The College of Emergency Medicine

Best Practice Guideline

Consent, Capacity and Restraint of Adults in Emergency Departments

March 2013

Summary of recommendations

1. Patients have the right to determine what happens to their own bodies.

2. A patient shall be assumed to have capacity unless it is established that they lack capacity.

3. In an emergency and if it is not possible to find out a patient's wishes, treatment can be provided without patient consent, provided the treatment is immediately necessary to save their life or to prevent a serious deterioration of their condition.

4. In the setting of an Emergency Department, short term restraint of a patient without capacity generally amounts to restriction rather than deprivation of liberty.

5. Persons liable to be detained under the Mental Health Act on grounds of mental illness may be treated without consent for their mental disorder.

6. Physical health problems can be treated under the Mental Health Act provided they are part of, or ancillary to treatment for the mental disorder.

7. For minor procedures, such as venepuncture, physical examination, small wound closure or ECG recording, cooperation with the procedure amounts to valid implied consent.

8. If completion of a consent form will result in an inappropriate delay and increase the risk of patient harm or prolong suffering, a record of the consent discussion should be clearly documented in the patient's notes. This should be completed as soon as reasonably possible.

Reason for development

Patients requiring care at the Emergency Department present particular challenges to ensure valid consent. Patients often attend in a crisis; have their capacity impaired by therapeutic or recreational drugs. These patients are attended to by clinicians who may have to make time critical decisions based on incomplete information. The Emergency Department can be a disorientating and frightening environment for patients.

A patient is often anxious, afraid and in pain and this can impair their ability to make reasoned and rational choices about their care. Good consent also forms a medico legal defence for the treating clinician in the event of adverse outcome or complaint

This guideline is designed to augment the guidance offered by the General Medical Council and the Department of Health as the College of Emergency Medicine has identified where further guidance is required.

Scope

This guideline offers guidance for clinicians working in Emergency Departments in England about obtaining consent from persons aged 18 years old and over. This guideline does not consider consent to participation in research studies, retention of human tissue or sharing of information.

Introduction

General guidance on obtaining valid consent for examination and treatment is provided by the Department of Health Reference guide to consent for examination and treatment - Second Edition (July 2009), The GMC 'Consent : Patients and doctors making decisions together' (2008), and the Mental Capacity Act (2005). The following aspects of consent; autonomy and capacity, are particularly relevant to the Emergency Care setting in England.

Patient autonomy – the foundation for consent

Patients have the right to determine what happens to their own bodies. For consent to be valid, it must be given voluntarily and freely, without pressure or undue influence being exerted to accept or refuse treatment, by an appropriately informed person who has the capacity to consent to the intervention in question.

In adults, consent may only be provided by the patient, someone authorised to do so under a Lasting Power of Attorney, or someone who has the authority to make treatment decisions as a court appointed deputy[3].

Capacity

The Mental Capacity Act 2005 defines a person who lacks capacity as a person who, at the time, is unable to make a decision for themselves because of an impairment or disturbance in the functioning of their mind or brain. A patient shall be assumed to have capacity unless it is established that he or she lacks capacity. Assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made. Capacity should be reassessed for each decision.

A person is unable to make a decision when they cannot do one or more of the following:

a) Understand the information given to them that is relevant to the decision.

b) Retain that information long enough to be able to make the decision.

c) Use or weigh up the information as part of the decision making process.

d) Communicate that decision.

A person's capacity to consent may be affected by factors such as mental disorder, cognitive impairment, emotional upset (confusion, panic), fatigue, pain or medication, illicit drugs/alcohol, and delirium secondary to systemic illness. However, the existence of such factors should not lead one to assume that the person lacks the capacity to consent.

