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Review

Emergency surgery on mentally impaired patients: standards in consenting

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Abstract

Emergency surgery is often performed on the elderly and susceptible patients with significant comorbidities; as a consequence, the risk of death or severe complications are high. Consent for surgery is a fundamental part of medical practice, in line with legal obligations and ethical principles.

Obtaining consent for emergency services (for surgical patients with chronic or acute mental incapacity, due to surgical pathology) is particularly challenging, and meeting the standards requires an up-to-date understanding of legislation, professional body guidelines, and ethical or cultural aspects.

The guidance related to consent requires physicians and other medical staff to work with patients according to the process of 'supported decision-making'. Despite principles and guidelines that have been exhaustively established, the system is sometimes vulnerable in actual clinical practice.

The combination of an 'emergency' setting and a patient without mental 'capacity' is a challenge between patient-centered and 'paternalistic' approaches, involving legislation and guidelines on 'best interests' of the patient.

Keywords : emergency surgery, consent, mental capacity, standards

Highlights

- ✓ Consent for surgery is a fundamental part of medical practice, and this is a significant challenge regarding emergency patients when (chronic or acute) mental incapacity is present.
- ✓ This article brings an update in terms of legislation, professional body guidelines, and ethical or cultural aspects.

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Introduction

Emergency surgery is often performed on elderly patients and those with significant comorbidities; as a consequence, the risk of death or severe complication is high. Consenting to treatment (including surgery) is a fundamental part of medical practice, in line with legal obligations and ethical principles.

The need for patient consent is generally established in international human rights law along with consequences for neglecting this 'duty of care'. For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision about treatment. However, the interpretation of gaining consent in practice may vary widely.

In emergencies involving surgical patients with chronic or acute mental incapacity (due to the surgical pathology), obtaining consent is challenging, and meeting the standards requires an up-to-date understanding of legislation, professional body guidelines, and ethical or cultural aspects.

What then are the standards for consent? What could be considered 'good practice'? And where are the 'grey' areas in actual clinical practice? In particular, what should happen with the most vulnerable patients – those who lack the capacity to give consent?

This article focuses on the guidance given by leading medical bodies in the UK - the National Health Service (NHS), the Royal College of Surgeons (RCS), the British Medical Association (BMA) and N.I.C.E (The National Institute for Health and Care Excellence) - as the source for answering these questions. In doing so, the authors are not declaring that this guidance is the best available; however, it is guidance that is regularly monitored and updated, clearly considering patients who lack mental capacity.

Discussion

- Consent

The foundation principles underlying any good practice standards are stressed unanimously as: showing respect for human life; making patient care the first concern; treating patients as individuals and respecting their dignity and decisions; giving patients the information they want or need in a way they can understand, including options, risks, and benefits of a treatment; and working with colleagues in a manner that best serves the patient's interests (1, 2).

The guidance on consent begins from the stand point that the objective is to work with patients through a process of 'supported decision-making'. As already stated, for consent to be valid it must be given by a person with the capacity to make the decision in question, voluntarily done and from an informed standpoint (based on appropriate information) and, for more complex treatment, be confirmed in writing (3). In addition to informing the patient about what is involved in any specific treatment, along with its benefits, the GMC (4) requires doctors to also tell patients about 'significant', unavoidable, and frequently occurring risks. Furthermore, the healthcare professional has a responsibility to answer honestly any other questions/ concerns the patient may have. When the patient does not want to know about these options, basic information should still be provided, and it must be formally noted that the patient has refused information.

- Capacity

Since consent can only be gained from a patient who has the capacity to make a decision about treatment, how then is 'capacity' assessed? What is the procedure for patients who lack the capacity to comprehend their situation and/or what they are being asked to consent to, or where there is no time to ask the patient's representative for consent (emergency situations)?

The Mental Capacity Act (5) outlines five "statutory principles" that aim to guide assessment and decision-making of patient capacity. These are:

1. Adults are assumed to have capacity unless shown otherwise;
2. All practical steps must be taken to help an individual make a decision;
3. A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision;
4. An act done or decision made on behalf of a patient who lacks capacity must be done in their 'best interests',
5. It must be done in the least restrictive way.

'Capacity' is defined as: The ability to make a specific decision at a particular time. This definition relies on the patient being able to understand the information relevant to the decision; retain the information long enough to be able to make the decision; use or weigh the information; and communicate the decision by any means.

If an individual is unable to do any one of these, then he or she is deemed to lack decision-making capacity in relation to the specific treatment under discussion (6). Therefore, capacity might be affected in chronic or acute conditions.

The Care Quality Commission (7) estimates that around 2 million people in England and Wales may lack the capacity to make certain decisions for themselves at some point due to illness, injury, or disability. The Independent Mental Capacity Advocacy Service in their

7th annual report states that 13,301 referrals were received in 2013/14, more than double the number in 2007/2008 (the majority of referrals - 64% -were for adults aged 66 and over). The most common mental impairments associated with a referral to the Independent Mental Capacity Advocacy service were dementia (42%), learning disability (20%), and mental health problems (13%).

- 'Best Interests' Guidelines

The RCS, GMC and BMA (3, 4, 8) all state that overall responsibility for assessing capacity remains with the health professional proposing the treatment (not with mental health experts) and outlines ways in which this can be achieved: People working with or caring for adults who lack capacity to make decisions for themselves have a legal duty to consider the Mental Capacity Act Code of Practice (9). If a patient has made an 'Advanced Decision' or authorized a 'Power of Attorney' or 'Court Appointed Deputy' to legally act on their behalf in circumstances where they lack capacity, then these must be followed by the health care professional.

