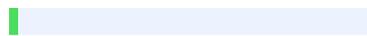




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Navigating the Grey: Capacity, Consent, and the Emergency Physician's Dilemma. 1  
Abstract 2 Background: In the high-stakes environment of Emergency Departments (ED),  
the intersection 3 of clinical urgency and legal obligation regarding patient capacity and  
consent creates significant 4 ethical and professional challenges. This study evaluates the  
knowledge, attitudes, and practices 5 (KAP) of Indian emergency physicians concerning  
the complexities of informed, implied, and 6 presumed consent. 7 Materials and Methods:  
A multi-center, cross-sectional, observational study was conducted 8 among 120 licensed  
medical practitioners across public and private hospitals in India. Data were 9 collected via  
a validated, structured questionnaire assessing knowledge of consent typologies, 10  
documentation habits, and conflict resolution strategies. Statistical analysis was performed  
using 11 Chi-square tests and logistic regression ( $p < 0.05$ ). 12 Results: The study  
revealed significant conceptual fragmentation: only 4.2% of participants 13 correctly  
identified that expressed consent could be both verbal and written. While 50.8% 14  
recognized the legal obligation to treat unconscious patients without consent in life-  
threatening 15 scenarios, documentation practices were inconsistent; only 33.3% of  
doctors reported "always" 16 documenting their actions. A distinct "maturation curve" was  
observed, with senior practitioners 17 (41–50 years) demonstrating significantly higher  
success rates in conflict resolution (71.4%) 18 compared to those under 30 (34.8%).  
Nearly 46% of clinical disputes regarding consent 19 remained unresolved, highlighting a  
critical gap in institutional support. 20

Discussion: Findings suggest that while experience mitigates some risks, junior doctors  
21 frequently operate in a "legal fog," relying on clinical intuition over formal legal  
frameworks. 22 There is a heavy reliance on "proxy-by-proximity" (family consultation),  
which remains legally 23 precarious. Practitioners identified a pressing need for specific  
training on patient rights (27.5%) 24 and legal clarity in emergencies (22.5%). 25  
Conclusion: There is a significant disconnect between legal mandates and bedside  
practice in 26 Indian emergency medicine. To improve clinical governance and protect

patient autonomy, 27 hospitals should implement standardized consent algorithms, simulation-based "soft skill" 28 training for junior residents, and digital documentation prompts within electronic health records. 29 Keywords: Emergency Medicine, Informed Consent, Mental Capacity, Medical Jurisprudence, 30 Bioethics, Clinical Governance. 31 Introduction: 32 Overview of Capacity and Consent in Medical Practice 33 In healthcare, capacity and consent form the fundamental pillars of ethical and legal 34 responsibility. Capacity refers to a patient's ability to understand information, appreciate the 35 implications of medical decisions, and communicate their preferences effectively [1]. Informed 36 Consent is the process by which a patient voluntarily agrees to a medical intervention after 37 receiving comprehensive information regarding risks, benefits, and alternatives [2]. This process 38 serves to uphold patient autonomy, empowering individuals within both emergency and non39 emergency healthcare settings [3]. 40

In emergency settings, obtaining consent is frequently complicated by time constraints and the 41 potential lack of patient capacity. Scenarios involving unconsciousness, cognitive impairment, or 42 severe injury necessitate rapid decision-making that may preclude traditional consent discussions 43 [4]. Failure to effectively manage these processes can lead to significant legal repercussions, 44 including malpractice lawsuits or professional disciplinary actions [5]. 45 Consent in Medical Emergencies 46 The Emergency Department (ED) presents a unique challenge to the traditional consent model. 47 During medical crises, delaying treatment to obtain explicit consent could result in morbidity or 48 mortality. In such instances, healthcare providers often rely on implied consent, presuming that 49 an incapacitated patient would desire life-saving interventions [6, 7]. However, navigating the 50 nuance between expressed, implied, and presumed consent—while remaining within ethical 51 boundaries—remains a defining challenge for Emergency Physicians [8]. 52 Legal and Regulatory Framework Surrounding Consent 53 In India, the legal framework is rooted in 3 the Indian Contract Act, the Consumer Protection Act, 54 and standards established by the National Medical Council (NMC). 2

