Lesson of the week

Managing patients with deliberate self harm who refuse treatment in the accident and emergency department

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Increasing numbers of patients attend the accident and emergency department after an episode of deliberate self harm,[1] and an appreciable proportion of them refuse urgent medical treatment. Conflict may then arise between a doctor who considers a particular treatment vital and the patient who refuses to consent to it. The doctor has complex clinical, ethical, and medicolegal issues to consider. There are no published data on how doctors in accident and emergency departments in the United Kingdom currently manage these difficult cases. We used a case scenario and developed a questionnaire to investigate how doctors in accident and emergency departments in the Trent region would manage such a situation.

Method

A scenario was constructed in which a woman who had taken a potentially life threatening drug overdose was brought to an accident and emergency department (box). A series of statements based on essential, decision making steps in her management was developed, and closed questions were used to determine what course of action doctors would take. The scenario and closed question interview style were designed to minimise any misinterpretation. Each of the four interviewers was given specific instructions on the use of the questionnaire and interview technique.

Participants

All 14 accident and emergency departments in the Trent region with at least one consultant in accident and emergency medicine were identified from the 1996 directory of the British Association for Accident and Emergency Medicine.[2] All doctors working in these departments were identified and contacted by telephone. The study was explained to them, and they were asked if they wished to take part. Arrangements were made to telephone at another more convenient time if necessary. Altogether 104 doctors were invited to participate, and all agreed to do so. The resulting convenience sample of duty senior house officers, middle grade doctors (training and non-training grades), and consultants from accident and emergency departments was representative of accident and emergency doctors in the region. Teaching and district general hospitals serving both urban and rural populations were represented.

Completing the questionnaire

The scenario was read out slowly to each doctor. They were encouraged to write down any details they wished. Several statements on the possible management of the case were then read to the doctors, and they were asked to agree or disagree with each statement. Doctors who stated that they would assess the mental capacity of the patient were asked to list the factors which they would include in this assessment. Finally the interviewees were questioned about what their present practice was based on. Five choices were given, and doctors were encouraged to provide any others. At the end of the interview the doctors were asked not to discuss the scenario with their colleagues.

Medical defence organisations

A copy of the questionnaire was sent to two medical defence organisations (the Medical Defence Union and the Medical Protection Society) for evaluation. They were asked to comment on what advice they would give if presented with such a scenario. The responses given were consistent and acted as model answers. The responses given by doctors were then compared with this model answer.

Results

Altogether 104 of 200 doctors (52%) working in accident and emergency departments in the Trent Region in July 1997 completed the study; 60 (58%) stated that they had been faced with between 1 and 10 similar cases in the previous six months. Respondents comprised 18 of 30 consultants (60%), 26 of 50 middle grade doctors (52%), and 60 of 120 senior house officers (50%). The three groups did not differ in their responses. Of the 80 doctors who correctly stated that they would have assessed the patient's capacity for consent, only 8 (17%) of the senior house officers, 10 (46%) middle grade doctors, and 10 (91%) of the consultants were able to provide at least two of the three essential components in assessing capacity.[3] Forty three doctors (41%) would have incorrectly detained the patient against her will (table). Of these, 28 (65%) would have performed a blood test and 19 (44%) would have performed gastric lavage.

In the final part of the interview, doctors were asked what their current practice for managing these patients

Failure to assess adequately a patient's capacity to refuse treatment may have serious medicolegal consequences

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Case scenario

- A 19 year old woman attends the accident and emergency department. She claims to have taken approximately 20 paracetamol tablets and some 30 amitriptyline tablets about an hour previously. The recommendations of the local poisons centre is for immediate gastric lavage and charcoal therapy.
- The woman has been brought in by a friend. She has not vomited. She has no history of deliberate self harm, is not intoxicated, and is fully alert. She states that her friend convinced her to come and that she still wishes to die.
- She expressly refuses any form of investigation or treatment despite requests from medical and nursing staff as well as her friend. No other family members are available.
- How would you manage this patient?

