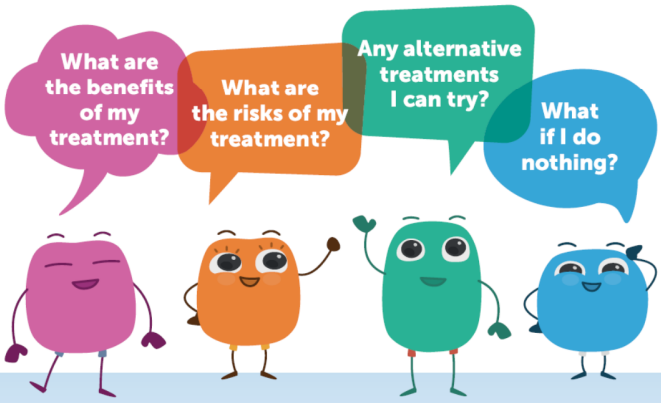
MIS • 270008 • 010415

Appendix C – It's OK to Ask

NHS SCOTLAND

It's OK to Ask

When you understand what's going on with your health, you can make better decisions around your care and treatment. That's why it's important to ask your healthcare team the right questions.



To find out more visit,
nhsinform.scot/its-OK-to-ask

00665-01 NHS It's OK to Ask A5 Leaflet OPTION B AW.indd 1 24/03/2021 09:22

Our healthcare staff are more than happy to answer these and any other questions you may have. Start feeling more informed about your health today and remember, it's OK to ask.

Your notes

You can use this space to write down your own notes.

To find out more visit,
nhsinform.scot/its-OK-to-ask

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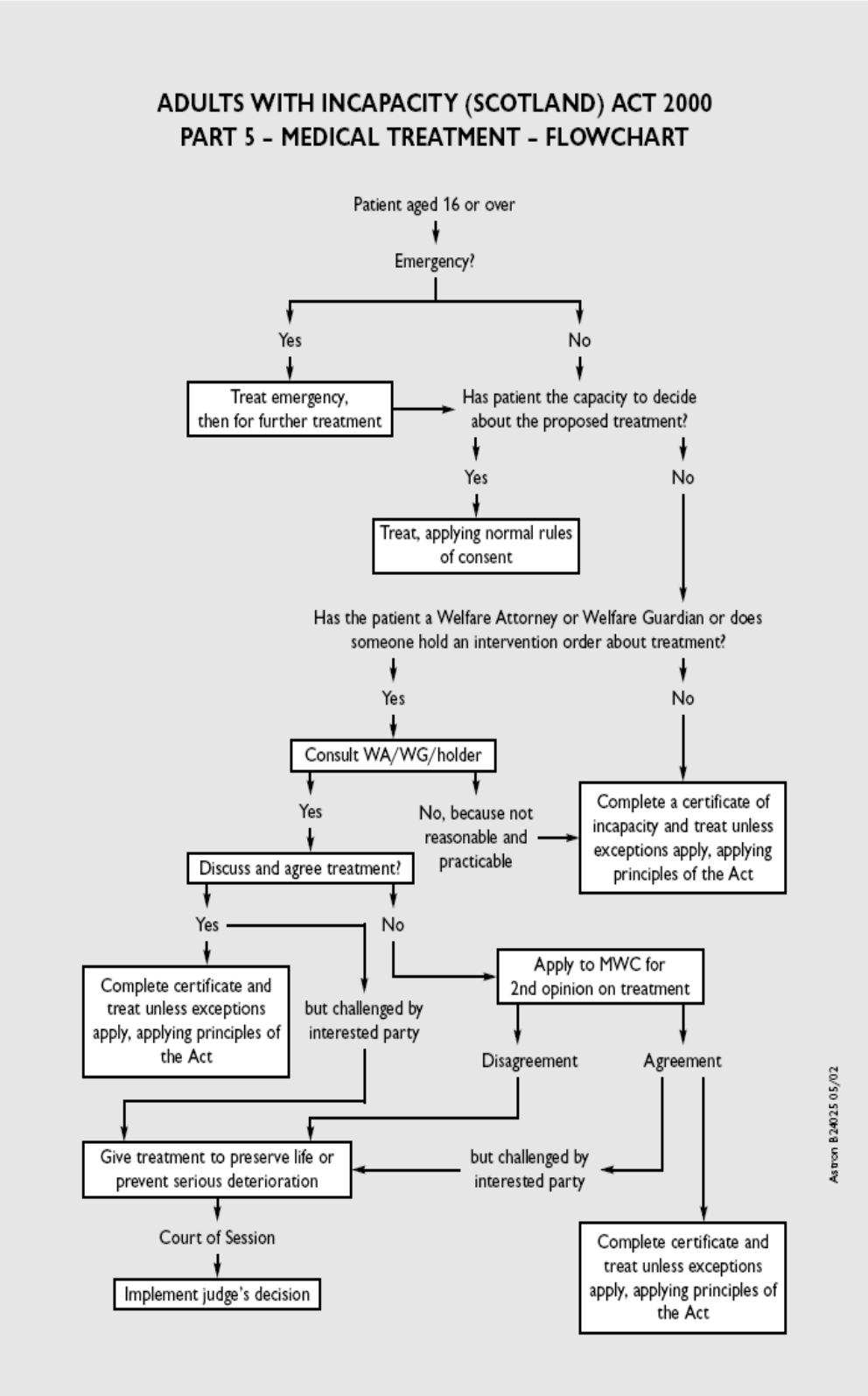
Appendix D – Adults with incapacity



