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A critical appraisal of the impact of Section 3 of the Mental Capacity Act (2005) on the role of paramedics in an emergency: relating specifically to the assessment of capacity

Paramedic's have verbalised uncertainty on how to proceed when treating unwell patients who refuse treatment, stating that they feel ill equipped to interpret situations when patients refuse treatment. They expressed a need, to be formally trained in how to systematically, yet quickly, assess a patient's capacity, rather than relying on intuition or opting out with the 'take them to hospital' approach, as they report it is better to face the accusation of assault or battery, than allegations of negligence. This article will explore the appropriate mechanisms and approach for the assessment of capacity in emergency situations. Capacity will be defined according to MCA (2005) with an explanation of consent and the particular difficulties faced by paramedics in the assessment of capacity in an emergency will be identified and analysed. Finally, there will be an attempt to explain the 'correct' way to assess capacity, with reference to the MCA, the accompanying Code of Practice.

The English law clearly states that the treatment of a competent patient is unlawful unless the patient consents to it¹. Consent is the legal expression of the principles of self-determination and autonomy². There is no statute specifically on consent; hence legal principles have been established through case law³. Consent must be informed and this is always difficult especially in emergencies. Jackson (2008) states that informed consent is commonly used to describe two legal duties; the duty to obtain the patient's consent before treatment and the duty to ensure that the patient has been adequately informed about the risks and benefits of their therapeutic options. Del Carman (2005) structured informed consent into five areas; disclosure, decision, understanding, capacity to give consent and voluntarism. Consent of the patient will prevent a paramedic from being liable for the tort of battery and Lord Mustill

¹ Re T (Adult: Refusal of Treatment) [1992] 4 All ER 649

² D. Feldman. (2000) 'Human Dignity and Legal Values – Part II' 116 LQR 61, p.67

³ Re C (adult refusal of medical treatment) [1994], Chester v Ashfar [2004] Chatterson v Gershon [1981]

showed this protection in *Airedale NHS Trust v Bland* when he stated:

‘.... bodily invasions in the course of proper medical treatment stand completely outside the criminal law. A competent adult cannot be treated without consent; this protects the patient's autonomy and bodily integrity. Butler-Sloss LJ in *Re T* ⁴ clarifies this matter by stating:

Table 1: Autonomy

The principle of respect for autonomy underpins the requirement for valid consent. Respect for autonomy is one of the four key principles developed by Beauchamp and Childress (2001) and acknowledges the right of persons to determine how to live their lives, make their own choices in life and reach self-fulfillment. Scanlon defined autonomy as: ‘To regard himself as autonomous...a person must see himself as sovereign in what to believe and in weighing competing reasons for decision’s.

Valid consent to treatment should be given voluntarily. Even if sufficient amount of information is disclosed to the patient, their consent will be invalid if anyone has pressurised them into choosing what they do ⁵. Relatives cannot consent on behalf of patients. Hence, the law is clear that patients must be presumed competent unless proven otherwise and any treatment performed requires valid consent from the patient.

Capacity plays a vital role in determining whether a person can exercise autonomy in making choices in all aspects of life, from simple decisions to far-reaching decisions such as serious medical treatment. In a legal context it refers to a person's ability to make a decision, which may have legal consequences for the person themselves or for other people. The common law ruling to treat incapacitated adults without consent, but in their best interests [*Re F v. West*

⁴ *Re T* [1993] Fam 95

⁵ *Re T* [1984] 1 All ER 1036

Berkshire Health Authority] ⁶stated that doctors have the power, and in certain circumstances the duty, to treat incapacitated patients in their best interests. This case applied *Bolam*⁷; a treatment fulfills the best interest's criteria if it is in line with current competent medical opinion. The legal definition of incapacity at that time remained ambiguous. *Re C*⁸, involving a patient with schizophrenia refusing amputation of his gangrenous leg provided a test for assessing whether a patient has the mental capacity to exercise autonomy and established criteria for incapacity. It emphasised that a patient does not have to blindly accept medical evaluation and can make their own decisions with any consequences. Following much debate related to the need to protect incapacitated individuals, The Mental Capacity Act (MCA) 2005 came into force in England and Wales in 2007

The test for capacity is contained in section 3 of the MCA (2005) as listed in Table 2.

Table 2: Determining Capacity

A person is unable to make a decision for himself if he is unable –

- a. to understand information relevant to the decision,
- b. to retain that information,
- c. to use or weigh that information as part of the process of making the decision, or
- d. to communicate his decision (whether by talking, using sign language or any other means).’