The Supreme Court of India 55 has emphasized that valid consent must be informed, voluntary, free of coercion, and provided 56 by an individual with sufficient cognitive capacity [9]. 57 Internationally, frameworks such as the United Kingdom's Mental Capacity Act 2005 mandates 58 that decisions for incapacitated patients 6 be made in their "best interests" [10]. Comparing these 59 international standards with Indian practices reveals varying approaches to balancing patient 60 autonomy against the provider's duty of care [11]. 61

Rationale for the Study 62 Despite established guidelines, there is a rising trend in medical litigation involving allegations 63 of improper consent [14]. Emergency doctors frequently operate in "grey areas" where the 64 urgency of treatment competes with the duty to inform. Knowledge gaps regarding the legal age 65 of consent, the limits of implied consent, and the documentation of capacity can expose both the 66 patient to harm and the physician to legal risk [14, 11]. This study seeks 1 to assess the current 67 level of awareness among Indian Emergency Physicians to identify critical training needs and 68 bolster clinical governance. 69 Material and Methods: 70 Study Design and Setting 71 This was a multi-center, cross-sectional, observational study conducted in Emergency 72 Departments across diverse public and private hospitals in India using a structured, validated 73 questionnaire. The study population included licensed medical practitioners actively practicing in 74 Emergency Departments (ED) with a minimum of one year of experience. This setting is critical 75 as ED physicians frequently encounter patients with impaired decision-making capacity (e.g., 76 trauma, intoxication, or psychiatric crises). Non-allopathic practitioners and those with less than 77 one year of ED experience were excluded from this study. Using a stratified random sampling 78 technique based on hospital type (public vs. private) and location (urban vs. rural), we ensured a 79 representative sample of 120 participants across different levels of experience was determined, 80 assuming a 5% margin of error and a 95% confidence level. 81 Data Collection 82

Data were gathered via a structured, self-administered questionnaire designed to evaluate the 83 knowledge, attitudes, and practices (KAP) of Emergency Physicians regarding patient capacity 84 and consent. This questionnaire was constructed in accordance with National Medical 85 Commission (NMC) guidelines and relevant legal precedents [15] and reviewed by a panel of 86 experts, including a Senior Emergency Consultant, and a Legal Expert. A pilot study (n=10) was 87 conducted to ensure face validity and clarity; results from the pilot were excluded from the final 88 analysis. The questionnaire was distributed physically and electronically via secure online forms. 89 Participation was voluntary, and anonymity was maintained using unique identification numbers. 90 Data collection spanned two months. 91 Statistical Analysis 92 Data were analyzed using SPSS version 25.0. Descriptive statistics (means, frequencies, and 93 standard deviations) summarized demographic data and knowledge scores. Inferential statistics, 94 including Chi-square tests and logistic regression, were employed to identify correlations 95 between independent variables (e.g., years of experience) and dependent variables (e.g., 96 knowledge level) [16]. Significance was set at  $p < 0.05$ . 97 Ethical Considerations 98 The study protocol 1 was approved by the Institutional Review Board (IRB) and adhered to the 99 principles of the Declaration of Helsinki [17]. Informed consent was obtained from all 100 participants prior to data collection. Data were stored on a secure, password-protected server to 101 ensure confidentiality. 102 Results 103

