Informed Consent and Assessing Decision-Making Capacity in the Emergency Department

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When the patient is a minor, the general rule is that informed consent must be obtained from a parent before a physician may proceed with nonemergency treatment. However, EMTALA (Emergency Medical Treatment and Active Labor Act) permits a physician to evaluate every patient, including minors, to assess whether an emergency medical condition exists and to stabilize any such condition. Many exceptions exist to the general rule of parents consenting for their minor children. For example, a minor may have the ability to consent to treatment of sexually transmitted diseases or drug addiction. These exceptions vary from state to state, however, so it is important to be familiar with the local laws where you practice.

Today, in the absence of a recognized exception to the requirement for informed consent, failure to obtain consent properly may also result in liability under the legal theories of privacy or negligence. In the emergency department (ED), we often find ourselves in circumstances in which the so-called emergency exception applies. The emergency exception states that consent is implied in cases in which an immediate threat to the life or health of the patient exists, when the proposed treatment is necessary to address the emergency condition, and when one is unable to obtain express consent of the patient or someone authorized to consent on the patient’s behalf. In these instances the EP may presume that the patient would consent to the emergency treatment, and the EP does not need to obtain express consent before proceeding with treatment.

ELEMENTS

To satisfy the requirements of informed consent, three elements must be met. First, the physician must provide the patient with adequate disclosure of information to enable the patient to make an informed decision. Second, the patient's decision must be voluntary. Finally, the patient must have the capacity to make the decision.

The scope of information to be disclosed is well established in theory but challenging in practice. The physician must disclose (1) the nature of the disease or problem and the nature and purpose of the proposed treatment or procedure; (2) the potential benefits and risks associated with the proposed treatment or procedure, as well as the likelihood that they will occur; and (3) alternative approaches, as well as the benefits and risks of such alternatives.

Fulfillment of the disclosure element in the ED poses several challenges. For example, the time for patient-physician...
interaction is often limited in the ED. In addition, a quiet and private setting for discussion is often unavailable. Furthermore, the EP is typically working with limited knowledge about the full scope of the patient’s medical history, intellectual capabilities, and emotional state. It is the EP’s responsibility, however, to minimize the impact of these challenges and to provide information that will maximize the likelihood that the patient will participate effectively in the decision-making process.

The second element, that consent must be given voluntarily, is not as well delineated in the medical literature or by the courts. Although it is obvious that outright threats or forced treatments violate this tenet, there are subtle ways in which a physician may coerce a patient into making a decision that are also unacceptable. For example, if a physician tells a patient that pain medicine will be withheld until the patient agrees to undergo a computed tomography (CT) scan, the voluntary nature of the patient’s decision will be compromised. Additionally, the physician cannot withhold or distort information to alter a patient’s decision. The physician must present information in a way that aids the patient in making the decision and leaves the patient feeling that he or she has an actual choice in the matter.

The final element—and the focus of the remainder of this chapter—is that the patient must possess decision-making capacity. Decision-making capacity refers to a patient’s ability to participate in and make a meaningful decision regarding diagnosis and treatment. The treating physician must determine whether the patient is able to make a specific decision regarding his or her medical care. However, the physician must start with the presumption that an adult patient has the capacity to give informed consent and, absent evidence to the contrary, health care decisions should be deferred to the patient. If the physician determines that the patient lacks the capacity to make medical decisions, the physician must then determine how to proceed. If the patient has specifically expressed health care wishes through an advanced directive, these wishes should be honored. Similarly, if the patient has designated an individual to make health care decisions for him or her, that person should be contacted to make decisions on behalf of the patient. In other instances, family members should be contacted to help make health care decisions.

Although psychiatric consultation may be helpful in assessing decisional capacity in patients, it is not required. Formal legal procedures also exist to assist in the determination, but evaluations of capacity are routinely made without recourse to the court system. The process is usually performed solely by the treating EP in the ED. Indeed, the EP assesses decision-making capacity as part of routine interactions with every patient treated.

**DECISION-MAKING CAPACITY**

*Decision-making capacity* is a clinical term that is specific to the particular medical decision at issue. If the physician determines that the patient lacks decision-making capacity, the patient can be denied the right to make meaningful decisions regarding his or her medical care.

To possess decision-making capacity, the patient must exhibit the following four abilities: (1) to communicate a choice, (2) to understand relevant information as it is communicated, (3) to appreciate the significance of the information to his or her own individual circumstances, and (4) to use reasoning to arrive at a specific choice. When patients cannot demonstrate these abilities, they lack the capacity to give informed consent for their medical care.

