ORIGINAL ARTICLE

How much do emergency healthcare workers know about capacity and consent?

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Aim: To assess knowledge of capacity and consent among emergency healthcare workers.

Design: A cross-sectional survey with a structured questionnaire.

Methods: 86 questionnaires were distributed and completed by 42 accident and emergency doctors, 21 accident and emergency nurses, and 23 emergency ambulance staff. Correct answers on assessing capacity to consent to or refuse treatment were given by 67% of the doctors and 10% of the nurses, but by none of the ambulance workers. 15% of all respondents wrongly believed that an adult who is found to have capacity can lawfully be treated against his or her will.

Conclusions: The results of this study indicate that emergency healthcare workers do not have adequate knowledge about how to assess capacity and treat people who either refuse treatment or lack capacity. It shows a need for further training among doctors, nurses and ambulance staff working in the emergency setting.

Since the introduction of the Human Rights Act¹ in the UK, there has been increasing public awareness of individuals' rights. Recent case law attracting wide media attention has raised the public's awareness of treatment of incapacitated adults.^{2–3}

Doctors and nurses have to make daily decisions regarding their patients' competency to consent to investigations and treatments. Ambulance workers have to make similar decisions when patients refuse to travel to hospital. In the current litigious climate clinicians face the possibility that some of their decisions will be examined critically in a court of law, either from the perspective of forcing a competent adult to have treatment they do not want (which may result in criminal charges of assault and civil action) or for omitting necessary treatment of a person lacking capacity. With the introduction of the Mental Capacity Act 2005,⁴ it is even more important that clinicians understand the steps to be taken in assessing capacity and treating incompetent adults. There is uncertainty among doctors about how to proceed when treating patients who refuse treatment. This is particularly true when patients have self-harmed and then refuse treatment.⁵

The National Institute of Clinical Excellence has recently produced guidelines for the treatment of patients who cause self-harm.⁶ They state that all healthcare professionals should be able to make decisions about capacity and about when treatment can be given without the patient's consent. These guidelines, along with others produced by medical and legal groups,^{7–8} use a definition of capacity based on the three-stage test used in Re C⁹ (see box). There are some small differences between the guidelines produced by the medical groups and the test set out in Re C,¹⁰ which forms the basis for assessing capacity under the Mental Capacity Act. However, a doctor who follows the guidelines produced by the National Institute of Clinical Excellence, or by the British Medical Association, should not be found to have acted negligently, as he or she has acted in accordance with a recognised body of medical opinion, and thus fulfils the criteria set out in Bolam v Friern Hospital Management Committee.¹¹

A recent study has shown that doctors have a poor understanding of the issues concerned with assessing capacity.¹² This study looked at psychiatrists, old-age physicians and general practitioners. The current study follows on from this. It looks at

doctors and nurses working in accident and emergency departments, and at paramedics and ambulance technicians working in the acute ambulance services. These clinicians are often required to make rapid decisions when patients refuse treatment.

METHODS

The participants were all staff working at City Hospital, Birmingham, UK, or on the West Midlands Accident and Emergency Registrar training programme. City Hospital is a teaching hospital, which has an accident and emergency department that sees around 110 000 new patients each year. The staff were recruited either while at work or while in teaching sessions.

A structured questionnaire (Appendix) was used to assess knowledge needed to make valid decisions about capacity. The questionnaires were distributed, completed and returned in the presence of the researcher (KE), in order to prevent cheating by collaboration or by collection of information. The questionnaire had been piloted and then used in a previous study.¹² Participants were offered a set of correct answers after data collection was completed. The questionnaire and answers were based on guidelines published by the British Medical Society and the Law Commission. They did not include any changes suggested in the Mental Capacity Act, as it was felt that this was too new to have been widely read, and is not due to be implemented until 2007.

Respondents were asked for basic demography, job title and grade. Participants were asked to specify what three criteria would need to be assessed when evaluating capacity to consent to or refuse medical treatment. They were then asked questions on the treatment of people without capacity. The questions had a multiple-choice format (yes/no/don't know). The answer to the three-part question of assessing capacity was scored leniently, looking for a general understanding of the criteria set out in Re C and given by the British Medical Association (box). When participants gave two or three of the criteria, they were scored positively. Participants giving zero or one correct answer were scored negatively.

Differences between groups were evaluated by χ^2 or Fisher's exact test, as appropriate.

RESULTS

Eighty-six questionnaires were distributed and completed by 42 accident and emergency doctors, 21 accident and emergency

Figure 1 Knowledge regarding capacity to consent or refuse treatment (% correct responses).

nurses, and 23 emergency ambulance staff. Table 1 shows basic details of the groups.

Figure 1 shows the results for the assessment of knowledge regarding the capacity to consent or refuse treatment. In all, 28 (67%) doctors were judged as correct in their knowledge regarding capacity to consent or refuse treatment, compared with 2 (10%) nurses and no ambulance staff ($p < 0.001$).