However, 'where an adult has no one to make a decision on his or her behalf, treatment can be provided where it is both necessary and in the patients best interests – a 'best interests' decision' (2). There are still other factors to take into consideration in this situation, such as the extent of the patient's ability to participate, now or in the future, and any past/present wishes/feelings/beliefs and values expressed by or known to be held by the patient. Although it is considered good practice to involve people close to the patient to better establish these factors, they do not have overriding authority to determine what is in the patient's best interests (unless they have been legally appointed to do so). The RCS and GMC also recommend discussion with colleagues who may have worked closely with the patient or who have particular expertise in assessing mental capacity. Despite these measures, 'best interests' is not strictly defined. In situations where there is serious doubt or dispute about what is in an incapacitated person's best interests, guidance is to consult legal advice, or even refer the case to the Court of Protection for a ruling (The legal body overseeing the operation of the Mental Capacity Act).

When an emergency arises in a clinical setting, such as patients who are admitted to a hospital unconscious, and it is therefore not possible to find out a patient's wishes, the patient can be treated without consent, provided the treatment is immediately necessary to save the life or to prevent a serious deterioration of their condition. The treatment provided must be the least restrictive of the patient's future choices – in their 'best interests' (10). For as long as the patient lacks capacity, ongoing care should be provided based on treating the patient as an individual, with respect and dignity, and in line with what is known about the patient's wishes and preferences. If the patient regains capacity while in the physician's care, he/she should be told what has been done, and why, as soon as the patient is sufficiently recovered to understand (3, 4).

- Clinical practice

The presence of guidelines and indeed, legislation, is not however a guarantee that standards are adhered to in practice. In 2016, N.I.C.E drafted guidelines (expected to be published in 7/2018) (11) re: Supporting decision-making for people who may lack mental capacity. The foundation for these new guidelines has been the House of Lords Select Committee on the Mental Capacity Act post-legislative scrutiny report, 2014. This report found that the Mental Capacity Act is not widely and adequately implemented. In particular: the 'empowering ethos' of the Act; the prevailing culture is one of risk aversion and paternalism; the wishes, thoughts, and feelings of the person are not routinely prioritized. The Select Committee report suggests a general lack of awareness of the provisions of the Act, as well as of the rights and responsibilities of different stakeholders as conferred under the Act. In addition, the element of sufficient time to devote to undertaking the task of gaining consent meaningfully is a real issue for practitioners under increasing pressure'.

Despite principles and guidelines being exhaustively established, the system is still vulnerable in practice. An important legal case brought by a patient against a health board in the UK affirmed that: 'doctors are no longer the sole arbiter of determining what risks are material to their patients. They should not make assumptions about the information a patient might want or need but they must take reasonable steps to ensure that patients are aware of all risks that are material to them' (12). This ruling should also be valid for those patients who lack decision making capacity at the point of treatment.

One of the really challenging questions is the extent to which a person's capacity must be impaired before he or she loses their right to make a decision. 'Capacity' is not an absolute and clear concept and assessing it can therefore be complex and uncertain. It is still subject to

opinion and therefore may be disputable in some cases. If a patient's incapacity is permanent rather than temporary, chronic or an acute deterioration, previous or in relation to the surgical pathology, it can affect decision making with regard to treatment.

The combination of 'emergency' setting and a patient who lacks 'capacity' is a challenge between patient-centered and 'paternalistic' approaches. Legislation and guidelines state that the physician has overall responsibility to make a decision in the 'best interests' of the patient, but in so doing has to consider evidence from a potential range of sources: any prior intentions or wishes expressed or 'implied' by the patient due to cultural beliefs and values and contributions from other professionals involved with and/or relatives of the patient. It also follows that, as with consenting patients, the physician still has the responsibility to inform those close to the patient and/or acting on their behalf of any 'significant', unavoidable and frequently occurring risks that might arise from treatment/surgery and to answer honestly in as much detail as requested any questions or concerns they might have. However, in practice, this is not always feasible given the time restrictions imposed by the urgency of the pathology, thus creating a potential dilemma for the surgeon. In addition, it could be argued that the more people involved in the process, the more room for confusion.

Conclusions

In the end, it is the surgeon who, more often than not, has ultimate responsibility in practice with emergency surgical patients with impaired mental capacity and who has to act in what is considered the patient's ′best interest′.

However, the view of ′best interest′ clearly might vary. In practice, problems tend to arise only when there is a negative outcome as a result of the action taken. It is then when 'best interest' is more likely to be disputed retrospectively. In these situations, especially, it is important to realize that best practice is not always synonymous and should not be confused with a good result. Since patient consent is rarely gained in this scenario and best interest may always be open to debate, it is possible (and probable) that it remains a grey area until disputed in court and then legally made black and white.

- **Definitions**

Power of Attorney: a legal document appointing one or more people selected by the patient (known as 'attorneys') to help or to make decisions on behalf of the patient not having mental capacity to do so at that time.

Court Appointed Deputy: appointed by the Court of Protection to make decisions for someone who is unable to do so on his/her own. They (the 'Deputy') are responsible for making these decisions until either the person in their charge dies or is able to make decisions on his/her own again.

Advanced Decision: a decision made in advance (written) to refuse a specific type of treatment at some time in the future. It is legally binding.

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