THE COMPETENT NOVICE

When and how to treat patients who refuse treatment

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Navigating the legal frameworks relevant to treating patients who refuse treatment can be daunting. This article provides a guide to which framework to choose in which situation

Knowing when and how to treat patients who refuse treatment is challenging. About 30% of acute medical inpatients lack capacity to make key decisions about their treatment,[1] and this rises to above 40% for psychiatric inpatients.[2] Clinicians tend to overestimate patients' capacity and miss cases where capacity is lacking.[3] Navigating the relevant legal frameworks (common law, the Mental Capacity Act (MCA), and the Mental Health Act (MHA)) can seem daunting. This article explains the basics of this complex area and provides advice for clinicians on which framework to use and when it should be used, focusing on the needs of doctors working in "general" hospitals in England and Wales who treat patients over 16 years. Scotland and Northern Ireland have separate legal frameworks and the law for those under the age of 16 is a specialist area beyond the scope of this article. However, despite these differences, the principles of how to manage patients who refuse treatment are the same.

SUMMARY POINTS

Common law can be used to treat patients in emergencies, especially when the diagnosis is unclear. It allows necessary and proportionate restraint until Mental Capacity Act (MCA) or Mental Health Act (MHA) assessments are completed

The MCA can be used to restrain and treat patients without capacity (for a specific decision) as long as it is in their best interests but cannot be used for the protection of others

The MHA can be used only to treat patients with a mental disorder, including those due to physical health conditions (such as delirium). It can be used for the protection of the patient or others but only in the presence of a mental disorder

Patients' and clinicians' values may differ, and patients are entitled to make decisions that clinicians think are unwise. Patients can be treated against their wishes only if their decision making capacity is impaired and if the proposed treatment is for something serious enough to warrant over-riding their wishes

Seek specialist advice (for example, from a psychiatry team) if it is unclear whether the patient has capacity to refuse treatment and which legal framework should be used

When should I treat patients who refuse treatment?

Before deciding to treat someone against his or her wishes, be aware that patients' values (such as attitude to risk) can differ from those of clinicians, leading to a different view on what treatments are in their best interests. Patients are entitled to make decisions that clinicians might think are unwise, and this entitlement is now protected by law in the MCA (see below). Patients can be treated against their wishes only if their decision making capacity is impaired and the proposed treatment is for something serious enough to warrant over-riding their wishes. Impairment of decision making capacity could be the result of mental illness (such as psychotic depression), intellectual disability, or a physical illness that affects mental functioning (such as delirium secondary to sepsis). It may also be necessary to treat patients who refuse treatment in emergencies where capacity is likely to be impaired but there is not sufficient time for its assessment.

What legal frameworks are currently in use?

In essence, there are three legal frameworks for treating someone who refuses treatment: (the) common law, the 2005 MCA,[4] and the 1983 MHA.[5] All clinicians need to be familiar with these frameworks (table 1).