Of the doctors 4 (100%) consultants were correct in their knowledge, compared with 15 (65%) registrars and 9 (60%) senior house officers. The two nurses who gave correct answers were F and D grade.

Table 2 shows the results for the multiple-choice questions.

For the first question, "if a competent adult refuses treatment, can you still treat them under common law?" (correct response = no), 3 (75%) consultants, 22 (96%) registrars and 13 (87%) senior house officers gave the correct answer, compared with 3 (100%) G grade nurses, 4 (80%) F grades, 2 (40%) E grades, 3 (75%) D grades and 2 (50%) untrained nurses, and 8 (89%) paramedics and 13 (93%) ambulance technicians.

For the second question, "if someone is deemed incapable of signing a consent form for a procedure, is it legally necessary to get a relative to sign it instead?" (correct response = no), 4 (100%) consultants, 23 (100%) registrars and 11 (73%) senior house officers gave the correct answer, compared with 1 (33%) G grade nurse, 3 (60%) F grades, 4 (80%) E grades, 3 (75%) D grades and 2 (50%) untrained nurses, and 2 (22%) paramedics and 5 (36%) ambulance technicians.

For the third question, "should the Mental Health Act be used to treat physical illness when someone with a mental disorder is refusing treatment?" (correct response = no), 4 (100%) consultants, 21 (91%) registrars and 9 (60%) senior house officers answered correctly. Compared with 2 (67%) G grade nurses, 5 (100%) F grades, 4 (80%) E grades, no D (0%)

grades and 2 (50%) untrained nurses, and 4 (44%) paramedics and 7 (50%) ambulance technicians.

DISCUSSION

Although doctors, nurses and ambulance workers are commonly involved in caring for and treating patients who lack capacity, the findings of this study show that these healthcare workers often do not know how to assess capacity. Only 10% of nurses and none of the ambulance staff knew how to correctly assess capacity (using lenient criteria). Nurses and ambulance staff will normally be the first people seeing and assessing a patient, either when an ambulance is called or when patients are presented to the accident and emergency department, and are seen in triage. It is essential that these members of staff know how to assess capacity, otherwise they will not know how to proceed when a patient refuses either to come to hospital or to stay for treatment.

Once in hospital, most of the patients in accident and emergency departments are seen by the senior house officers. Only 60% of the senior house officers questioned in this study knew how to assess capacity, and 13% of them believed that even when a patient had capacity they could still be treated against their wishes.

The results of this study show that while the Government and the National Institute of Clinical Excellence recommend that all healthcare workers should be able to assess capacity, at present they are unable to do this. Healthcare workers are leaving themselves open to criticism and legal action if, because of their inability to assess capacity, they incorrectly treat, or perhaps worse, incorrectly allow a patient to refuse treatment when they should not have done so. Furthermore, if patients who have caused self-harm are incorrectly allowed to leave hospital before they receive treatment, they may, unfortunately, suffer harm, that could, and should, have been prevented.

The practicalities of assessing capacity are often harder than the three-stage test would suggest. Consideration has to be given to the patient's state of distress and emotional upset, as well as to the effects of any drugs or alcohol they have taken. Furthermore, capacity may fluctuate over time, and will vary according to the complexity of the intervention being discussed. If there is any doubt as to the patient's capacity, it is safer to err on the side of caution and treat any life-threatening or serious problems.¹³ Treatment provided to patients who lack capacity must be given in their best interests, as determined by the treating clinician. Healthcare workers should try to persuade the patient to cooperate with the treatment; however, restraint may occasionally need to be used. This should always be a last resort, and any restraint used should be the minimum possible needed and should be used for the shortest time possible.^{1 4 14 15} Chemical restraint is often preferable to physical restraint.

Given time and proper explanations many patients will consent to treatment. If, despite this, a patient who has been determined as having capacity still refuses treatment, then his or her decision should be respected. This situation will rarely occur when there is a serious risk to the patient's health. The level of capacity required has to match the seriousness of the decision to be made.¹⁶ Therefore, patients may have the capacity

Table 1 Basic details of the emergency healthcare workers questioned

	Doctors (n = 42)	Nurses (n = 21)	Ambulance staff (n = 23)
Male/female	27/15	4/17	16/7
Year of qualification			
<1990	9	6	2
>1990	33	15	21
Grade	Consultant 4	G 3	Paramedic 9
	Registrar 23	F 5	Technician 14
	SHO 15	E 5	
		D 4	
		Untrained 4	

SHO, senior house officer

Box: Test of capacity

There are three stages to the decision

- To take in and retain the information
- To believe it
- To weigh that information, balancing risks and needs

