The Royal College of Emergency Medicine

Best Practice Guideline

Consent in Adults, Adolescents and Children in Emergency Departments

The Royal College of Emergency Medicine

50 Years of Emergency Medicine

Revised:
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Summary of recommendations

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

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

3. 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.

4. 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 and in their best interests

Scope

This guideline offers guidance for clinicians working in Emergency Departments in the United Kingdom about obtaining consent. The guideline is mainly written for clinicians working in England and Scotland. Legislation in the other devolved nations and the Republic of Ireland differs, though the principles of autonomy and capacity are broadly similar and the clinical practice of obtaining consent varies little between these nations. This guideline does not consider consent to participation in research studies, retention of human tissue or sharing of information.

Reason for development

Patients requiring care at the Emergency Department present particular challenges to ensure valid consent. Patients often attend in a crisis and may 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 Royal College of Emergency Medicine has identified where further guidance is required.

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) (MCA). In Scotland, the relevant legislation governing the issues of consent, capacity and autonomy is primarily contained in the Mental Health (Care and Treatment)(Scotland) Act 2003 and in the Adults with Incapacity (Scotland) Act 2000.

The following aspects of consent; autonomy and capacity, are particularly relevant to care in Emergency Departments. There is guidance on the MCA specific to the Emergency Department written by the Royal College of Emergency Medicine.

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, such as a court appointed deputy in England and Wales, or a guardian with welfare powers in Scotland.

No one else can make a decision on behalf of an adult who has capacity.

Emergency Treatment - Patients Lacking Capacity

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.

Patient care should be the Emergency Department clinician's first concern. Patients should be treated as individuals, and their dignity should be respected. 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. Any treatment decision made in the absence of consent must be made in that person's best interests. (see RCEM guidance on the Mental Capacity Act)

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.

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:

- 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:

- 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.

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

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.

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. 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, this has subsequently been refined by the Montgomery judgement. 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. 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 as well as important occupational and lifestyle factors.
- 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 Montgomery judgement describes 'materiality' "A material risk is one that a reasonable person in the patient's position is likely to attach significance to, or if the doctor is or should reasonably be aware that their patient would be likely to attach significance to it." What is important (or likely to be important) to the patient needs to be discussed as part of the consent process, not only risks that are considered significant, and this necessitates discussing with the patient their opinions on risks and outcomes as well as their concerns and preferences.

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.

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Review

Usually within three years or sooner if important information becomes available.

Conflicts of Interest

None declared

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

None suggested

Audit standards

None suggested

Key words for search

Consent, Restraint, Capacity

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.

Evidence Levels

1. Evidence from at least one systematic review of multiple well designed randomised control trials
2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting
3. Evidence from well designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies
4. Evidence from well designed non experimental studies from more than one centre or research group
5. Opinions, respected authority, clinical evidence, descriptive studies or consensus reports.

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