Questionnaire statements on management decisions in relation to the patient in the scenario, model answers from medical defence societies, and number (percentage) of study respondents giving model answers

Statement	Model answer	No (%; 95% CI) of respondents giving model answer
1 A psychiatrist deems the woman to be mentally competent and fully aware of her situation, but you would forcibly detain her under common law (applied to all respondents)	Disagree	61/104 (59; 49 to 68)
2 You would first assess the patient's capacity for consent/refusal of treatment before applying common law (applied to all respondents)	Agree	80/104 (77; 68 to 85)
3 You would investigate the patient against her will, but in her best interests, by measuring her paracetamol/salicylate concentration every 4 hours (applied to doctors who agreed with statement 1)	Disagree	15/43 (35; 21 to 51)
4 You would, against her will, but in her best interests, treat her by performing gastric lavage and giving charcoal therapy (applied to doctors who agreed with statement 1)	Disagree	24/43 (56; 40 to 71)

was based on. All three groups relied predominantly on their experience of working in accident and emergency medicine (97 doctors (93%)) and a philosophy of providing the best possible medical care (96 doctors (92%)). Fifty eight doctors (56%) followed departmental guidelines. One consultant reported a specific interest in that a patient was bringing a claim against his NHS trust for assault in similar circumstances.

Discussion

Assessment of capacity to refuse treatment

All doctors, but particularly those working in accident and emergency, must know how to proceed when dealing with a patient who refuses essential medical treatment. Faced with such a situation, doctors must balance the necessity of emergency medical treatment and their duty of care against the patient's autonomy based on his or her capacity. The issue of capacity is crucial as it determines if the patient is competent to make a valid decision over refusing treatment.

Although our scenario was hypothetical, it was plausible. Fifty eight per cent of doctors taking part in the study stated that they had been faced with a similar situation in the six months before the interview.

A competent adult patient has the right to withhold consent to examination, investigation, or treatment even if such a decision is likely to result in death. This right to self determination takes priority in law over the duty of care that the doctor feels obliged to practise.[4] It is essential, therefore, that doctors are able to assess capacity using established criteria (box) set out by the Law Society[3] and the BMA[5] and agreed to by the defence organisations.[6 7]

An irrational decision in itself does not compromise capacity;[8] it is the process by which the patient arrives at their decision, rather than the decision itself, which is the central factor in determining capacity. Of doctors who stated that they would assess capacity in our study, only 15% could provide even two of the three factors given in the box.

In some circumstances, the assessment of capacity may be compromised by coexisting illness, drugs, or alcohol. The more serious the situation and the potential threat to life, the greater the capacity required by the patient to make that decision.[8]

Assessing capacity

To show that they have the capacity to refuse treatment, patients:

- Must be able to understand and retain information on the treatment proposed, its indications, and its main benefits, as well as possible risks and the consequences of non-treatment
- Must be shown to believe that information
- Must be capable of weighing up the information in order to arrive at a conclusion

How should doctors proceed?

A psychiatric opinion is essential at an early stage to determine the presence of any mental disorder and the resulting impact on the patient's capacity. After psychiatric evaluation the patient may be detainable under the Mental Health Act,[9] although the presence of mental illness in itself does not automatically render the patient incapacitated.[10] If the overdose is considered to be a consequence of a mental disorder then the patient can also be treated medically for the overdose under the terms of the Mental Health Act. However, treatment is to be instituted only under the direction of the patient's responsible medical officer—that is, the psychiatrist taking care of the patient.