Table 2 Responses to multiple-choice questions

Question posed	Number (%) giving correct response			
	Total (n = 86)	Doctors (n = 42)	Nurses (n = 21)	Ambulance staff (n = 23)
If a competent adult refuses treatment, can you still treat them under common law? Correct response = NO	73 (85%)	38 (90%)	14 (67%)	21 (91%) (p<0.05)
If someone is deemed incapable of signing a consent form for a procedure, is it legally necessary to get a relative to sign it instead? Correct response = NO	58 (67%)	38 (90%)	13 (62%)	7 (30%) (p<0.01)
Should the Mental Health Act be used to treat physical illness when someone with a mental disorder is refusing treatment? Correct response = NO	58 (67%)	34 (81%)	13 (62%)	11 (48%) (p<0.05)

p value is the difference between all three groups.

to refuse treatment for a minor laceration, but not to refuse life-saving treatment for a potentially lethal overdose. In such situations it will normally be possible to show that the patient did not have the ability to weigh up the information to arrive at a valid decision.¹⁷ It would certainly be advisable to seek legal advice before allowing a patient to refuse life-saving treatment.

It is unlikely, though of course possible, that someone who has been treated against his or her will for self-harm will later sue, claiming that he or she had the capacity to refuse the treatment and that the treatment was therefore illegal. It is also unlikely that the courts would favour the patient if it can be shown that the correct test of capacity was considered and applied.

The results of this study indicate a need for further training among doctors, nurses and ambulance staff working in the emergency setting. Although the results indicate that doctors have a better understanding of the stages needed in assessing capacity than nurses and ambulance workers, none of the groups scored 100% (or even near 100%) correct responses for all the questions.

Part of the implementation of the Mental Capacity Act should be to include training for those who will be involved in its use. At present there are a variety of courses being run by independent groups trying to achieve this, but there is no government strategy in place to train those who should be using the Act.

CONCLUSION

Emergency healthcare workers do not have adequate knowledge about how to assess capacity and treat people who either refuse treatment or lack capacity. This is especially true for ambulance workers, who, in this study, were unable to identify the stages in testing capacity.

STUDY LIMITATIONS

The main limitation of this study is the small number of respondents. The small numbers make it difficult to assess differences between grades within the groups. A further weakness is that some of the recruitment took place during teaching sessions. This could have resulted in selection bias. However, it is felt that this would have selected those clinicians who are more motivated and well informed, resulting in an over-optimistic view of the clinicians' knowledge.

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REFERENCES

- Human Rights Act 1998.
- B (consent to treatment: Capacity)*, Re (2002) EWCH 429 (Fam); (2002) 1 FLR 1090.
- Re Guardianship of Schiavo (2005) WL 600377.
- Mental Capacity Act 2005.
- Hassan TB, MacNamara AF, Davy A, et al. Managing patients with deliberate self harm who refuse treatment in the accident and emergency department. *BMJ* 1999;319:107-9.
- National Institute for Clinical Excellence, Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. National Clinical Practice Guideline number 16. London, 2004.
- British Medical Association and The Law Society. *Assessment of Mental Capacity, Guidance for Doctors and Lawyers*. London: BMJ Books, 2004.
- Department of Health. *12 Key points on consent: the law in England*. London: The Stationery Office, August, 2001.
- Re C (Adult: Refusal of Medical Treatment) (1994) 1 All ER 819 at 822.
- Tan JAO, McMillan, JR. The discrepancy between the legal definition of capacity and the British Medical Association's guidelines. *J Med Ethics* 2004;30:427-9.
- Bolam v Friern Hospital Management Committee (1957) 2 All ER 118; (1957) 1 WLR 582.
- Jackson L, Warner J. Doctor's knowledge about assessing capacity. *JR Soc Med* 2002;95:601-3.
- Kennedy I, Grubb A. *Principles of Medical Law*. Oxford: OUP, 1998:117-8.
- Violence: the short term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments. National Clinical Practice Guideline number 25. National Institute of Clinical Excellence, 2005.
- Mental Health Act 1983, Code of Practice.
- Re T (adult: refusal of medical treatment) (1993) 4 All ER 649.
- Jacob R, Clare ICH, Holland A, et al. Self-harm, capacity and refusal of treatment: implications for emergency medical practice. A prospective observational study. *Emer Med J* 2005;22:799-802.

APPENDIX

QUESTIONNAIRE USED FOR STUDY

1. Consent/Refuse Medical Treatment.

The assessment of an adult's (>18 years) capacity to make a decision about his or her own treatment is a matter for clinical judgement guided by professional practice and subject to legal requirements.

What three points would you look for in assessing one's capacity to give valid consent?

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2. If a competent adult refuses medical treatment that you are proposing, can you still treat them under common law? Y/N/DK (don't know)

3. If someone is deemed incapable of signing a consent form for a procedure, is it legally necessary to get a relative to sign instead? Y/N/DK

4. Should the Mental Health Act be used to treat physical illness when someone with a mental disorder is refusing treatment? Y/N/DK