The study analyzed responses from 120 emergency doctors to evaluate knowledge and practices 104 regarding patient capacity and consent. The cohort demonstrated a balanced demographic 105 profile: 50% were female, 50% were male, and participants were evenly distributed between 106 public and private hospitals (50% each), as well as urban (50.8%) and rural (49.2%) locations. 107 The mean age was 36.02 years (SD = 5.47), with the majority (57.5%) falling within the 31–40 108 age bracket, representing a predominantly mid-career sample. 109 Knowledge of Consent Typologies 110 Significant variability was

observed in the conceptual understanding of consent. Regarding 111 expressed consent, participants were divided; 48.3% believed it required a written form, while 112 47.5% considered verbal communication sufficient. Only 4.2% correctly identified that it could 113 be either. Interpretations of implied consent were similarly fragmented: 43.3% recognized the 114 broad concept, while others tied it specifically to patient actions (28.3%) or clinical conditions 115 (28.3%). Presumed consent was most frequently associated with unconscious patients in life116 threatening (34.2%) or urgent (32.5%) situations. 117 Clinical Practice and Legal Obligations 118 When managing unconscious patients, 50.8% of doctors correctly identified the legal obligation 119 to treat without consent in life-threatening cases. Key factors justifying the waiver of consent 120 included "urgency and severe injury" (30.8%) and "immediate risk to life when family is 121 unavailable" (17.5%). While 64.2% of respondents reported obtaining 5 informed consent as a 122 standard frequency, 35.8% indicated they do not, likely due to the acute nature of emergency 123 medicine. 124

Documentation and Conflict Resolution 125 Documentation practices, essential for legal and ethical accountability, showed inconsistency. 126 While 33.3% of doctors always document their actions in the medical record, 20.0% admitted to 127 rarely documenting unless family consent is obtained. Furthermore, 54.2% of doctors reported 128 that they occasionally document decisions to waive consent. 129 In terms of clinical disputes, 54.2% 1 of participants reported no conflicts over consent. In 130 instances where conflicts did arise, the primary resolution strategy involved consulting and 131 informing family members (5.8%). Although 54.2% of all conflicts were successfully resolved, a 132 notable 45.8% remained unresolved, highlighting a significant gap in conflict management 133 within emergency departments. 134 Consent Dynamics and Conflict Resolution 135 A primary finding of this study is that while the majority of cases (54.2%) reported no conflict 136 over consent, 1 a substantial portion of medical interactions involved navigating familial and 137 ethical complexities. In instances where conflicts arose, healthcare

providers utilized diverse 138 strategies, most notably consulting families for consent (5.8%) and obtaining family consent 139 even in critical conditions (4.2%). Despite these efforts, conflict resolution remains a challenge; 140 while 54.2% of disputes were successfully resolved, 45.8% remained unresolved, highlighting a 141 critical gap in institutional support and communication protocols. 142 Legal Awareness and Institutional Improvements 143

The data underscores a significant demand for legal clarity within the medical community. 144 Respondents identified "training on patient rights and legal clarity" (27.5%) and "increased 145 awareness on emergency consent" (22.5%) as the most pressing needs to mitigate legal 146 consequences. Furthermore, the most frequently suggested improvement measures included an 147 improved understanding of consent (20.0%) and enhanced legal awareness (19.2%). This 148 suggests that practitioners often operate in a state of legal ambiguity, particularly regarding 149 emergency protocols. 150 Impact of Demographic Factors 151 Chi-square tests of independence ( $\chi^2 = 138.366$ ,  $p = 0.000$ ) revealed that age and experience 152 significantly influence professional behavior and perceptions: 153  Hospital Type and Experience: A significant association was found between age and 154 hospital type ( $\chi^2 = 6.542$ ,  $p = 0.038$ ), with younger professionals ( $\leq 30$  years) more likely 155 to work in private institutions (69.6%). As expected, age and years of experience were 156 highly correlated ( $\chi^2 = 138.366$ ,  $p = 0.000$ ), confirming that senior professionals bring a 157 deeper reservoir of clinical practice to consent scenarios. 158  Implied and Presumed Consent: Age significantly influenced how doctors justified 159 treatment without explicit consent. Older professionals (41–50 years) relied more heavily 160 on general implied consent (60.7%), whereas younger doctors were more likely to base it 161 on specific patient conditions ( $\chi^2 = 15.264$ ,  $p = 0.028$ ). Similarly, justifications for 162 presumed consent varied significantly ( $p = 0.008$ ), with older respondents prioritizing 163 life-threatening situations. 164