Capacity/ competence is assessed in terms of whether the individual is unable to make a decision as a result of an impairment or disturbance in the functioning of the mind or brain. Indeed, Section 2 (1) of the MCA (2005) provides:

⁶ *Re F v. West Berkshire Health Authority*

⁷ *Bolam v Friern Hospital management Committee* [1957] 1 WLR 582; [1957] 2 All ER 118

⁸ *Re C (Adult: Refusal of treatment)*, *Re* [1994]1 WLR 290; [1994] 1 All ER 819

"[F]or the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain".

The MCA (2005) fully implemented in England and Wales in October 2007, provides a statutory framework for dealing with individuals who may lack the ability to make decisions regarding their treatment, welfare or finances as detailed in by Jones (2005a) who states that *'It covers a wide range of protocols pertaining to, among other things, court powers, advance decisions, independent advocacy and powers of attorney. At its heart the legislation is concerned with preserving the autonomy of the individual as far as possible whilst allowing protection and care to be provided in the best interests of those who are unable to make their own decisions'*

The Act is accompanied by a detailed Code of Practice (CoP hereafter), designed to assist clinicians and health professionals to ensure that capacity is properly assessed; decisions on behalf of those lacking capacity are made in their best interests; and to provide legal protection for those responsible for such decisions. The tenets of the MCA are based on common law principles established in key landmark legal rulings and several resultant consultation papers by the Law Commission.⁹ In the early 1990's a number of difficult cases arose that highlighted a gap in legislation for determining when an adult was incapacitated and how he or she should be treated if found to be incapable of making a decision. Against the background of the European Convention on Human Rights (ECHR) and an increasing focus on the rights of the individual, respect for personal autonomy has become the predominant governing principle in health care law (Gunn, 1994, p.8). This is the case so long as the individual retains the capacity to make a decision about his or her treatment.

⁹ (No. 129, 1993; No. 128, 1993; No. 119, 1991)

Common law is clear that treating a competent patient involuntarily amounts to the clinician committing a battery (Grubb, 2004, p.161).

The common law principle of necessity dictates that there is a duty of care towards incompetent patients to save life, ensure the provision of beneficial medical treatment or prevent deterioration, or to act in the patient's best interests as determined by prevailing medical opinion (Raymont, 2002). The assessment of capacity is thus of crucial importance in medical decision-making and it is essential that the way it is tested sets a standard that strikes a balance. The MCA and its associated Code of Practice in Section 2(1) describe capacity as functional and its assessment should be based on evaluating the processes a patient uses to arrive at a decision rather than the content of the decision itself: "*What matters is [the] ability to carry out the processes involved in making the decision – and not the outcome*" (CoP, section 4.2).

This could result in dilemmas for paramedics who are faced with numerous challenges which include: Patients are unknown to them, hence their usual state of mind and treatment is unknown; Patients may have had the ambulance called for them, rather than they having initiated the call; It is established that for patients who lack capacity to consent, the paramedic endeavours to treat according to patients best interests under the doctrine of necessity.¹⁰ However, the challenge arises when competent patients refuse treatment, which is potentially lifesaving. Alternatively, a doctor doing a home visit or a relative and not necessarily the patient himself or herself may have called the ambulance. Often, these patients are very ill, yet refuse to be taken to hospital or to accept medical treatment.

This is supported by the following studies: A study by Evans et al (2007) looked at doctors

¹⁰ Eburn, M.(2005) *Emergency law: Rights, liabilities and duties of emergency workers and volunteers*. 2nd ed. Leichardt, NSW: The Federation Press

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. 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. There are also more 3 million ‘emergency patient journeys’ undertaken each year by National Health Service (NHS) ambulances¹¹. A series of cases in the 1990s had held that none of the other emergency services was duty bound to go to the aid of persons in peril¹². Hence, there is a duty to respond to calls for medical attention. However, paramedics have often encountered on some occasions when they have arrived, patients refuse treatment and this has proven an ethical dilemma, which they have verbalised being unsure of how to deal with.

Stark et al¹³ conducted a retrospective, descriptive and analytical cohort study of pre-hospital patient refusal of care over a 6month period. The study found that paramedics left behind patients with potentially impaired medical capacity, due to legal constraints. Police at the scene told paramedics that they would be arrested if they attempted to restrain or transport a patient against their will. Patients were therefore left at the scene often against medical advice. While none of these cases have resulted in legal action against paramedics, litigation against paramedics has increased over the past decade¹⁴. They also identified that further

¹¹ *Ambulance Services, England: 2004–05*, (NHS Health and Social Care Information Centre, (2005) at para 2.3.1.

