

CLINICALEDU

C1

Foundations of consent and shared decision-making

Detailed learner reading material

Consent: Shared Decision-Making, Risk, Refusal and Valid Authority

Source review: 19 September 2026

Official and authentic sources only. This educational material is not a substitute for current local policy, specialist legal advice or case-specific clinical judgment.

How to use this reading

This downloadable reading expands the browser module. It is intended for reflection, portfolio evidence and later reference. The browser module remains the interactive learning route; this PDF provides deeper explanation, practical tables, worked scenarios and the full official reference list.

Learning outcomes

- Define consent, shared decision-making and documentation as related but distinct concepts.
- Explain why a signed form cannot substitute for meaningful dialogue.
- Recognise that valid consent is decision-specific, proportionate and revisitable.
- Identify the limits of family involvement and the need for jurisdiction-specific authority when an adult cannot decide.

Why this module matters

Many consent failures arise not because no form was signed, but because the clinical team and patient never achieved a shared understanding of the decision. A useful mental model is therefore: identify the decision; identify reasonable options; learn what matters to the patient; exchange information; check understanding; allow a voluntary choice; record the decision; and review it when circumstances change.

This model is deliberately broader than procedural consent. It applies to investigations, medicines, long-term treatment plans, discharge decisions, changes in treatment goals and other healthcare choices. The depth of the process should be proportionate to the significance and complexity of the decision.

Practice point

Ask: What is the actual decision today? What options are clinically reasonable? What matters to this patient? What has changed since any earlier discussion?

Consent, shared decision-making and documentation

Consent is an outcome of a legitimate decision process, not a document. Shared decision-making is the method of reaching the decision in partnership. Documentation is evidence of the process and the resulting plan. Each is important, but none can stand in for the others.

A clinician may recommend what they consider clinically best, but should explain the reasons and avoid language that closes down choice. Conversely, shared decision-making does not require a clinician to offer an option they judge clinically unreasonable. The task is to make the available reasonable choices intelligible and to connect them to the patient's goals.

Myth to avoid

"The form is signed, therefore consent is complete." A form records part of a process; it does not replace the process.

Information and participation

The GMC guidance states that patients should receive the information they want or need to make a decision. This usually includes diagnosis and prognosis, uncertainties, options for treatment or management including no action, the nature of each option, and potential benefits, harms and likelihoods. The clinician should not assume which outcomes matter most to the individual.

Participation also requires time and opportunity for questions. A rushed explanation followed immediately by a request for a signature may be administratively complete but clinically weak. The more preference-sensitive, risky or irreversible the decision, the greater the need for space to reflect.

Expression of consent and scope

Consent may be expressed verbally, in writing or through clear behaviour depending on the context. Written documentation is valuable for complex or high-risk interventions, but the legal and professional focus remains on the quality of the decision process. The patient's permission is also limited to the scope of what was discussed and agreed. New or materially different interventions may require a further decision unless immediate circumstances justify action under the relevant legal framework.

When a patient becomes uncomfortable during an examination, the correct response is not to assume the initial agreement continues regardless. Pause, check what the patient wants, explain any next step and proceed only within the patient's ongoing permission unless a separate lawful basis applies.

Reviewing earlier decisions

A previous consent discussion can remain useful, but it is not timeless. Review is particularly important when there is a change in diagnosis, prognosis, treatment plan, risk, the clinician delivering the treatment, or the patient's priorities. The Royal College of Anaesthetists makes this concrete in perioperative care: where discussion occurred before the day of surgery, the clinician on the day still has responsibility to ensure the patient continues to understand and agree with the plan.

Review need not mean restarting the entire process from zero. It means checking whether the basis of the earlier decision remains sound and updating the discussion where something material has changed.

Four-nation legal orientation

GMC professional standards provide a UK-wide baseline. When an adult cannot make the relevant decision, however, the statutory route is not the same in every nation. England and Wales use the Mental Capacity Act 2005. Scotland uses the Adults with Incapacity (Scotland) Act 2000 and associated Part 5 processes. Northern Ireland's Mental Capacity Act (NI) 2016 remains only partially commenced, so current Department of Health material and local legal/governance advice must be checked. This module introduces the distinction without replacing the dedicated Mental Capacity course.

Proportionality in everyday practice

Not every healthcare decision requires the same length or formality of discussion. Proportionality means matching the process to the nature of the decision, the seriousness and likelihood of harm, the degree of uncertainty, the reversibility of the intervention and the patient's circumstances. A routine low-risk examination may need a short explanation and clear cooperation. A major operation, a preference-sensitive treatment or an intervention with serious irreversible consequences requires a much more developed conversation.

Proportionality should never become an excuse for skipping the patient's role. Even a brief interaction should make it clear what is being proposed and allow the patient to decline or ask questions. Conversely, paperwork should not become more elaborate than the underlying decision. The quality of the exchange remains more important than the volume of documentation.

Documentation examples and common pitfalls

A useful consent record shows the decision, the main options, the information that was particularly relevant to this patient, material concerns raised, questions answered and the resulting plan. If an earlier decision was reviewed, record what changed and whether the patient continued to agree. Where a patient declines information or asks for a more clinician-led recommendation, document that preference and the key information still discussed.