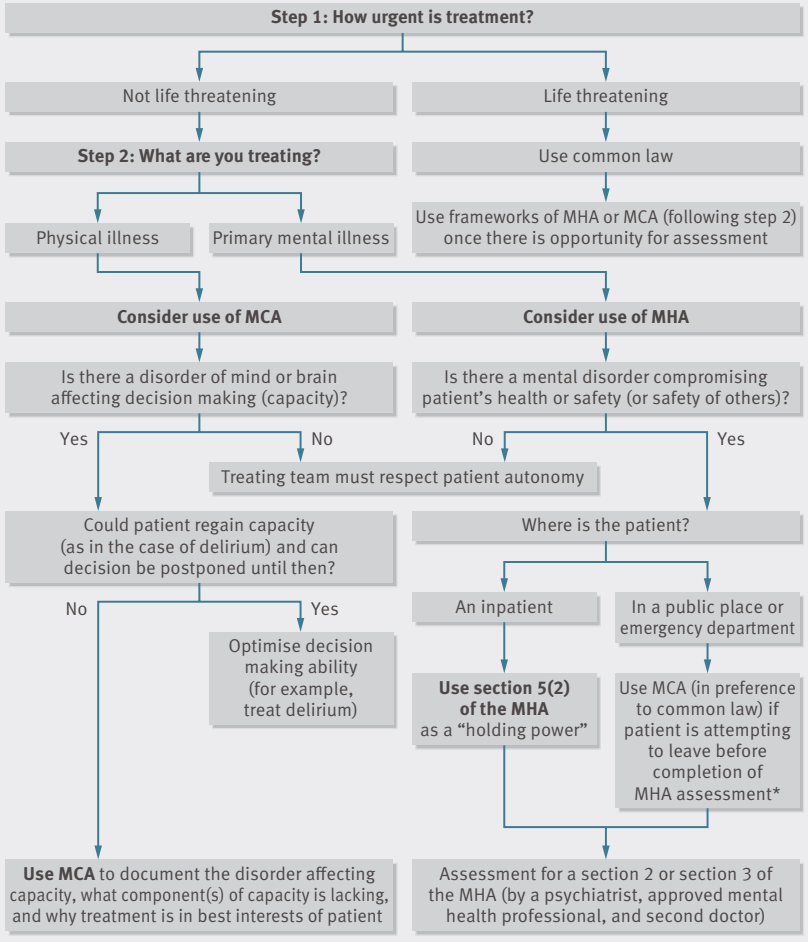
Common law is more informatively known as the "doctrine of necessity" and is only one form of common law, which is based on judgments of individual cases (also known as case law). This differs from statutory law, which is based on acts (of parliament), such as the MCA and the MHA. Since implementation of the MCA, common law is now relevant only in emergency situations when there is insufficient time to assess an individual's capacity.

The MCA (box 1) was implemented in 2007 and codified (detailed) previous common law on the treatment of those without capacity. It covers patient's best interests only, not the protection of others, and applies only to those aged 16 years and over. In addition, the MCA sets more limits to the amount of restraint that can be used than do common law or the MHA. Under the MCA, two conditions must be satisfied to justify restraint. Firstly, restraint must be deemed necessary to prevent harm to the person lacking capacity

Summary of key differences between common law, the Mental Capacity Act (MCA), Mental Health Act (MHA)*

Aspect	Common law	MCA	MHA
Disorders covered	Any disorder (physical or mental)	Disturbance in functioning of brain or mind	Any disorder or disability of the mind
Criteria	Action is needed to prevent harm; **in emergencies only** until there is time to assess capacity or undertake an MHA assessment	The patient **lacks capacity for a specific treatment decision(s)**; applies only to patients aged 16 years and over	The patient's **mental disorder** is of a **nature** (type) **and degree** (severity) that requires compulsory assessment or treatment in hospital
Who it protects	Patient or others	**Patient only**	Patient or others
Disorders that can be treated	Mental and physical health treatment	Mental and physical treatment in patient's best interests	Treatment of mental disorder only
Limits of restraint†	Emergencies only	Deemed a necessary and proportionate response to prevent harm to the patient	Involuntary detention in hospital
Important exclusions of application	Non-immediately life-threatening situations where there is time to assess capacity	**Cannot be used to treat patients under the age of 16 years**	**Cannot be used to treat physical disorders** unless it is causing the mental illness or is a direct consequence of it (discussed below)

*Important differences are highlighted in bold.
†Restraint should always be proportional and necessary.



* Depending on local definitions of a 'place of safety' or a 'place to which public have access' police may use section 136 of the MHA to keep patient in an emergency department including subsequent transfer to a special facility within a psychiatric hospital (often referred to as a 's136 suite')

Fig 1 | Algorithm for treating patients who refuse treatment. MCA=Mental Capacity Act; MHA=Mental Health Act. *Depending on the local definitions of a "place of safety" or a "place to which the public have access," the police may use a section 136of the MHA to keep the patient in an emergency department. Patients may also subsequently be transferred to a special facility within a psychiatric hospital (often referred to as an "s136 suite")

Box 1 | Five key principles of the Mental Capacity Act

Capacity is assumed: diagnoses, behaviour, or appearance should not lead to presumptions that capacity is absent