In all instances the physician must balance the interests of protecting the patient from harm while respecting patient autonomy. The level of scrutiny that a physician applies to evaluating capacity therefore varies depending on the decision to be made and the risks and benefits of the proposed medical care. For example, if a patient with a superficial abrasion refuses the application of a bandage, the EP should exercise a very low level of scrutiny when assessing the patient’s capacity to make decisions. If the same patient, however, refuses a CT scan after head trauma with prolonged loss of consciousness, the EP should scrutinize the patient’s capacity at a much higher level. This general approach to evaluating decision-making capacity is often referred to as the sliding scale model. Determination of capacity can be made only with reference to the particular facts surrounding an individual decision by the patient; as the risks associated with a decision increase, the level of capacity needed to consent to or refuse the intervention also increases.

**WHEN TO EXERCISE ADDITIONAL CARE IN ASSESSING CAPACITY**

Assessing a patient’s decision-making capacity is an implicit part of every medical encounter in the ED. The process is generally spontaneous and straightforward and takes place as the EP examines and talks with the patient. The EP’s starting point is always the presumption that an adult patient has the requisite capacity to consent to or refuse medical treatment. Under certain circumstances, however, a more detailed and direct inquiry into a patient’s decision-making capacity must be performed (see the “**Red Flags**” box). Although no accepted rules exist regarding when the EP must delve more deeply into this issue, certain situations should alert an EP to the need to assess a patient’s decision-making capacity more carefully.

### **Red Flags**

**Signs That a More Careful Evaluation of Capacity Might Be Warranted**

- Patients who refuse recommended treatment (especially if they refuse to discuss their decision)
- Patients with a change in mental status
- Patients who frequently change their mind or make inconsistent decisions
- Patients with known risk factors for impaired decision making, such as the following:
  - Chronic psychiatric or neurologic conditions
  - Cultural or language barriers
  - Educational-level concern or developmental delay issues
  - Significant stress, anxiety, or untreated pain
  - Extremes of age: older than 80 years because of an increased risk for dementia; younger than 18 years because of a potential need for parental involvement
The most common situation that triggers a more detailed inquiry into a coherent patient’s decision-making capacity occurs when the patient chooses a course of treatment contrary to the one recommended by the EP or refuses treatment entirely. Simple disagreement with an EP’s recommendation, however, is not grounds for declaration of a lack of capacity. If the EP believes that the patient’s choice is not reasonable, it may trigger the start of an inquiry, but it is not the end of the inquiry. As discussed earlier, refusal of treatment is more worrisome if the consequences of the patient’s decision are great. Furthermore, if the patient is unwilling to discuss the reasons behind his or her refusal, the EP should be even more concerned about performing a careful evaluation of the patient’s decision-making capacity before simply accepting the patient’s choice.

A second general area that should raise the EP’s concern regarding decision-making capacity is when a patient has an abrupt change in mental status. Although the reasons for the change in mental status may be as varied as infection, stroke, head trauma, or ingestion of mind-altering substances, the result is the same. The EP is under an obligation to conduct a more careful evaluation of the patient’s capacity to participate in decisions on medical care. The simple existence of a change in mental status, however, does not automatically preclude a patient from possessing the requisite capacity. It is simply a situation that should trigger the EP to make a more detailed inquiry.

A third broad area that should prompt the EP to evaluate the patient’s capacity more carefully is the presence of a known risk factor for impaired decision making. Risk factors may include known psychiatric conditions such as severe depression or schizophrenia. Although the presence of mental illness does not automatically preclude a patient from having the right to participate in his or her medical care, in such an instance it may be helpful to seek the opinion of a psychiatrist. If cultural or language barriers are present or if concerns exist about a patient’s level of education, the EP should also exercise heightened scrutiny of the patient’s decision-making capacity. In these instances the EP must take steps to compensate for these factors to ensure that the patient has the greatest opportunity to participate in his or her medical care. The EP should arrange for a translator when necessary and should take additional time to explain the issues in terms that the patient can more readily understand. Extremes of age are also known risk factors for impaired decision making. Although not every patient over a certain age exhibits dementia, the EP must be aware of the increased prevalence of this condition in elderly patients. Other common risk factors in the ED are extreme pain, stress, and anxiety, each of which can impair a patient’s ability to receive or process information.