Appendix E Adults with Incapacity Form

ADULTS WITH INCAPACITY
(SCOTLAND) ACT 2000

Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000

I _____ (name)

of _____ (address)

*am the medical practitioner primarily responsible for the medical treatment of; or

*am a person who is *a dental practitioner/an ophthalmic optician/a registered nurse and who satisfies such requirements as are prescribed by the Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 and who is primarily responsible for treatment of the kind in question of:

_____ (name)

of _____ (address) D D M M Y Y (date of birth)

for whom the *guardian/welfare attorney/person appointed by intervention order/nearest relative/carer

is _____

I have examined the patient named above on D D M M Y Y (date). I am of the opinion that *he/she is incapable within the meaning of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") in relation to a decision about the following medical treatment:

_____

because of (nature of incapacity) _____

_____

_____

This incapacity is likely to continue for _____ months.

*I therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist from:

D D M M Y Y (date of examination) until D D M M Y Y, being a period which does not exceed one year from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me; or

*I am of the opinion that (a) *he/she is suffering from *a severe or profound learning disability/dementia/a severe neurological disorder; and (b) *what he/she is suffering from is unlikely to improve within the meaning of the Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Medical Certificates) (Scotland) Regulations 2007/ Y Y and therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist until:

D D M M Y Y being a period which does not exceed three years from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me.

The authority conferred by section 47(2) of the 2000 Act shall subsist for the period specified above or until such earlier date as this certificate is revoked.

In assessing the capacity of the patient, I have observed the principles set out in section 1 of the 2000 Act.

Signed _____ Date D D M M Y Y

*delete as appropriate

Appendix F -

Principle of Mental Health (Care & Treatment) (Scotland) Act 2003

Non-Discrimination	People with mental disorders should wherever possible retain the same rights and entitlements as those with other health needs.
Equality	All powers under the act should be exercised in line with responsibilities as detailed in the Equality Act (2010) and without any direct or indirect discrimination on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation.
Respect for Diversity	Service users should receive care treatment and support in manner that accords respect for their individual qualities, abilities and diverse background and properly takes into account their age, gender, sexual orientation, ethnic group social cultural and religious background.
Reciprocity	Where society imposes an obligation on an individual to comply with a programme of treatment of care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.
Informal Care	Where ever possible, care treatment and support should be provided to people with mental disorder without the use of compulsory powers.
Participation	Services users should be fully involved so far as they are able to be in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all information and support necessary to enable them to participate fully. Information should be provided in a way which makes it most likely to be understood.
Respect for Carers	Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice and have their views and needs taken into account.

Appendix G - Guidance on Consent for Children & Young People

Introduction

Children have the right to say what they think should happen, adults are making decisions that affect them, and to have their opinions taken into account.
(Article 12 UN Convention on the Rights of the Child)

The process of consenting children or young people (those aged 12 years or more) for healthcare assessment, care or treatment is different to the process for adults. The fundamental difference is set in legislation, The Age of Legal Capacity (Scotland) Act, 1991 (Section 2(4)), which states that:

"A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment."

In practice, this means that a child or young person under the age of 16 years may have the legal capacity to consent (or refuse), to any surgical, medical or dental treatment where, in the opinion of a qualified health care professional attending the child or young person, they are capable of understanding the proposed procedure or treatment and possible outcomes which could arise.

Information provision

Information about the proposed procedure or treatment must be given in appropriate terms which the child or young person understands e.g. the words for a 14 year old differ from those for an adult or from those for a 9 year old. Use of complex language or jargon may result in poor understanding, misunderstanding or in increased fear and anxiety.

There are different ways of passing on information including orally, in age-appropriate writing, storyboards, videos (no one way suits all) and the use of paediatric preadmission programmes.