□ Emergency Decision-Making: There was a highly significant association between age 165 and the rationale for acting without consent in emergencies ( $\chi^2 = 56.941$ ,  $p = 0.000$ ). 166 Younger respondents emphasized "urgency and severe injury," while older practitioners 167 focused on the "immediate risk to life" and the unavailability of family. 168 Documentation and Professional Practice 169 Documentation practices showed a clear maturation with age ( $\chi^2 = 30.350$ ,  $p = 0.000$ ). Older 170 professionals demonstrated higher adherence to protocol, with 46.4% "always" documenting 171 consent, compared to younger professionals who showed more inconsistent ("occasional") 172 documentation. Interestingly, mid-career professionals (31–40 years) were found to be the most 173 consistent in obtaining informed consent (68.1%), while older professionals sometimes relied on 174 experience-based discretion in emergency settings ( $p = 0.042$ ). 175 Finally, age was a significant predictor of conflict resolution success ( $p = 0.033$ ); practitioners 176 aged 41–50 reported a 71.4% success rate in resolving consent disputes, compared to only 177 34.8% for those under 30. This suggests that the "soft skills" of negotiation and ethical 178 navigation improve significantly with career longevity. 179 Discussion 180 The intersection of legal obligation and clinical urgency in emergency medicine creates a high 181 stakes environment where the principles of autonomy and beneficence often collide (18) This 182 study provides a granular look at how 120 emergency physicians navigate the complexities of 183 patient capacity and consent. Our findings reveal a landscape marked by conceptual 184

fragmentation, a significant reliance on experiential wisdom over formal legal frameworks, and a 185 critical "resolution gap" in clinical disputes. 186 The Conceptual Fog of Consent 187 One of the most striking findings is the lack of consensus regarding the basic typologies of 188 consent. While consent is the bedrock of ethical medical practice, only 4.2% of participants 189 correctly identified that expressed consent can be 3 either verbal or written. This suggests a binary 190 misunderstanding: half the cohort views it as a purely administrative/paperwork task (written), 191 while the other half views it as a casual

dialogue (verbal). 192 This conceptual ambiguity extends to implied and presumed consent. In emergency settings, 193 "implied consent" is a legal fiction that allows a physician to act when a patient is unable to 194 provide consent and a delay would result in serious harm (18). However, our data shows that 195 nearly 30% of doctors tie implied consent strictly to specific patient actions or conditions rather 196 than the broader legal doctrine. This "fragmented understanding" aligns with previous 197 international studies suggesting that emergency providers often rely on "clinical intuition" rather 198 than the specific legal definitions of their jurisdiction (19). 199 The Experience Gap: Junior vs. Senior Practitioners 200 The data revealed a robust statistical correlation between age/experience and the nuances of 201 consent practice ( $\chi^2 = 138.366$ ,  $p = 0.000$ ). We observed a distinct "maturation curve" in how 202 consent is handled: 203

- Decision-Making Rationale: Younger physicians (< 30 years) focused heavily on the 204 immediate pathology (urgency and severe injury), whereas older practitioners (41–50 205 years) prioritized the broader legal and ethical context, such as the unavailability of 206 family. This suggests that as doctor's age, they transition from a "disease-centric" model 207 of consent to a "person-centric" and "risk-mitigation" model. 208 □

Documentation Standards: Documentation is the primary defense in medical litigation. 209 Our study found that nearly half of older professionals always document consent, while 210 younger doctors were more likely to be inconsistent. This is a concerning trend, as the 211 legal maxim "if it isn't written, it didn't happen" is particularly relevant in the high 212 litigation environment of the Emergency Department (ED) (20). 213 □ Conflict Resolution:

Perhaps the most significant finding regarding seniority was the 214 success rate in resolving disputes. Older practitioners had a 71.4% success rate, compared 215 to a meager 34.8% for those under 30. This suggests that the "soft skills" of 216 communication, de-escalation, and ethical negotiation are largely learned through years 217 of exposure rather than formal training. 218 The Resolution Gap and the "Family Factor" 219 A critical finding of this study is that nearly 46% of consent-related conflicts

remain unresolved. 220 In the ED, where time is a luxury, an unresolved conflict over consent can lead to delayed 221 treatment, moral distress among staff, or legal repercussions (21). 222 The data indicates a heavy reliance on family members as a surrogate for patient autonomy. 223 While 5.8% of doctors used family consultation as a primary resolution strategy, the "family 224 factor" often complicates the emergency workflow. In many jurisdictions, family members do 225

not have automatic legal standing to provide consent unless they are designated proxies, yet our 226 respondents frequently deferred to them to resolve ethical tension. This "proxy-by-proximity" 227 approach is common but legally precarious (22). 228 Documentation: The "Achilles' Heel" of Emergency Care 229 Despite 50.8% of doctors correctly identifying their legal obligation to treat in life-threatening 230 cases without consent, documentation practices remain suboptimal. Only 33.3% of the total 231 cohort —alwaysll documents their actions. The admission by 20% of participants that they rarely 232 document unless family consent is obtained reveals a dangerous misconception: that family 233 approval supersedes the need for a rigorous medical-legal record. 234 Standardized documentation of capacity assessments and the rationale for "presumed consent" is 235 essential for hospital risk management (23). The "occasional" documentation reported by 54.2% 236 of doctors suggests that in the chaos of resuscitation, the legal narrative is often lost, leaving the 237 practitioner vulnerable if the outcome is poor. 238 Towards Legal Clarity and Training 239 The study highlights a profound desire for institutional improvement. Participants identified 240 "training on patient rights" (27.5%) and "increased awareness on emergency consent" (22.5%) as 241 urgent needs. This suggests that the current medical curriculum and hospital orientations may be 242 failing to provide doctors with the practical legal tools required for the ED. 243 Practitioners are operating in a state of "legal ambiguity." When doctors are unsure of the 244 boundaries of presumed consent, they may hesitate in critical moments or, conversely, overstep 245

and infringe on patient autonomy (24). Institutional protocols must move beyond abstract ethics 246 and provide clear, algorithm-based guidance for consent in the unconscious patient. 247 Limitations 248 This study is limited by its self-reported nature, which may be subject to social desirability 249 bias—particularly regarding documentation and conflict resolution. Additionally, while the 250 sample was balanced by hospital type and location, the specific legal jurisdictions of the 251 hospitals were not analyzed, which may influence how "legal obligation" is interpreted. 252 Conclusion 253 Our study reveals a significant gap between the legal requirements of consent and the practical 254 realities of emergency medicine. While experience provides a natural buffer—improving 255 documentation and conflict resolution—junior doctors are left navigating a complex ethical 256 landscape with insufficient tools. 257 To bridge this gap, hospitals must implement:

- 258 1. Standardized Consent Algorithms: Clear pathways for treating unconscious patients 259 when family is unavailable. 260
2. Interdisciplinary Training: Simulation-based training that includes "soft skill" 261 negotiation and legal briefings for junior residents. 262
3. Digital Documentation Prompts: Integrating capacity and consent checklists into 263 Electronic Health Records (EHR) to ensure documentation is not overlooked during acute 264 care. 265

Addressing these issues **3** is not merely a legal necessity but a fundamental requirement for 266 respecting patient autonomy and ensuring the psychological well-being of the healthcare 267 providers who must make these life-and-death decisions. 268

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