All practical and appropriate steps must be made to give a patient the best chance of being able to make a decision for themselves. The following should be considered:

- Ensure all relevant information has been provided.
- Ensure that this information has been presented in a way that makes it as easy as reasonably possible for the patient to understand.
- Can the patient environment be altered to one more conducive to making a valid consent decision, i.e. one less noisy / stressful?
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A person is entitled to make a decision which may be perceived by others as unwise or irrational as long as they have the capacity to do so6. However, a decision which appears irrational and may be based on a misperception of reality rather than a different value system to the clinician's should prompt a careful re-evaluation of the patient's ability to comprehend, weigh or make use of the relevant information. If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment, this decision must be respected, even if this may result in the death of the person[7] (and/or the death of an unborn child, whatever the stage of pregnancy[8]). Conclusions about capacity assessment should be documented in the patient's clinical records.

Emergency treatment

In the setting of a clinical emergency and if it is not possible to find out a patient's wishes, treatment can be provided without patient consent, provided the treatment is immediately necessary to save their life or to prevent a serious deterioration of their condition[1,2].

Patient care should be the Emergency Department clinician's first concern. Patients should be treated as individuals, and their dignity should be respected[9].Patients should be treated with respect and not discriminated against[9].

Where there is doubt as to the appropriateness of treatment, there should be a presumption in favour of providing life-sustaining treatment[1].Any treatment decision made in the absence of consent must be made in that person's best interests[3].A decision or act can be regarded as being in the patient's 'best interests' if it would be supported by a responsible body of professional opinion – the 'Bolam test'[10].

The person(s) making a best interest decision should consider all relevant circumstances. In particular, the following should be considered[3]:

- The person's past and present wishes and feelings, including any written statement made whilst the patient had capacity, including a valid and applicable advance refusal of treatment.
- The beliefs and values that would be likely to influence their decision if the patient had capacity.
- Any other factors that he would be likely to consider if the patient were able to do so.

The views of the following persons should be taken into account where it is practicable and appropriate to consult them[3]:

- Anyone named by the patient as someone to be consulted on the matter in question or on matters of that kind.
- Anyone engaged in caring for the patient or interested in his/her welfare.
- Any donee of a lasting power of attorney granted by the patient
- Any deputy appointed for the patient by the court.

Emergency 'best interest' decisions must not be determined merely on the basis of3:

- The person's age or appearance
- A condition of his, or an aspect of his/her behaviour which might lead others to make unjustified assumptions about what might be in his best interests.
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A best interests decision can mean a decision to give, withhold or stop treatment.

If the patient regains capacity while in your care, you should tell them what has been done, and why, as soon as they are sufficiently recovered to understand[2].

If a decision is time-critical, consideration should be made of whether the patient is likely to regain capacity in sufficient time to allow him/her to give consent[1]. If not, and a delay in initiating treatment would likely be detrimental to the patient's wellbeing, a best interest decision should be reached.

Where there is a choice of treatment, the treatment provided must be the least restrictive on the patient's future choices[3].

Restraint

Emergency Department clinicians are occasionally asked to consider restraining a patient, either physically or chemically. The clinician should look for underlying treatable causes of the condition that requires restraint.

Restraint is defined as[3]:

- The use or threat of using force to make a person do something that they are resisting or, the restriction of liberty of movement, whether or not the person resists.

Restraint may at times be considered a 'best interest' intervention, allowing effective management of a patient lacking capacity whose behaviour represents a risk to that patient. It can only be considered acceptable if[11]:

- The person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity.
- The restraint used is a proportionate response to the likelihood and seriousness of harm.
- This action does not conflict with a previous decision made by an attorney or deputy under their powers.

Restraint by its nature will infringe on the liberty of the treated individual. Such infringement may amount to restriction or deprivation of liberty. This distinction is an important one as deprivation of liberty in the absence of 'a procedure prescribed by law' is a contravention of Article 5(1) of the Human Rights Convention[12].

In the setting of an Emergency Department, short term restraint of a patient without capacity generally amounts to restriction rather than deprivation of liberty[13,14]. This is permissible under the Mental Capacity Act. Where repeated or prolonged restraint is required, the boundary from restriction into deprivation risks being crossed. Such deprivation of liberty can be medically justified under the Mental Health Act, or under the Deprivation of Liberty Safeguards (DoLS) as part of the Mental Capacity Act. The Mental Capacity Act DoLS[14]protect vulnerable adults, who lack capacity to consent to treatment or care in hospital that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty, and where detention under the Mental Health Act is not appropriate for the person at that time. DoLS aim to prevent arbitrary deprivation of liberty. Formal authorisation for deprivation of liberty should currently be made to the patient's Primary Care Trust.

