COUNTIES MANUKAU HEALTH

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NAME:_____ NHI:_____

GENDER: ____ DOB_____ AGE:_____ WARD:_____

Assessing competence in non-consenting patients

SDate: _____

This guideline is for decision-making when considering treating and/or detaining a patient who is refusing treatment.
First read the explanatory notes overleaf and then follow these 3 steps.

STEP 1 Beneficence

Is there good clinical reason to provide treatment / care, to prevent a likely or possible harm befalling the patient, or to make the patient better?

☐ **NO:**
Treatment not indicated, treatment should not be provided

☐ **YES:**
Go to the Step 2

STEP 2 Autonomy

Is the patient 'competent' in relation to the following three components of autonomy: *knowledge / understanding / freedom*?

1. Knowledge: *Does the patient know enough?*
   a) Is the patient informed of the problem, the options to address the problem and the pros and cons of the options? This step requires you to explain these things to the patient.

   ☐ **Explanation given**

2. Understanding: *Can the patient think enough?*
   Does the patient understand the problem, the options to address the problem and the pros and cons of the options? Ask the patient to explain back what he/she understands.
   a) Reduced level of consciousness to point of not hearing information, or not able to express a view?

   ☐ **Yes = Not competent** ☐ **No = Competent**

   b) Level of intoxication: Intoxication does not mean someone is incompetent, a patient may belligerently refuse to partake in such a conversation yet still understand. Do you believe that the patient does not understand because the patient is too disorientated / confused (for whatever reason)?

   ☐ **Yes = Competence is unlikely** ☐ **No = Competent**

   c) Reasoning: This question gives an opportunity to *mitigate* and *negotiate*, so that the reasons for the patient's refusal might be addressed and then the patient might willingly consent (e.g., *"Okay, I understand you need to go home to see your girlfriend. Can we call her and ask her to come in here?"*)
   After exploring understanding ask: "*Can you tell me why you are choosing to refuse treatment?*" Can the patient give a reason (i.e., *"I am doing this because…"*)?

   ☐ **No = Not competent** ☐ **Yes = Competent** – Implies rational thought, i.e., able to think enough

3. Freedom: *Is the patient free enough?*
   Suicidality causing self-harm is usually considered a coercive influence undermining an individual's free autonomy. In that context the patient might not have the competency to refuse treatment. Rarely there might be other coercive influences and the question mentioned above regarding *reason* might reveal such influences.

So, is the patient competent in relation to the three components of autonomy?

☐ **NO:**
There is good reason to believe that the patient is **NOT competent** in relation to any of these autonomy components
Proceed to Step 3

☐ **YES:**
The patient seems to know enough, be thinking enough, and is free enough
Competence should be assumed, refusal of care should be accepted
NB: It might be important to have further discussion to ensure the patient is well informed and to discuss alternative acceptable options.

STEP 3 Concordance

This far: it is considered that there is good clinical reason to provide care AND good reason to believe the patient is not competent.

Consider: if the patient was able to adequately express his true autonomous wishes (competent), is it likely that the patient would consent to the treatment suggested?

☐ **YES:**
Patient would likely consent to treatment, if competent and able: **Treatment should be provided**

☐ **NO:**
Patient is unlikely to consent to treatment, even if competent and able: **Treatment should not be provided**

FINALLY:
1. Re-read the notes on page 2
2. Go through the steps again if in doubt
3. Document well in the clinical notes

Assessment by:

Name	Signature	Designation	Time

ASSESSING COMPETENCE IN NON-CONSENTING PATIENTS

Background notes for the assessing competence in non-consenting patients

Read and understand these notes when applying the steps of the guideline.

Three foundation points

1. Patients have a right to refuse treatment, no matter how important that treatment might seem to the clinicians. However, under certain circumstances explicit or apparent refusal of care might be over-ruled and treatment provided. These circumstances often involve impaired patient 'autonomy' – often called 'incompetence' or 'lack of decision making capacity.'
2. Autonomy includes (among other things) these three key competencies:
   a) knowing enough (being sufficiently informed),
   b) thinking enough (cognitive ability), and
   c) being free enough (not being forced into a decision)
3. Providing treatment without consent is ethically justified – and should have legal authority if **ALL** of the following three elements are present:
   a) There is good clinical reason to provide treatment.
   AND
   b) There is good reason to believe the patient is not able to express his true autonomous wishes because the patient doesn't know enough, can't think enough or isn't free enough.
   AND
   c) There is good reason to believe that, if the patient was able to adequately exercise his true autonomous wishes, the patient would consent to the treatment suggested.

Three final key points

1. Such decision making isn't black and white. Discuss with (senior) colleagues.
2. The provision of treatment should be by the least freedom restricting method that works, with the following being an indicative 'ladder' of options. It is expected that each step will be entertained, albeit briefly in some circumstances, before going to the next:
   a) Reassurance – *"It's okay, we're doctors and nurses, we'll look after you…"*
   b) Bargaining – *"Sit down and we'll have a look at that wound and then…"*
   c) Threats – *"We'll have no choice but to call security if you…"*
   d) Medical symptom management (analgesics, anxiolytics, sedatives)
   e) Physical restraint
   f) Medical sedation / anaesthesia
3. Documentation is very important and the 'ABC' format might be used:
   A. Autonomy – what is the proof of deficient competence?
   For example: *"Unable to understand or repeat anything I told him. Clearly confused, disorientated in place and only speaking in grunts / groans / prophanities."*
   B. Beneficence – what is the clinical need for treatment?
   For example: *"Nature of injury and subsequent increasing agitation could represent extradural haematoma. Urgent CT scan indicated."*
   C. Concordance – does the outcome match 'A' and 'B'?
   For example: *"Autonomy impaired, worried re EDH. I believe he would consent to CT scan if autonomous, therefore restrained, sedated and escorted to CT."*

Adapted from: Ardagh, M. (2015) Ethics in Emergency Medicine: An Ethics Toolkit for the Emergency Department. In P. Cameron, G. Jelinek, A-M. Kelly, A. Brown, M. Little (Eds.) *Textbook of Adult Emergency Medicine* (4th ed., Chapter 25.5). Edinburgh: Churchill Livingston
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