¹² *Capital and Counties plc v. Hampshire County Council* [1997] Q.B. 1004 (fire fighters), *Alexandrou v. Oxford* [1993] 4 All E.R. 328 (police) and *OLL Ltd v. Secretary of State for Transport* [1997] 3 All E.R. 897 (coastguard).

¹³ Stark et al (2004) Patients who initially refuse prehospital evaluation and /or therapy. *The American Journal of Emergency Medicine*. **8** (6) 509-511

¹⁴ Soler, J.M. et al (1985) The ten-year mal-practice experience of a large EMS system. *Annals of Emergency Medicine*. 14:982-985

studies are needed to address patient refusal. Since this study Selden et al¹⁵ and Goldberg et al in a study on paramedic litigation reported that acts or omission, including failure to transport in cases where patients refuse treatment is a common cause of legal action. Steers outline other difficulties encountered by paramedics in Table 3.

Table 3: Difficulties faced by Paramedics

1. Extreme time pressure, where minutes can make a difference between life and death. The time taken to inform patients, gather information or to check for competency may actually compromise patient welfare.¹⁶
2. Extreme emotion by anyone at a scene, for example, at a traumatic cardiac arrest, affecting the ability to make well-balanced judgements.
3. Informational deprivation, for example, being unable to determine the age or medical history of a patient, or being unable to come to an accurate diagnosis, again making *informed* choices very difficult.¹⁷
4. Resource limitations and demands, where excessive time spent at the scene ties up crews, increases response times and removes paramedics from the pool of resources.¹⁸
5. Conflict at scene, for example, between the patient and relatives or callers and paramedics.¹⁹
6. Impaired judgement on the part of the paramedic due to dangers, inexperience, stress or fatigue from shift work.²⁰

¹⁵ Selden, B.S. (1990) Medical documentation of prehospital triage. *Annals of Emergency Medicine*. **19**: 547-551

¹⁶ Iserson K.V, Sanders A.B, and D. Mathieu (1995) *Ethics in Emergency Medicine*. 2nd ed. Tucson: Galen Press

¹⁷ Beauchamp T.L, & J.F. Childress (2001) *Principles of Biomedical Ethics*. 5th ed. New York: O.U.P;

¹⁸ Deschamp. C.(2000) Scene Times: What is reasonable for paramedic-level *Prehospital care*? *EMS*:96-7.

¹⁹ *ibid*

²⁰ Robinson, R.(2002) Follow up study of health and stress in Ambulance Services of Victoria, Australia Victorian Ambulance Crisis Counselling Unit. Melbourne, Australia.

In some cases it is reasonably clear that a *prima facie* refusal can be ignored. If, for example, a person is assessed as having a significant distortion of perception, mood, thought or memory, and is a danger to self, others or property then the MCA²¹ allows paramedics to use reasonable restraint to treat and transport these patients to hospital for treatment. In these instances patients are considered to lack capacity to provide informed consent. If a patient passes all the tests for informed consent, and refuses, then the paramedic has to balance a respect for the patient's autonomy with a duty to protect life. One way through this difficulty is for paramedics to refer decisions and thus responsibility to emergency physicians via consultation. However, in a recent study²² this strategy was found to be inadequate in increasing the reliability of either accurately recognizing or documenting competency, or more accurately determining if the elements of informed consent had been met – the disadvantages of not being at the scene outweighed any advantages gained from expert involvement. Aside from this, referring to on-line medical command does little to help gain expertise in decision making or advance the move of paramedics into professional ranks, where autonomy is one essential trait.²³ Hence, ensuring paramedics understand how to assess capacity is vital to their role.

The case study in Table 4 and Table 5 explores the principles of capacity as set out in the guiding principles in Section 2(3) of the MCA which clarifies that a lack of capacity cannot be established by reference to a person's age, appearance, and aspect of behaviour or merely by the fact that they have made a decision that is deemed unwise as considered in the clinical vignettes in Table 4 & 5.

²¹ MCA 2005

²² Stuhlmiller DFE, Cudnik MT, Sundheim SM, Threlkeld MS, Collins TE Jr.(2005) Adequacy of online medical command communication and emergency medical services documentation of informed refusals. *Academic Emergency Medicine* 12(10):970-977

²³ Wyatt, A.(March,1998) Towards professionalism – an analysis of ambulance practice. *Australasian Journal of Emergency Care* 5(1);16-20

Table 4: Clinical Vignette 1

An elderly person with terminal cancer has exhausted all treatment options and is under palliative care at the home where the patient has raised a family. There is no available Advanced Health Directive. The patient deteriorates and according to ambulance guidelines meets criteria for treatment and transport. Though very weak, the patient is alert and fully aware that his death is imminent. A distressed relative calls for an ambulance because he/she does not want the patient to die in the family home. A crew arrives to find considerable conflict. Despite phone calls to various persons, including the palliative caregivers, there seems no way to resolve the conflict between the desire of the patient to stay at home and the insistence with some force by the relative to transport the patient to hospital. The crew transports the patient, despite the patient's objections.