Decision making ability must be optimised before concluding that capacity is absent. Sufficient time must have been given for assessments and all practicable steps must be taken where relevant—for example, using interpreters, sign language, or pictures

Unwise decisions can be made: it is not the decision but the process by which it is reached that is being assessed

Decisions (and actions) made for people lacking capacity must be in their best interests

Decisions (and actions) made for people lacking capacity must be the least restrictive option(s)

Box 2 | The two key principles of common law

The clinician must reasonably believe that action is necessary to prevent harm to the patient (or others)

Actions must be proportionate to the likelihood of the patient (or others) being harmed and the seriousness of that harm. This governs treatment in emergency situations, it enables restraint, and it can be used for both physical and mental health disorders

(and not be used to protect others); secondly, it must be proportionate in degree and duration to the likelihood of the person being harmed and the seriousness of the harm.[6] Restraint under the MCA can amount to restriction, but not deprivation of liberty. However, it can be difficult to distinguish between restriction and deprivation of liberty. Details of this can be found elsewhere,[7] and in a clinical setting, specialist (psychiatry) advice should be obtained.

Non-psychiatrists will be expected to be familiar with only a few of the 140 plus sections of the MHA, which will be discussed later.

The algorithm (fig 1) provides an approach to managing patients who refuse treatment and selecting the relevant legal framework. There are two key steps in this process. The first is to determine the urgency of treatment to see whether common law is applicable. The second is to determine what is being treated—a primary physical (organic) disorder or a primary mental (psychiatric) disorder. We will now explain how to work through these two steps as we look at the evolving case scenario.

CASE SCENARIO: PART 1

An unidentified young man is brought to the emergency department after being found by the side of a dual carriageway with severe injuries. He has signs of a tension pneumothorax and is agitated, confused, and resisting treatment.

Step 1: how urgent is treatment? Is common law applicable?

In the first part of the case scenario, failure to act immediately and treat the tension pneumothorax would probably result in serious harm to the patient. In such situations there is clearly not sufficient time for a formal assessment of capacity and common law should be used. Common law is widely used in emergency settings, because there is rarely time for consent. Clinicians are often unaware that they are using it and that it is the legal defence of their actions. No specific documentation is needed when using common law. However, the MCA and MHA should be the default legal frameworks when the situation is not immediately life threatening. Box 2 lists the key principles of common law.

CASE SCENARIO: PART 2

After restraint, the patient receives emergency treatment for his pneumothorax under common law. He is subsequently intubated and ventilated on the intensive care unit and a few days later he has surgery for femoral and pelvic fractures. His brother visits and tells the team that the patient has a history of paranoid schizophrenia. Three days after surgery the patient becomes confused and combative and starts pulling out intravenous cannulae.

Step 2: what are you treating? Should the MCA or MHA be used?

As a general rule, when acting against a patient's wishes, the MCA is used to treat physical disorders that affect brain function and the MHA is used to treat primary mental (psychiatric) disorders. In part two of the case scenario the patient's behaviour has changed. Is this due to a physical or

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- Motivational interviewing (*BMJ* 2010;340:c1900)
- How to handle stress and look after your mental health (*BMJ* 2009;338:b1368)

a primary mental disorder? If after examination and investigation the patient has clinical evidence of delirium (such as fluctuating level of consciousness, disorientation, and poor attention) and evidence of an underlying cause (such as pneumonia), a physical disorder is present. In such cases the patient's capacity should be assessed (for the specific decision about having treatment for pneumonia). If capacity is found to be lacking, the MCA should be used.

In less clear cut cases of delirium it is important not to assume lack of capacity because the patient has a history of mental illness. It is also important not to assume that all behavioural change in a patient with severe mental illness is due to the mental illness because this risks other treatable causes, such as delirium, being missed. Sometimes it can be difficult to distinguish between mental disturbance caused by an organic illness (such as delirium) or a primary mental illness (such as relapse of schizophrenia). In such cases it is advisable to seek specialist support from a liaison psychiatry service or on-call psychiatrist.

Using the MCA: how do I assess capacity?