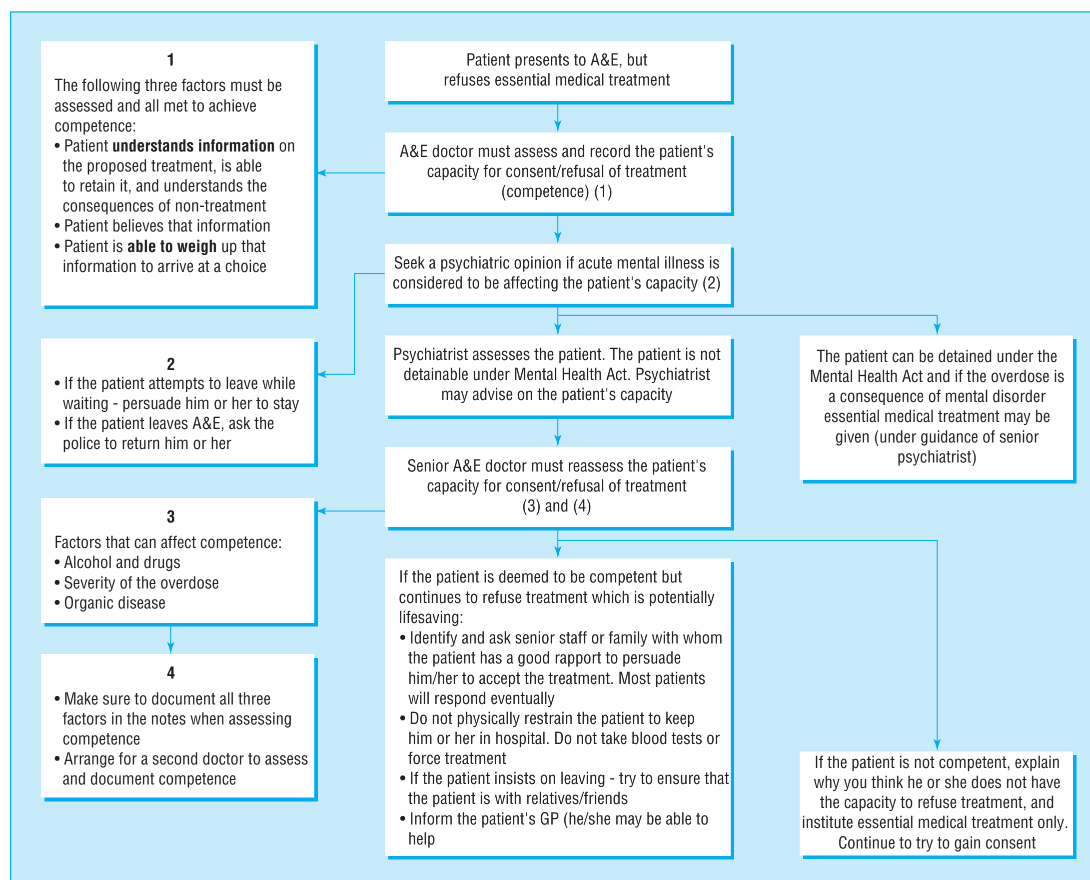
In our scenario, over 40% of doctors interviewed agreed that if the patient were deemed to be mentally competent they would still detain her under common law. Common law is not based on parliamentary statute, but on the decision of the court in deciding previous cases. It clearly sets out the principles of assessing capacity, providing necessary treatment, and defining a doctor's duty of care. This term—common law—is often poorly understood. In this study most doctors said they would assess the patient's capacity for consent or refusal of treatment before detaining them under common law, but only a few doctors could recall the criteria involved in making this assessment.

Nearly half of doctors who would have incorrectly detained such a patient would have gone on to do a blood test against her will, but "in her best interests," while one in three would have performed gastric lavage. In practice, this could amount to charges of battery, and has potentially serious consequences.

The non-competent patient: how to proceed

A patient who is not competent may be judged to be either permanently or transiently non-competent. If, after assessment, the patient in our scenario did not fulfil the criteria for competence, she would be judged transiently non-competent, and only that treatment considered essential to preserve her life should be given.[3] If a patient is deemed permanently non-competent, doctors may provide treatment considered to be in the patient's best interests, and not just that required to save life or limb.[4]

Obtaining the opinion of a second senior doctor is recommended. Clear and detailed documentation is essential. Although there is no legal necessity, it is wise to discuss the proposed treatment with the patient's relatives (if they are present) and continue to try to gain consent. In practice, patients can often be persuaded to accept treatment by medical and nursing staff or relatives and friends. However, they must not be coerced into doing so.[5]



Algorithm for managing patients admitted to accident and emergency (A&E) departments after deliberate self harm who refuse essential treatment

The competent patient: how to proceed

In patients considered competent, the decision regarding capacity to refuse treatment must have been made by a senior doctor. This must take into account the effect of physical as well as mental illness, alcohol, and any drugs which have been taken.

If, despite full and clear explanations of treatment and the consequences of non-treatment, the competent patient continues to refuse treatment, it is essential to maintain a supportive approach. If the patient has given consent for family and friends to attend, their support may be invaluable at this stage. The patient should be allowed to discharge himself or herself from the department, and it should be clearly explained to them that their current refusal of treatment in no way precludes further assessment if they wish it.

Decisions on how to proceed in these cases are often made at short notice by the doctor on duty in the accident and emergency department. It is important that all cases are managed in a consistent manner. The algorithm (figure) will allow doctors working in accident and emergency departments to follow a pragmatic and legal pathway in managing these patients. It attempts to balance the principles of the doctor's duty of care against the rights of the competent patient.

Conclusion

An appreciable number of doctors at all levels of seniority would have contravened the existing legal rights of the patient in our scenario had they been dealing with a real patient. This could amount to charges of battery. In managing these difficult cases, it is important to involve a senior doctor and a psychiatrist. Doctors must also be fully conversant with the law on assessing the capacity to consent to treatment, and its application. If there is any doubt about how to proceed, doctors should seek advice from their defence organisation. Guidelines and policies agreed with the hospital's solicitors constitute good risk management.

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