It is not appropriate to apply the DoLS where sedation or other medication is intended to facilitate treatment, for instance the use of sedation to facilitate ventilation in a patient with respiratory failure, but rather to situations where the primary aim is restraint[15].

Lasting Power of Attorney (LPA)

In England and Wales, a person over 18 years old can appoint an attorney to look after their health and welfare issues if they should lack the capacity to do so in the future[3].

The LPA must meet the requirements specified in the Mental Capacity Act 2005, and be registered with the Office of the Public Guardian before it can be used.

The LPA may specify limits to the attorney's authority and must specify whether or not the attorney has the authority to make decisions about life sustaining treatment.

Within the specified boundaries laid out in the LPA, the appointed attorney can make decisions that are as valid as those of the person themselves .If there is a dispute between doctor and the attorney, then the case may be referred to the Court of Protection, though this type of resolution cannot be achieved within an Emergency Medicine timeframe. A lasting power of attorney replaces the former Enduring Power of Attorney. However, an existing Enduring Power of Attorney remains valid.

The law in the devolved nations of the United Kingdom varies slightly and Fellows working in these are advised to check

Consent

Consent must be given voluntarily and freely, without pressure or undue influence being exerted on the patient to accept or refuse treatment. A person needs to understand the nature and purpose of the procedure in order to give valid consent. Any misrepresentation of these elements will invalidate consent[1].

Emergency Department clinicians should be aware of the potential influence of family, friends and healthcare workers on a patient's consent decision. As far as reasonably possible, the Emergency Department clinician should establish that any consent decision made is truly that of their patient[16]. Coercion (persuasion by threat, trickery, intimidation or other form of pressure or force) is unacceptable and invalidates consent; this should not be confused with appropriate reassurance concerning a particular treatment, or the highlighting of potential benefits of treatment on a patient's health.

When deciding on what information to provide, the principles of the 'Bolam test' should be employed. However, the courts have in the past been critical of responsible bodies of medical opinion, and they are consequently the final arbiter of what constitutes responsible practice[1,17]. As a result, it is advisable to inform the patient of all significant possible and/or unavoidable risks however unlikely, the potential benefits of treatment, the risks of procedural failure, details of alternatives to that particular treatment, and the risks incurred by doing nothing.

- In assessing risk, consideration should be given to any patient-specific factors such as severity of illness or co-morbidity which raise the likelihood of adverse outcomes occurring.
- Where relevant, information about anaesthesia or sedation should be provided as well as information about the procedure itself.

- Information should be provided using clear, simple and consistent language. Simple and accurate written information, visual or other aids may be used if they help your patient to understand.

The clinician providing the treatment or investigation is responsible for ensuring that valid consent has been obtained before treatment begins. However the task of obtaining consent may be delegated to another suitably trained and qualified person.

A competent patient can withdraw consent at any time, even during a procedure. This wish must be respected provided that the patient still has capacity. If withdrawal of consent occurs mid-procedure, the Emergency Department clinician should ascertain the problem, ensure the patient's capacity has not changed, and explain the consequences of abandoning the procedure. If stopping the procedure might endanger the life of the patient, the healthcare professional is entitled to continue until that is no longer the case[1].

If a patient states that they do not wish to know in detail about their condition or the proposed treatment for which consent is being sought, their wishes should be respected as far as possible. However, if competent, they must still receive the basic information required in order to give valid consent. Such information is likely to include whether the procedure is invasive, what level of pain they might experience, what can be done to minimise this, and if it involves any serious risks. Patient refusal to know in detail about the proposed treatment should be carefully documented in the patient's notes.

- The mere fact that a patient might become upset by hearing information, or might refuse treatment upon hearing it is not sufficient justification to exclude such information whilst attempting to gain consent for a particular intervention.