The information should include the benefits and significant risks of the proposed treatment and any relevant alternatives including not having the intervention.

All questions must be answered truthfully and if a question cannot be answered the Clinical Practitioner should involve a colleague who knows and then listen when the issues are discussed with the family.

Voluntariness

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

Once a decision is made it is still possible for the child or young person or the parent, whoever consented, to change their mind.

Verbal or written consent
With verbal or non-verbal/implied consent (e.g. holding out an arm for an injection), there is a need to be explicit about the consent process. Written consent is not required unless the procedure involves sedation or unless there is a legal requirement for written consent (HDL page 4).

It is important that the health professional and the patient/parent understand what has been agreed and also that there is documentation in the patient casenotes that verbal information has been provided and what the outcome is.

Written consent will only be required when procedures are complex, pose risk or requiring a general, regional anaesthetic or sedation are being proposed. In addition, written consent must be obtained as required by the NHSGGC Policy on Photography and Video Recording of Patients. It is good practice to record consent discussions even where there is no requirement for written consent

Who can give consent?
Under Scottish Law, young people aged 16 and over have the same right to consent or refuse as adults

Children and young people under 16 are able to give their own consent if the qualified health care professional considers the patient capable of understanding the nature and possible consequences of the procedure or treatment, according to the Age of Legal Capacity (Scotland) Act, 1991. Where a child or young person does give their own consent, it is appropriate to discuss the details with the parent (see Section 2.6 below for definition) or the person with parental responsibility, providing confidentiality is not breached.

Responsibility for signing a consent form cannot be passed on by a competent child to a parent. If a competent child consents verbally but refuses to sign the consent form this should be fully documented noting that the verbal consent has been given and the reasons why the consent form has not been signed (there is space on the child consent form). The procedure can go ahead. In cases like this the parents should not consent on the patient's behalf; although it is good practice to involve the parent, their written consent is not legally applicable in these cases

Where a child or young person lacks capacity, consent should normally be obtained from a person with parental rights and responsibilities (See Section 2.6 below).

There are occasions where the person with parental responsibility and rights is not available. If the procedure cannot be deferred until the parent is available, the Children (Scotland) Act 1995 (Section 5) gives a person, who has care or control of the child but no parental responsibility or rights in relation to that child, the power to do what is reasonable in all circumstances to safeguard the child's health, development and welfare. This could include a step-parent, relative or child-

minder but excludes teachers and others with control of a child in school. This person may consent to any surgical, medical or dental treatment or procedure where the child cannot give his/her own consent and it is not within the knowledge of the person that a parent would refuse. (HDL (2006) 34).

Where the mother of the patient is under 16 years old, she may have the capacity to consent for her child. It is however good practice to involve the person with parental responsibility for the mother under 16 years (often the patient's grandmother) in the information provision and consent process.

Capacity or competency (to consent)
Judging capacity or competency depends on:

- Clinical judgement
- The maturity of the patient
- The complexity of the proposed intervention
- Its likely outcome
- The risks associated with it.

If the child or young person is not capable of understanding the nature of the intervention and its consequences the parent or legal carer should be asked for their consent to proceed.

Competence decisions can only be made by senior staff. If a child's capacity to consent is unclear, the medical practitioner attending the child may wish to involve an independent health professional (e.g. a paediatric clinical psychologist) but he/she will ultimately have the responsibility of deciding the child's competency. If the child's or family's capacity to consent is complicated by family or psychiatric problems, then discussion with a child or adolescent psychiatrist may be useful.

Legal definition of 'parent' (*if unclear seek advice from senior colleagues*):

- The mother whether married to the father or not.
- The child's natural father, if married to the mother, at any time from conception or subsequently.
- The child's natural father, even if divorced from the mother.
- An unmarried father whose name is on the child's birth certificate, registered on or after 04 May 2006, has full parental responsibility and rights as though married to the mother**.
- An unmarried father who has entered and registered a formal Parental Responsibilities and Parental Rights Agreement with the mother.
- A legal guardian nominated in writing by a parent before the parent's death. This appointment comes into effect automatically on the death of the parent.
- A person holding a Residence Order in relation to the child, or any other court order giving them the right to consent on the child's behalf.
- A person aged 16 or over who has care or control, unless it is within their knowledge that a parent would refuse consent.

The above is covered more fully under 'New Law on Children & Medical Consent'
** This bullet point has been added as a result of the Family Law (Scotland) Act

When to obtain consent (elective situations)
In the elective situation, the health care professional carrying out the procedure or treatment should go through the consent procedure with the parents and child or young person.

