Royal College of Surgeons in Ireland

123 St. Stephen's Green
Dublin 2
Ireland

www.iaem.ie
www.emergencymedicine.ie

12th August 2011

Submission from the Irish Association for Emergency Medicine (IAEM) on the proposed Mental Capacity Legislation

IAEM is aware that the focus of the planned mental capacity legislation may be on people with permanent incapacity. While this focus is undoubtedly needed, there is another context which needs to be considered and indeed there may be considerable overlap.

In acute medical situations, difficult issues may arise regarding capacity to consent to treatment in people not previously known to lack capacity. This may be as a result of temporary loss of capacity due to illness, injury or intoxication or the initial stages of more long-term capacity loss. There may also be situations where there appears to be loss of capacity or circumstances may suggest capacity loss and assessment may be difficult e.g. a person refuses to co-operate with capacity assessment.

However, the other side of the same issue can be more critical in relation to time dependant treatment: *refusal of care, and capacity to refuse consent for treatment.* These can also be issues, of course, for people with longer term or permanent loss of capacity.

In the context of need for urgent intervention, full assessment of capacity in the pre-hospital or Emergency Department (ED) setting may be very difficult. This poses unique challenges in what may be life or death situations with the need for rapid decision making. In addition, this decision making may need to be made by front-line staff at any time of day or night without immediate the availability of expert opinion or the time to carry out more detailed assessments.

In drafting legislation, we believe this aspect of the issue needs specific consideration.

The following are some possible suggestions for an approach to a person refusing consent to treatment.

Possible responses to ED refusal of care

1. Check criteria for valid consent. It is voluntary, information is provided, capacity exists and age is appropriate;
2. Check for mental and medical evidence of brain impairment:

   a. orientation
   b. intoxication
   c. danger to self / others
   d. medical (e.g. Glasgow Coma Score; blood glucose; oxygen saturation; temperature; pulse; blood pressure; any loss of consciousness.)
   e. cognitive impairment (Consider carrying out Mini Mental State Examination, abbreviated mental test score, GPCOG (assessment of cognition))

3. If there are no issues of concern so far, perform a four stage capacity check:

   • can the patient understand the information relevant to the decision?
   • can the patient retain the information relevant to the decision?
   • can the patient use or weigh the information?
   • can the patient communicate the decision (by any means)?

   If any aspect of 2 or 3 raises concern, the patient is assessed as not having capacity to refuse care.

   If consent for assessment is refused, one should assume lack of capacity if medical personnel or next of kin suspect issues of concern in 2 or 3.

Summary

While the elements of capacity determination can be concisely summarised in a protocol there are aspects to carrying out an assessment of capacity and gaining informed consent (or refusal of consent) which are complex. These involve application of knowledge, skills and attitudes which require training and practice. Complexity is increased when decisions about capacity need to be made by treating staff who are not experts in capacity evaluation; are time constrained and whose decision may have serious medical consequences.

IAEM submits therefore that:

- Legislation must take cognisance of the special circumstances of emergency care;
- Clear guidance on capacity evaluation criteria should be included;
- While a patient's rights must be protected, their health and safety must be safeguarded pending resolution of questions about their capacity;
- Staff acting in good faith in such difficult conditions must be legally protected (similar to provisions in Section 5 of the UK Mental Capacity Act).