Deciding on whether capacity is absent for a specific decision is a two stage test.[8] The first stage is to establish if the functioning of brain or mind is impaired or disturbed; this stage is often overlooked. This might involve performing bedside cognitive testing, looking for signs of disturbance in mood or thinking, and obtaining a collateral history for a change in behaviour or functioning. The second stage is to assess the four components of the decision making process, only one of which needs to be absent for the person to be considered to lack capacity. The process assesses whether the person can (1) understand, (2) retain, (3) use or weigh information relevant to a decision, and (4) communicate a choice. The MCA does not require any specific paperwork, but details should be clearly documented in the notes—retrospectively if there is not sufficient time initially. Take care to explain both stages of the test and, if capacity is lacking, why the treatment to be given without consent is considered in the patient's best interests. Some trusts or health boards provide specific capacity assessment forms to guide clinicians and structure documentation.

Make all reasonable efforts to establish what the patient's wishes would have been if he or she still had capacity. Consult with next of kin and the patient's general practitioner. Any advance decisions (treatment preferences documented before the patient lost capacity) must be respected. For patients without family or friends to advise on this matter, and for decisions about serious medical treatment or changes in accommodation, NHS or local authority staff have a duty under the MCA to instruct an independent mental capacity advocate (IMCA) to take on this role (when a rapid decision is not needed).[9] Most hospitals should have an MCA lead who can facilitate referral to the local independent mental capacity advocacy service.

Another key point is that capacity is both decision specific and time specific. Patients may have capacity for some decisions but not for more complex ones, and capacity can fluctuate over time, particularly with conditions in which cognitive function varies, such as delirium.

The code of practice stipulates that a patient's capacity to make a decision should be assessed by the person directly concerned with the patient at the time the decision needs to be made.[10] In most instances of hospital inpatient care, the professional within the multidisciplinary treating team responsible for the patient's treatment will be responsible for ensuring that a capacity assessment has taken place. However, when the existence of a disorder of the mind or brain, or the presence of capacity, is unclear, specialist support should be sought from a psychiatry colleague.

Box 3 | How to place someone on a section 5(2) order

Before you start, ensure:

- The patient is already admitted: a section 5(2) order can be used only in the inpatient setting (but not emergency or outpatients departments, although in some trusts or health boards the clinical decisions unit may count as an inpatient setting)
- The situation is an emergency, and it is not possible or safe to wait for completion of an assessment for detention under section 2 or 3
- All other least restrictive measures have been tried and failed

When filling in the section 5(2) form (see fig 1), ensure:

- The full address (including postcode) for the hospital in which the patient is being detained is given. Incorrect or incomplete information can make the form invalid
- The appropriate sentence is deleted regarding whether: (a) the clinician in charge of the treatment of the patient is filling in the form, or (b) a "nominee" (a junior member of the team or the on-call clinician covering this team) is filling in the form
- The full reasons why informal treatment is no longer appropriate are documented; include mental state abnormalities and potential risks to the patient or others (or both)

After filling in the form:

- The section 5(2) form must be filed in the patient's notes and the hospital Mental Health Act office informed
- The reasons for detaining the patient under section 5(2) should also be documented clearly in the patient's notes

CASE SCENARIO: PART 3

When assessed on the ward, the patient seems very anxious and frightened and is observed responding to auditory hallucinations. He states that he wants to leave hospital to escape from undercover policemen who are watching him. He has not adhered to instructions to remain non-weight bearing. You decide to detain him under a section 5(2) order (under the MHA) and organise a registered mental (health) nurse to be with him on the ward.

The next day he is reviewed by the liaison psychiatrist, who makes a first recommendation for a section 2 of the MHA, and he is started on oral olanzapine. In the meantime, you assess his capacity regarding the decision to adhere to advice about not weight bearing.

Using the MHA: how do I put someone on a section?

In the above scenario, signs of delirium had resolved and the patient was having consistent persecutory delusions about the ward staff colluding with undercover police officers and was experiencing auditory hallucinations. This would be in keeping with a relapse of schizophrenia.