Where consent is obtained at the outpatient clinic for surgery, and it is supported by written information, it would be wise and consistent with good practice to ensure continued understanding on admission to hospital. A member of the medical team should review the consent close to the surgery, especially where:

- significant time has elapsed between obtaining consent and the date of surgery
- there have been material changes in the patient's condition, or any aspects of proposed surgery
- new information has become available about surgical options
- the parents and child do not appear to understand clearly the procedure to be undertaken.

It is good practice to check with the parent(s) and patient that they know what procedure is to be undertaken and they still give valid consent at the time of admission. Details should be explained at a level appropriate for the maturity of the child.

Emergency situations
In an emergency, where:

- the child or young person either lacks capacity or is too ill to consent *and* where there is no-one with parental responsibility present
- the treatment is in the best interests of the child to prevent death or permanent damage.

Life saving treatment can be carried out immediately. The treatment given must be no more than the immediate situation requires (HDL (2006) 34). The practitioner should then seek legal advice as soon as possible.

Where consent is required in an emergency, the doctor may proceed with either verbal consent or no consent if it is in the best interest of the child. Where written consent is possible this should be obtained.

Best Interests
An assessment of 'best interests' will include, but is not limited to, what is clinically indicated in a particular case. Other factors include:

- the views of the child or young person, so far as these are ascertainable, including any previously expressed preferences
- The views of parents and others close to the child or young person
- The child's or parents' cultural, religious or other beliefs and values
- The views of other health care professionals involved in providing care to the child or young person
- Which choice, where there is more than one, will least restrict the child or young person's future options

- This list is not exhaustive and any other relevant information should be considered.

Who should obtain consent?
The person obtaining consent must be properly qualified to do so. The appropriate level of seniority will therefore depend on the complexity of the procedure and any likely consequences. In many cases, especially complex ones, a medical consultant will obtain consent.

However, where a doctor obtaining the consent is more junior, he/she should be deemed by him or herself and by the consultant to be competent to do so and should be sufficiently familiar with the procedure and possible side effects to enable this to be done competently.

The consultant is not legally bound him/herself to carry out the procedure, despite having obtained consent in outpatients. This possibility should be explained by the doctor while obtaining the original consent and where possible the name of the Clinical Practitioner should be given.

There are situations where other qualified (and appropriately trained in the consent process) health professionals, e.g. Nurse Practitioners, take consent for a procedure or treatment (e.g. inoculation in special circumstances) which they will carry out (BMA 2001).

Separate consent for anaesthesia
There is no legal requirement for separate consent for anaesthesia. The anaesthetic should be explained in detail by the anaesthetist at the time of pre-operative assessment and discussion recorded. There may be situations where it is appropriate to have more than one Clinical Practitioner involved in taking consent if the procedure has particularly complex implications ranging over more than one specialty (Association of Anaesthetists of Great Britain and Ireland, 1999).

When a child refuses to consent
If a child or young person is able to understand the nature, purpose and possible consequences of the proposed surgery, as well as the consequences of non-treatment, the child can refuse to undergo surgery. It should be borne in mind that:

- at age 16 a young person has the same right to consent or refuse as adults
- under age 16 children/young people may have the capacity to decide, depending on their ability to understand what is involved
- The best interests of the child or young person must not be compromised by their refusal to consent to a procedure or to treatment
- if a competent child/young person refuses treatment, those with parental responsibilities cannot authorise procedures. Legal advice may be helpful in how to deal with such cases.

Failure to respect a competent child's or young person's wishes and treating him or her without consent can, as it does with adults, leave health professionals open to criminal charges, civil actions and allegations of professional misconduct.

If consent is refused by a competent child or young person for urgent treatment, the medical practitioner should consider taking legal advice. In some circumstances, the refusal of consent by or on behalf of a child or young person may be overridden by the courts which in terms of the Children (Scotland) Act 1995 (Section 11(2)) may authorise medical treatment. Any person with an interest which could include a medical practitioner can apply to the court which will decide the matter on the basis of the best interests of the child. Such circumstances are likely to be limited but could arise in a life or death situation.

When a child or young person and their parent disagree
It is good practice to encourage children or young people to involve their parents in making healthcare decisions. Occasionally there may be a difference of opinion between the child or young person and the parent but dealing with the situation professionally and tactfully may help reach an agreement.

Where a child or young person has the capacity to make the healthcare decision in question, then the Age of Legal Capacity (Scotland) Act 1991 requires the child or young person's decision be respected, even if it is different from the parent's views or the healthcare professional's views. In other words, the decision of a competent child or young person may not be overruled by a parent or health professional.

Where to obtain advice
In the event that clarification about consent is required, advice should be sought from an experienced colleague.