Common weak records include only "risks and benefits discussed", a pre-printed complication list with no indication of patient priorities, or a signed form without evidence of alternatives. Better documentation is still concise: for example, "Discussed surgery versus continued conservative management; patient prioritises maintaining walking independence and is particularly concerned about prolonged rehabilitation; explained risk of X and expected recovery; patient wishes to proceed and will contact team if preferences change."

Consent, shared decision-making and documentation

Concept	What it is	What it is not
Consent	The patient's permission or refusal for the specific decision	A signature or a clinician's recommendation
Shared decision-making	The dialogue used to understand choices, evidence and patient priorities	A transfer of all clinical responsibility to the patient
Documentation	A proportionate record of information, discussion and decision	Proof that understanding occurred merely because a form is complete

Four-nation orientation

Nation	Adult incapacity framework - high-level orientation
England and Wales	Mental Capacity Act 2005 for adults lacking capacity; common-law consent principles remain central for adults with capacity.
Scotland	Adults with Incapacity (Scotland) Act 2000 and related Part 5 processes.
Northern Ireland	Mental Capacity Act (NI) 2016 is only partially commenced; check current DoH NI materials and local advice.

Worked scenarios

Scenario 1

A patient signs a procedure form after receiving a leaflet, but no one has discussed alternatives or what matters most to them. The problem is not simply missing paperwork; the decision process itself is incomplete.

Application: The consent process needs a real dialogue about options, patient priorities and understanding; paperwork alone is insufficient.

Scenario 2

A relative says, "I am next of kin, so I can sign for him." Clarify that family involvement can be important, but legal authority for an adult who cannot decide must be identified under the applicable framework.

Application: Clarify that next of kin alone is not general legal authority. Identify the relevant incapacity/proxy framework.

Scenario 3

A patient agreed to surgery three months ago. New renal impairment now materially changes perioperative risk. Revisit the discussion rather than relying on the old form.

Application: Revisit the earlier consent because a material change in risk has occurred.

Practice checklist

- Name the decision and the reasonable options, including no treatment/no change when relevant.
- Elicit the patient's goals and concerns before deciding which information matters most.
- Explain benefits, harms, uncertainty and why you recommend a particular option.
- Check understanding and invite questions.
- Confirm the choice is voluntary and within the patient's current wishes.
- Record the discussion proportionately and review it when circumstances change.

Official references

S001 - GMC: Decision making and consent. Scope: UK.

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent>

S002 - GMC: The dialogue leading to a decision - part 1. Scope: UK.

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/the-dialogue-leading-to-a-decision>

S008 - GMC: Recording decisions. Scope: UK. <https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/recording-decisions>

S009 - GMC: Good medical practice. Scope: UK. <https://www.gmc-uk.org/professional-standards/the-professional-standards/good-medical-practice>

S018 - NICE: NG197 Shared decision making - recommendations. Scope: England; clinically useful more widely with jurisdiction label. <https://www.nice.org.uk/guidance/ng197/chapter/recommendations>

S024 - UK legislation: Mental Capacity Act 2005. Scope: England and Wales.

<https://www.legislation.gov.uk/ukpga/2005/9/contents>

S028 - Scottish legislation: Adults with Incapacity (Scotland) Act 2000. Scope: Scotland.

<https://www.legislation.gov.uk/asp/2000/4/contents>

S030 - Department of Health NI: Mental Capacity Act (Northern Ireland) 2016 - topic hub. Scope: Northern Ireland. <https://www.health-ni.gov.uk/topics/mental-capacity-act>

Reference status: Links were verified in the Stage 2 dossier on 18 September 2026. Core high-risk pages were rechecked during Pass 2 on 19 September 2026. Recheck high/very-high update-risk sources immediately before publication.

Key takeaways

- Consent is a decision process, not a form.
- Information and support must be tailored to the particular patient and decision.
- The legal route for adults who cannot decide differs across UK jurisdictions.
- Where the situation is complex or disputed, seek senior, governance or legal advice and verify current local policy.

ClinicalEdu - Authoritative Stage 2 source map

C1: Foundations of consent and shared decision-making

This appendix is the controlling source map for this module. Source IDs follow the Stage 2 Research Dossier v1.0 (evidence reviewed through 18 September 2026). Any legacy shorthand labelled SUPP is supplementary and is not a Stage 2 source ID.

S001 - GMC: Decision making and consent

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent>

S002 - GMC: The dialogue leading to a decision - part 1

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/the-dialogue-leading-to-a-decision>

S008 - GMC: Recording decisions

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/recording-decisions>

S009 - GMC: Good medical practice

<https://www.gmc-uk.org/professional-standards/the-professional-standards/good-medical-practice>

S018 - NICE: NG197 Shared decision making - recommendations

<https://www.nice.org.uk/guidance/ng197/chapter/recommendations>

S024 - UK legislation: Mental Capacity Act 2005

<https://www.legislation.gov.uk/ukpga/2005/9/contents>

S028 - Scottish legislation: Adults with Incapacity (Scotland) Act 2000

<https://www.legislation.gov.uk/asp/2000/4/contents>

S030 - Department of Health NI: Mental Capacity Act (Northern Ireland) 2016 - topic hub

<https://www.health-ni.gov.uk/topics/mental-capacity-act>

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