FORM H1 *Regulation 4(1)(g)* **Mental Health Act 1983**
Section 5(2) – report on hospital in-patient

PART 1
(To be completed by a medical practitioner or an approved clinician qualified to do so under section 5(2) of the Act)

To the managers of *(name and address of hospital)*

St Elsewhere Hospital, London, SI8 9GE

I am *(PRINT full name)*

Dr Anthony Melly

and I am *(Delete (a) or (b) as appropriate)*

(a) ~~the registered medical practitioner/the approved clinician (who is not a registered medical practitioner~~ *(delete the phrase which does not apply)*

(b) a registered medical practitioner/~~an approved clinician (who is not a registered medical practitioner)~~* who is the nominee of the registered medical practitioner ~~or approved clinician (who is not a registered medical practitioner)~~ *(*delete the phrase which does not apply)*

in charge of the treatment of *(PRINT full name of patient)*

John Smith

who is an in-patient in this hospital and not at present liable to be detained under the Mental Health Act 1983.

It appears to me that an application ought to be made under Part 2 of the Act for this patient's admission to hospital for the following reasons-
(The full reasons why informal treatment is no longer appropriate must be given)

This patient with a history of paranoid schizophrenia and with current active psychosis (auditory hallucinations and persecutory delusions) is trying to leave hospital despite having severe physical health problems (femoral and pelvic fractures, pneumonia). He lacks insight into his mental and physical health problems and is suspicious/unstrusting of staff advice and intentions.

(if you need to continue on a separate sheet please indicate here ( ) and attach that sheet to this form)

continue overleaf

Fig 2| Example of a completed section 5(2) form

FURTHER RESOURCES FOR CLINICIANS

Mental Capacity Act (MCA)

- MCA Code of Practice. www.publicguardian.gov.uk/mca/code-of-practice.htm
- Office of the Public Guardian website (www.publicguardian.gov.uk/index.htm)—Information and forms concerning all aspects of the Mental Capacity Act
- BMJ Learning (http://learning.bmj.com/learning/module-intro/mental-capacity-act.html?moduleId=6056672&locale=en_GB)—Interactive learning module on the MCA

Mental Health Act (MHA)

- Department of Health. MHA Code of Practice. Revised 2008. www.lbhf.gov.uk/Images/Code%20of%20practice%201983%20rev%202008%20dh_087073[1]_tcm21-145032.pdf
- The maze. 3rd ed. 2013. A practical guide to the Mental Health Act 1983 (amended 2007). South London and Maudsley NHS Foundation Trust
- BMJ Learning (http://learning.bmj.com/learning/module-intro/mental-health-act.html?locale=en_GB&moduleId=10011551)—Interactive learning module on the MHA

In your trust, health board, or locality

- Local policies and guidelines
- Senior colleagues
- On-call or local psychiatrists ("liaison" psychiatry if available)
- On-call approved mental health professional in your borough
- Local Mental Health Act Office
- Hospital legal team
- Patient Advice and Liaison Service (PALS) for information on local independent mental capacity advocate service

Where possible, the MCA should be used before the MHA. In this case, it would also be appropriate to use the MHA to keep the patient on the ward to treat his mental disorder. If he refused treatment, ongoing treatment of his physical health conditions (femoral and pelvic fracture) would need to take place within the framework of the MCA.

As a non-psychiatrist, section 5(2) is the most important section of the MHA to be aware of. Any registered medical practitioner at any level can "complete" (arrange) this section as long as he or she is the "nominated deputy" of the clinician in charge of the patient's care—for example a junior doctor on the medical team or someone in the relevant on-call team. However, it is best practice for the clinician in charge of the patient's care to complete the form (see fig 2) if possible. In a general hospital this will be the consultant physician or surgeon, whereas in a psychiatric hospital it is generally a consultant psychiatrist. Ward managers should have access to section 5(2) forms or be able to locate one through the hospital or site manager. A section 5(2) order lasts for up to 72 hours as a "holding power" to cover the time sometimes needed to arrange an MHA assessment. During these assessments two clinicians (ideally, one of whom has previous knowledge of the patient—for example, the patient's GP) and an approved mental health practitioner (previously an approved social worker) assess a patient for a longer term section such as a section 2 or 3 of the MHA (see below). Importantly, this section applies to inpatients only and cannot be used in outpatients or emergency departments, although it can theoretically cover patients admitted to clinical decisions units (wards within emergency departments). Of note, emergency treatment cannot be given under section 5(2), so, if needed, the patient's capacity should be assessed and treatment given under the MCA.