Mental health – consent to treatment

Persons liable to be detained under the Mental Health Act on grounds of mental illness may be treated without consent for their mental disorder.

Physical health problems can be treated under section 63 of the Mental Health Act provided they are part of, or ancillary to treatment for the mental disorder, i.e. treating wounds self-inflicted as a result of a mental disorder, or treating a potentially lethal drug overdose[4,18,19].

The Mental Health Act (1983) cannot be applied to justify treatment of patients for physical conditions unrelated to the mental disorder.

This treatment, if felt to be necessary and if the patient is judged to lack capacity, remains subject to common law principles and may be provided if felt to be in the patient's best interests.

If a patient with known or suspected mental disorder refuses a time-critical emergency intervention, careful assessment of capacity should be made. If their capacity is judged to be borderline or fluctuating, a second opinion should be urgently sought. The more serious the consequences for non-treatment, the greater the capacity required to refuse. If there are doubts about the capacity of a patient, then it is good practice for another appropriately qualified clinician to assess the capacity of the patient.

Form of consent

A single stage process for obtaining consent will usually be employed in the Emergency Department. Consent to treatment may be explicit or implied. For minor procedures, such as venepuncture, examination, small wound closure or ECG recording, cooperation with the procedure amounts to valid implied consent.

The validity of consent does not depend on whether a form is completed or not. The use of written consent is advised if:

- The investigation or treatment is complex or involves significant risk of morbidity/mortality.
- The procedure involves general anaesthesia or sedation.
- There may be significant consequences for the patient.

It is wrong to consider that a patient's signature on a consent form automatically equates with having obtained valid consent. The use of standardised forms, Department of Health forms 1-4 or Trust-specific modifications are recommended.

If completion of a consent form will result in an inappropriate delay and increase the risk of patient harm or prolong suffering, a record of the consent discussion should be clearly documented in the patient's notes. This should be completed as soon as reasonably possible.

A copy of the consent form should be offered to the patient. A copy should be also be secured in the patient's notes for future reference. If a patient is unable to read or write, they may wish to make a mark on the form to indicate consent. This should be witnessed by a third party, and the fact that the person has chosen to make their mark in this way documented in the notes.

Key clinical vignettes

(a) **"A 30 year old lady is brought to the Emergency Department claiming to have taken a total of 30 paracetamol. Her paracetamol level indicates the need to commence treatment with N-acetylcysteine to reduce her risk of developing liver failure. She refuses this treatment however, stating that she 'just wants to die'."**

A careful discussion should be had with the patient to identify her reasons for refusing treatment. There may be additional issues aside from suicidal intent such as 'needle phobia' which may need to be addressed. Therapy can then be modified accordingly, e.g.: oral methionine.

If appropriate, an attempt to lower levels of emotional arousal should be made. Further discussion should then aim to persuade the patient to freely accept treatment.

If treatment refusal continues, an assessment of her capacity should be made. This will form the basis of subsequent management, and should be carefully considered and documented.

When assessing her capacity, one must first determine if there is impairment of or disturbance in functioning of mind or brain related to such factors as: mental illness (with associated suicidal intent), cognitive impairment, drug/alcohol intoxication, or delirium related to systemic illness. She should not be subject to undue influence by a third person. Heightened emotional arousal may also be implicated in temporary impairment of capacity and may be relevant in this scenario. The ability to understand information relevant to the decision, retain it, weigh it and communicate a decision can then be assessed.

If the patient clearly lacks capacity to consent to treatment, the decision to treat can be taken in the patient's best interests under the common law doctrine of necessity.

If in the absence of capacity, she resists treatment or attempts to abscond, restraint should be considered. If this is felt to be a 'reasonable' intervention to facilitate safe and effective delivery of care and prevent harm to the patient, certain principles must be employed:

a) The force used must not be excessive. It must be no more than is necessary to control the patient's behaviour and allow the proposed procedure to be carried out successfully,
b) The degree of force used or the method of restraint employed must be in proportion to the expected benefits of successful completion of treatment. Physical restraint of a hand, with or without, oral sedation may be appropriate whereas a general anaesthetic may not be, for example.

