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Information paper

Consent and Physiotherapy Practice (3rd Edition)

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Consent and Physiotherapy Practice

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Consent and Physiotherapy Practice

Introduction

This guidance sets out the framework upon which good clinical decision-making should be based and covers the many factors that may be considered when gaining person consent to physiotherapy.

The law relating to decision-making and consent, particularly for People who lack capacity, varies across the UK. Everyone working in healthcare, including students, needs to understand the law as it applies to the country in which they work.

This paper is aimed at

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

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

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

Update from the 2nd Edition.

The document has been edited to provide a shorter paper for readers, whilst still providing accurate and relevant information

SECTION 1 – PRINCIPLES OF CONSENT

What is consent?

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

What is 'informed' consent?

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

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

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

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

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

When should consent be obtained?

Consent should be obtained prior to assessment and/or treatment where the person has capacity to do so. Provision in law is made to allow emergency treatment without consent due to necessity to save life. It is important to recognize that where ongoing treatment is required, the 'informed consent' of

the person is an ongoing event and not a one-off occurrence, and the presence of on-going consent to treatment should be reaffirmed. Consent should be reaffirmed if there are significant changes to

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

What types of consent are there?

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

- **Oral/verbal**

Oral consent is where the person gives their consent by speaking to you to tell you their decision. In most cases, oral consent will be acceptable provided an adequate record of the oral consent is documented.

- **Written**

The CSP - recommends written consent in the following cases:

- Where treatment is complex or involves significant risk
- For treatment involving general or regional anaesthesia
- Where treatment could result in significant adverse consequences even when performed properly.

In the context of physiotherapy, good practice should be to obtain written consent for any intervention that is invasive.

Written consent should be recorded on the relevant forms for healthcare in each of the devolved nations. This ensures that all providers have a consistent approach to the recording of written consent and reduces duplication of effort.

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

Who gains the consent of the person?

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

Delegating the consent process

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

- they are suitably educated, trained and competent to do so
- they have sufficient knowledge of what you propose to offer the person and are fully able to explain the risks, benefits, alternatives and comparisons to the person
- they are able to answer person questions in sufficient detail to allow the person to make a proper decision,
- They are able to perform the techniques themselves

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

Similarly, another professional may delegate gaining consent of the person to you. You should follow the same points above, although in some cases, e.g. surgery, you may not be able to undertake the procedure yourself.

Disclaimers

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

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

SECTION 2 – INFORMATION SHARING AND EXCHANGE

Good clinical decision-making requires that you have shared and exchanged information with your person. When sharing information with People should not make assumptions about:

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

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

- The purpose of any intervention and/or treatment and what it will involve in broad terms
- The potential risks, benefits, side-effects and likelihood of success for each treatment option to be considered

- Any alternative or comparative treatment that may be available for the condition, even if these treatments cannot be offered by yourself and/or your hospital
- The person, or wider team members, who may be responsible for and involved in the person's care, and whether pre-registration students may be involved
- The person's right to refuse to take part in teaching or research or to allow students to treat them
- their options to seek a further opinion from a colleague and/or to be reviewed by a doctor if indicated
- any bills and/or costs that the person will have to pay

You must make it clear that the person can change their mind about a decision at any time. You must not put pressure on the person to accept your advice. The person may choose any option for treatment, including refusal of treatment, even if such a decision results in a deterioration of their condition, or even their death.

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

Discussing risks, benefits, side-effects and complications

You must provide your person with any information they ask for. You may not need to discuss every possible eventuality with your person. You must not make any assumption about a person's understanding of risk, or apply your interpretation of risk to what you share with the person. A risk that you, as the professional, consider may be minor may be considered by the person to be 'serious'.

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

Discussing Comparative and Alternative treatment options.

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

Answering Questions

You should answer questions honestly and in a balanced manner, and must answer as fully and in as much detail as the person or their nominated representative wishes. Where you are unable to answer a person's specific questions you should endeavor to find the answer from a more experienced colleague. You may also wish to consider the circumstances whereby it may be that no definitive answer to a person's question is yet known.

Reasons for not discussing information

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

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

Involving others in decision-making discussions

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

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

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

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

Where appropriate, you should consider the role of other members of the healthcare team, and what other sources of information and/or support might be available to the person. You may wish to provide people with information leaflets or signpost them to advocacy services or relevant support groups.

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

Presenting information

You must ensure information contained within information leaflets is accurate and up to date at the time you give it to the person. You should record the edition and/or version number of the document provided to the person in the clinical records. In this way, if the information provided to a specific person needs to be reviewed, there will be a clear record of what was provided.