Box 3 explains how to complete a section 5(2) form and fig 2 shows an example of a completed form.

Non-psychiatrists should also be aware of a few other sections of the MHA. Two clinicians (normally psychiatrists) and an approved mental health practitioner must all agree to the use of sections 2 and 3.[10] Although section 2 is used for assessment, an order lasts for up to 28 days, so treatment often begins while patients are under this section. When patients have an established diagnosis, and a period of assessment is not necessary, section 3, which lasts for up to six months, can be considered. A section 2 or 3 order can sometimes be initiated for patients in a general hospital, but these sections are more commonly used in general hospitals for patients who have been transferred from a psychiatric hospital for physical health treatment. Such patients usually require ongoing physical treatment in a general hospital, as well as concurrent assessment

or treatment of a mental disorder against their wishes because of risk to themselves or others. Remember that the MHA does not usually cover physical treatments. Once the patient is physically fit for discharge, the section can be transferred to the appropriate mental health facility if the patient still requires assessment or treatment under that section.

What are the challenges?

The general rule of using the MCA for a physical disorder and the MHA for a mental health problem has some important exceptions. These are rare and the identification and management of such cases is beyond that expected of non-specialists. The distinction between a physical and mental disorder can become blurred theoretically and in practice. Furthermore the MCA can be, but rarely is, used to treat a mental disorder. The MHA can also be used to treat physical disorders that directly cause mental illness (such as HIV causing encephalitis, profound hypothyroidism) or result from mental illness (for example, nasogastric feeding in life threatening anorexia or the physical sequelae of a suicide attempt, such as poisoning or fractures).

It can be complex to work out which framework to use in a specific situation. In many situations, it is possible to justify the use of more than one framework, as in the above scenario. However, usually one framework will be most suitable or more practical.

One scenario that doctors often find difficult is when a patient presents to the emergency department after taking an overdose but refuses treatment. Complex personality factors may be at play, and often it is unclear whether the patient has capacity to refuse treatment.[11 12] In these situations, it is important to share the decision of whether to treat the patient against his or her wishes among the treating team, and for a specialist opinion to be sought. Most hospitals have an on-call psychiatry service or an integrated liaison psychiatry service that can provide advice or assist with capacity assessments in complex cases. In addition, trusts or health boards will have a legal team that should be on hand to provide advice.

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ANSWERS TO ENDGAMES, p 38

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ANATOMY QUIZ

Anteroposterior radiograph of the lumbar spine

A: L1 right transverse process
B: Left 12th rib
C: L3 right pedicle
D: Right iliac crest
E: L4 spinous process
F: Right sacro-iliac joint

STATISTICAL QUESTION

Cross sectional studies: advantages and disadvantages

Statement *b* is true, whereas *a*, *c*, and *d* are false.

PICTURE QUIZ

A complicated case of diarrhoea

1 The irregular fluid collection containing an air bubble is a pericolic abscess, probably a complication of underlying diverticular disease (as seen by the outpouchings of colon).
2 Complications include mild clinical inflammation; confined pericolic abscess; distant intra-abdominal, retroperitoneal, or pelvic abscess; generalised purulent peritonitis; and faecal peritonitis. Disease is graded according to the Hinchey classification.
3 Acute management involves bowel rest, analgesia, and the use of oral or intravenous antibiotics. Percutaneous drainage is used for larger collections and those that do not respond to conservative management. In the acute phase, surgical resection is reserved for life threatening cases.
4 Patients with diverticulosis are advised to consume a high fibre diet and maintain an adequate fluid intake. In addition, bulk forming laxatives and paracetamol may be prescribed. Elective surgery is reserved for patients with recurrent acute diverticulitis and those with fistulas or strictures.