The means by which treatment is enacted must be determined by the consultant responsible for that patient's care.

However, the decision regarding patient competence to make a life threatening treatment refusal may not be clear. Additional expert psychiatric assessment is important where there is suspicion of mental illness or uncertainty as to the influence of other factors underlying more subtle impairment of mind or brain on a patient's capacity. The more serious the implications of a decision, the greater the capacity required by that individual, and the more rigorous the treating clinician must be to ensure that a comprehensive assessment has been made.

If it is established that she has a mental disorder, it may be appropriate to detain her under a Section of the Mental Health Act. Whilst under section, she could be treated for the paracetamol overdose as an ancillary treatment under section 63 of the MHA.

Any attempt to abscond from the ED prior to formal mental health assessment should ideally be prevented. Consider modifying environmental factors associated with her desire to leave, 'talking her' into staying, or involving friends and family. If she absconds despite best efforts, hospital security should be notified, and the Police informed with the aim of returning her to the department.

It is possible that she does not have a mental disorder, and gives no reason to doubt her capacity. These instances are rare and require expert legal advice to be sought, but refusal of medical treatment by a competent patient even if that refusal leads to premature death is a recognised legal standpoint3,6. Neither restraint nor enforced treatment can be justified under ANY circumstances in the non-consenting patient who has capacity.

(b) **"A 30 year old man is brought to the Emergency Department having collapsed. Based on your history and examination you suspect him to be suffering from an upper gastrointestinal haemorrhage. He is haemodynamically unstable, and his initial venous blood gas reveals haemoglobin of 4.5g/dl. You arrange for an urgent endoscopy and decide to continue your resuscitation with blood products. When you mention this intervention he tells you that he is a Jehovah's Witness and cannot give his consent."**

Every patient has a right to be treated with respect, and staff must be sensitive to their individual needs, acknowledging their values, beliefs and cultural background.

Jehovah's Witnesses regard blood as sacred. On the basis of this deeply held core value, they decline treatment with allogeneic (donor) blood (red cells, white cells, platelets, and plasma). With regard to autologous transfusion JW patients make a personal decision whether or not to accept this. This includes all forms of perioperative / intraoperative blood salvage (cell salvage), haemodilution, and postoperative blood salvage. Predeposited Blood is not acceptable to Jehovah's Witnesses.

It should be noted that some Jehovah's Witnesses carry a card by way of an advance directive. There are cases where the validity of these cards has been brought into question. In an Emergency, and if doubt exists about the validity of a blood refusal card, physicians should aim to preserve life and administer the necessary blood products.

A competent patient with the capacity to make such a decision has the right to decline treatment, even if doing so might lead to his or her death. This right pertains 'regardless of whether the reasons for the refusal were rational or irrational, unknown or even non-existent'.

A patient's wishes should be made clear at the earliest possible opportunity by completion of a specific blood/blood product refusal form. If this man were to subsequently fall unconscious, his consent refusal remains valid and administration of blood products would be illegal[21]. Had he presented unconscious initially and as the treating physician you were unaware of his religious beliefs, then administration of blood as a potentially lifesaving emergency intervention would have been justified. In this case emergent endoscopic or surgical haemostasis should be the aim as this provides the best available chance of patient survival.

Decisions not to treat of this magnitude should not be made in isolation. We would advise early involvement of senior colleagues, the hospital legal department and the Jehovah's Witness Hospital Liaison Service.

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First published in March 2013

Acknowledgements

Meng Aw-Yong

Simon Smith

Abel Wakai

Jenna Thompson

Bhaskar Choubey (From the Lay Advisory Group)

Stephen Timmons (From the Lay Advisory Group)

Review

March 2016

Disclaimers

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations

Nil proposed.

Audit standards

Suggested audit standard is 100% documented evidence in cases where written consent has been obtained.

Key words for search

Consent, Capacity, Mental Health Act, Mental Capacity Act, Human Rights Act, Emergency Department, Emergency Medicine.

Appendix 1

Methodology

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

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Incorporated by Royal Charter, 2008
Registered Charity number 1122689