In **Wales** you will need to comply with requirements under the Welsh Language Standards 2018.

Giving people time to consider and reflect

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

Respecting a person's decision

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

seek to discuss with the person their reasons for refusing treatment and seek to explore if those reasons can be resolved.

It may be appropriate to discuss the person's refusal of your treatment with other members of the healthcare team directly involved in the person's care, particularly if refusing physiotherapy treatment may have some effect on care being delivered by other professionals, but you are not required to have explicit consent.

A person's decision must be voluntary. You must be aware of situations and circumstances in which people may be particularly vulnerable to undue influence and seek to ensure that the decisions made are their free choice.

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

SECTION 3: DOCUMENTING CONSENT

Duration of consent

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

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

Recording refusal of treatment

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

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

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

Recording Consent

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

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

SECTION 4: CAPACITY TO GIVE CONSENT

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

England:

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

<https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition>

Scotland:

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

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

Wales:

Guide to Consent for Examination or Treatment July 2017.

<http://www.wales.nhs.uk/sitesplus/documents/1064/Welsh%20Government%20Guide%20to%20Consent%20for%20Examination%20or%20Treatment%20%28July%202017%29.pdf>

Northern Ireland:

Reference Guide to Consent for Examination, Treatment or Care. Department of Health, Social Services and Public Safety Northern Ireland. (2003) <http://www.dhsspsni.gov.uk/consent-referenceguide.pdf>

Presumption of Capacity

Unless determined otherwise you must assume that every adult, and every 16-17 year old has the capacity to make their own decisions about their treatment. Some children will also be able to make their own decisions, depending on the context. The presence of a mental health condition does not automatically mean that a person does not have capacity to make decisions about treatment for their physical conditions.

Adults with capacity

An adult with capacity has the absolute right to consent to, or refuse, treatment. All adults (18+) are presumed to have capacity unless proved otherwise.

16-17 year olds with capacity

All 16-17 year olds with capacity can give their own consent to medical, dental and surgical treatment. It is good practice to seek to ensure that young people involve their families in their treatment decisions, if they agree to information being shared. However, if a 16-17 year old specifically refuses to allow you to share information you should respect their decision.

Children with capacity

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

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

If a child has the capacity to make their own decisions, it is not necessary to obtain additional consent from the parent/person with parental responsibility.

If a child is deemed to have the capacity to make their own decisions, a parent/person with parental responsibility cannot override a child's valid consent to treatment. A parent/ person with parental responsibility may be able to override a child's refusal of treatment. You should consider the context and reasons why a child may be unwilling to proceed with treatment and seek further advice as necessary.

Children who lack capacity

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

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

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

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

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

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

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

Planning Ahead: Lasting Power of Attorney

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

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

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

Planning Ahead: Advance Decisions

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

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

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

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

SECTION 5: SPECIAL CIRCUMSTANCES FOR CONSIDERATION

Using video recordings / photographs / mobile phone photos

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

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

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

Photographs and recordings of staff

Sometimes people and/or their families may wish to film consultations or treatment sessions, either openly or covertly, which may include filming you. These recordings may be as a record of events for personal use, including sharing recordings social media platforms.

Ideally, you should be asked for your consent to be filmed, however people do not have to do this and may record you, even if you refuse to be filmed.

NHS Protect (2016) Patients recording NHS staff in health and social care settings. London. NHS Protect.

http://www.proceduresonline.com/barnet/fs/files/patient_record_nhs.pdf

Social networking media

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

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

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

Using People as models/participants in educational events

You may wish to ask a person to be a model and/or participant for an educational event such as a conference or study day.

In such circumstances, because the purpose of the person's participation is education and/or research, the person must give written consent if they agree to take part in such activities. You must ensure that your person has the capacity to understand the nature of their participation, weigh up the information and make a free choice as to whether to agree to the invitation.

It is not good practice to invite people with cognitive impairments that may affect their capacity to make a voluntary decision to be participants in educational events. People have the right to refuse to act as a model in practical classes/demonstrations and the right to withdraw from a practical (or part of a practical) at any time.

The Use of Interpreters including Child Interpreters

Where people do not use English as their first language, they may require the services of an interpreter to enable them to fully participate in their treatment. You should follow your employer/organization's policies and procedures for using interpreters. If you are unable to access an interpreter this is a governance issue for the organization and you should raise the issue through the appropriate governance procedures.

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

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

Consent and Public Interest Disclosures

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

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

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

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