Table 5: Clinical Vignette 2

A student paramedic and colleague are called to a young man with no medical history who feels short of breath, but is otherwise quite well communicating the problematic nature of the rhythm, the patient refuses to go to hospital. On examination the patient is assessed to be in supra-ventricular tachycardia. Despite some time spent by the student paramedic Feeling a sense that he is responsible for any significant medical consequence, the paramedic calls the police and the patient, under duress, goes to hospital.

The principles for assessing capacity as outlined in the MCA (2005) are detailed in Table 6 below.

Table 6: Principles for Assessing Capacity

Principle 1: Capacity should always be assumed. A patient's diagnosis, behavior, or appearance should not lead you to presume capacity is absent

Principle 2: A person's ability to make decisions must be optimized before concluding that capacity is absent. All practicable steps must be taken, such as giving sufficient time for assessments; repeating assessments if capacity is fluctuating; and, if relevant, using interpreters, sign language, or pictures

Principle 3: Patients are entitled to make unwise decisions. It is not the decision but the process by which it is reached that determines if capacity is absent

Principle 4: Such decisions must also be the least restrictive option(s) for their basic rights and freedoms

Principle 5: Best interests – anything done for or on behalf of a person who lacks capacity must be done in their best interest.

Hence, treatment provided to patients who lack capacity must be given in their best interests, as determined by the treating clinician. This is to reinforce to paramedics the importance of understanding the guiding principles of the MCA (2005) and that if, despite this, a patient who has been determined as having capacity still refuses treatment, then his or her decision should be respected²⁴. In English law there is no mechanism by which a relative or friend can make the decision lawfully on an adult's behalf²⁵.

Sections 2 and 3 of the Act set out a two-stage process for testing capacity. The first stage checks the inclusion criterion that the person must be suffering from an impairment or disturbance to his mental functioning, whether this is temporary or permanent (CoP, section 4.11). Only if this criterion is fulfilled does assessment proceed to the second stage, which stipulates that for a person to come under the powers of the Act, the impairment of mental functioning must be causing an inability to make the relevant decision. Examples of such impairment include delirium, coma, severe brain damage, dementia and severe learning

²⁴ General medical Council (1998) *Seeking patient's consent: the ethical considerations*. London.GMC

²⁵ The old *parens patriae* jurisdiction permitted the court to consent on behalf of an adult patient but this was abolished under the Mental Health Act 1959. Hornett makes it clear that a power of attorney could not be used to authorise proxy healthcare decisions, see S. Hornett, 'Advance Directives: A Legal and Ethical Analysis' in J. Keown (ed), *Euthanasia Examined* (Cambridge: Cambridge University Press, 1998), p.303

difficulties and these are discussed in Table 7.

Table 7: Factors that Impair Mental Functioning

Delirium, which is a common source of incapacity in hospitalised patients, conspicuously affects a person's decision-making ability by altering cognition and disrupting thought processes to render the actions and utterances of the person incomprehensible (Raymont, 2002). The severe cognitive impairment typical of advanced dementia is perhaps the classic example of a clear indication that a patient may lack capacity (Kim et al., 2002; Nygaard et al., 2000). Capacity may also be impaired by external factors that have only a temporary effect. Shock, confusion, sedation, fatigue, panic, pain and medication may all potentially undermine capacity by diminishing the person's ability to take in information or engage in a coherent process of decision-making (Grubb & Laing, 2004, para 3.91).

The above problems are commonly encountered by paramedics in clinical practice as mentioned in previous studies highlighted earlier.

A necessary requirement for capacity is that one understands and retains the information relevant to the decision. This includes having an awareness of the purpose of the treatment, an idea of what it will involve and the consequences of deciding to receive or refuse the treatment, or of not making a decision at all (Ashton et al., 2006, para 2.57). Every appropriate effort must be made to assist in communicating this information to the patient. These criteria aim to minimise the gap between potential and actual understanding so that the patient is able to participate in the decision-making process to the best of his abilities (Gunn, 1994, p.18).

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