If further clarification is required advice is available from:

- The Central Legal Office
- The Medical and Dental Defence Union for Scotland
- The General Medical Council
- The Child Law Centre.
- Hospital Liaison Committee (in Jehovah's Witness cases)

Confidentiality
To protect confidentiality, there are circumstances where it is appropriate to discuss matters with a young person without the parents present e.g. prior to x-raying a female or preoperatively, in case of pregnancy. It is however good practice to include the parents later in the general discussion.

Literacy in the child or parent
Where there is a question about literacy in either a competent child or young person or in the parent, information giving and discussion should be carried out in the presence of a witness and documented in the casenotes.

Equality

Where there is doubt about comprehension i.e.

- the parent or carer does not understand the procedure (if the child lacks capacity)
- English is not the first language of the child or young person or of the parent
- The child or young person or the parent use British Sign Language.

Information giving and discussion should be carried out in the presence of a witness and documented in the casenotes.

To proceed with the latter two, without appropriate language support, could contravene the Race Relations (Amendment) Act, 2000 or the Disability Discrimination Act, 2005.

Special situations
Medical photography
Section 15 of the main Policy provides the basis for consenting for Medical Photography. In addition, local policy, including the correct consent process, will provide more detail and must be followed when photographing children or young people for clinical, teaching, audit or research purposes.

Children and young people with mental health problems
See separate NHSGGC guidance covering the Mental Health (Care and Treatment) (Scotland) Act 2003.

Health care within school education
Where medical examination or treatment e.g. vaccination in the course of school education is concerned, if the child or young person has capacity then he/she must still give his/her own consent.

In the event that the child or young person lacks capacity, then parental consent should be obtained (HDL (2006) 34).

Looked after or accommodated children or young people
Where a child or young person who is looked after or accommodated by a local authority has capacity, she/she can give their own consent; no other consent is required.

If a child is accommodated by Social Work under Section 25 of the Children Scotland Act (1995) or is subject to a Child Protection Order the parent retains full responsibility for consenting to health care procedures or treatment. In such cases, the child should have a BAAF Health Record booklet which contains a section where the parent should have signed consent for urgent medical and dental treatment at the time of the child becoming accommodated. The Essential Core Record document contains a similar section. Where this is not the case, or where the signature of the parent is required for a particular reason, the child's Social Worker should be contacted for clarification.

If a Court has made a Parental Responsibilities Order in favour of a local authority and if a child or young person lacks the capacity to consent, the consent of the authority would be required (HDL (2006) 34).

A Children's Hearing
A Children's Hearing may make a supervision requirement to oblige a child or young person to submit to any medical examination or treatment.

If the child or young person has capacity then he/she must still give their own consent.

In the event that the child or young person lacks capacity then parental consent should be obtained (HDL (2006) 34).

Consent to disclose healthcare information
A young person aged 12 years or more can given permission for either the patient themselves or for other people to see identifiable information about him/her (Data Protection Act, 1998).

In the case of a child under 12 years, the parent's written permission is needed before identifiable information about their child can be shared with other people.

There are some exceptions to the above rule which include:

- the statutory requirement to report particular events
- where a court requires a disclosure
- Clinical situations where disclosure of healthcare information may be a matter of public safety.
- Cognisance should be given to any potential child protection issues in respect of information sharing.

Non-identifiable information can be used for audit purposes and for healthcare planning without consent.

Guidance is available from Data Protection Officers, Caldicott Guardians and publications (Data Protection Act 1998, NHS Code of Practice on Protecting Patient Confidentiality).

Non therapeutic procedures
Tissue donation. In Scotland, those aged 16 or more and those under 16 years who have legal capacity can consent to non-therapeutic procedures such as tissue donation. There is BMA guidance about e.g. donation of whole organs (BMA 2001 p58).

Where non-therapeutic procedures or those of uncertain therapeutic benefit e.g. circumcision for non therapeutic reasons, the child's best interests – which may include cultural or religious benefits - must be considered. The Age of Legal Capacity (Scotland) Act 1991 applies, i.e. only one parent with parental responsibility and rights is required to consent. The GMC recommends that in the

case of non-therapeutic circumcision both parents should be asked to give consent where possible.'

Research
There is specific national guidance on undertaking research with children of different ages and young people. See the Central Office for Research Ethics Committees (COREC) website and the Royal College of Paediatrics and Child Health website http://www.rcpch.ac.uk/ for guidance.

Involvement with the Media
Written consent is required from any child or young person and their parent having their photograph taken by/for the media or for NHS publications. Consent forms are available from NHSGGC Communications. https://www.nhsggc.org.uk/about-us/corporate-communications