Although the foregoing situations are by no means all-inclusive, they represent instances that should put the EP on notice that a more careful and detailed evaluation of capacity may be needed. Again, none of these circumstances will alter the presumption that an adult possesses the requisite capacity to participate in his or her medical care. They simply mark the need for a more detailed inquiry. In each of these instances the EP should take additional care when documenting the care of the patient, as well as his or her interactions with the patient. Specifically, the physician should document any evaluation that is conducted of the patient’s capacity (see the “Documentation” box).

### When Capacity Is at Issue

If any of the “red flag” situations exist or if there are other reasons to have heightened concern regarding a patient’s decision-making capacity, the emergency physician (EP) should take care to document the following elements carefully:

- Whether the patient exhibits each of the elements of decision-making capacity
- The patient’s medical condition
- The proposed treatment or procedure and its necessity
- The urgent or emergency nature of the proposed treatment or procedure
- Actions by the EP to maximize patient capacity
- Actions by the EP to minimize impediments to patient capacity
- Availability and involvement of family members or surrogate decision makers
- Psychiatric consultation when obtained

### Suggested Questions to Aid in the Determination of Capacity

The final determination of a patient’s decision-making capacity depends on whether the EP believes that the patient exhibits the four abilities required for capacity: (1) to communicate a choice, (2) to understand relevant information as it is communicated, (3) to appreciate the significance of the information to his or her own individual circumstances, and (4) to use reasoning to arrive at a specific choice. Thus the EP’s inquiry should consist of focused questions to evaluate each of these areas (see the “Tips and Tricks” box).

The first requirement, communicating a choice, can be evaluated simply by asking the patient what he or she wants to do. Stability of the choice is also important. Although this may not be a factor given the urgency of many procedures in the ED, if the proposed treatment or procedure will not occur immediately, the EP should confirm that the patient’s choice remains the same after a certain period. If, for example, patient A agrees to a lumbar puncture for his headache, the EP can simply confirm the patient’s decision after preparations for the procedure have been made.

To test the patient’s ability to understand relevant information, the EP may start out by simply asking the patient to paraphrase what he or she has been told. Patients should use their own words and not simply parrot back the information recited by the physician. The EP can also ask pointed questions such as “What is your understanding of your condition and the options that we have discussed?” Patient should be able to explain, in their own words, the nature of the condition, the available options, and the risks and benefits of these options. This includes their understanding of what will happen if they do nothing. In the foregoing example of a lumbar puncture, patient A needs to understand the risks of the procedure, as well as the possibility that a negative CT scan without a negative lumbar puncture may mean that he still has a life-threatening condition.
To evaluate the patient’s ability to reason, the EP should ask the patient why he or she has chosen a specific option. The EP can inquire what factors influenced the patient’s decision and what weight was given to these factors. In the foregoing example, patient A may tell the EP that he cannot wait for a lumbar puncture after the CT scan because he has to pick up his daughter after school or that he has had similar headaches in the past and therefore thinks that this headache is not serious. Alternatively, patient A could tell the EP that he believes that when the procedure is performed, the EP will inject radioactive material into his body because the EP is trying to kill him. Sometimes simple questions yield very complex and interesting answers that can aid the EP’s determination of capacity.

In addition to asking focused questions relevant to capacity, the EP has the option of obtaining a consultation from a psychiatrist if time allows. Although no requirement mandates that a psychiatrist be involved, it may be helpful in certain circumstances. First, it can never hurt to obtain a second opinion when making a determination of capacity. Second, psychiatrists are skilled at interviewing patients. Third, they are experts in diagnosing mental illnesses that may impair a patient’s decision-making ability. Involvement of a psychiatrist does not relieve EPs of their responsibility to take part in determination of capacity. Decision-making capacity relies on the communication of adequate medical information that is unique to the patient’s condition and proposed treatment. Only the treating EP can ensure adequate disclosure of this information, and the EP cannot delegate this task to a psychiatrist.

**CONCLUSION**

In every encounter in the ED, it is the treating EP’s responsibility to ensure that the patient gives informed consent for medical care. This consent must be given voluntarily by a patient with the requisite decision-making capacity, and the patient must receive adequate information to make the decision. Although some evaluation of decision-making capacity is an inherent part of every patient-physician encounter, certain situations should alert the EP to the need for a more detailed inquiry. To this end, the EP should ask questions in the clinical interview that specifically address the requisite elements of capacity.

**REFERENCES**

*References can be found on Expert Consult @ www.expertconsult.com.*
REFERENCES