What happens if the interviewee doesn't remember very much of what has been told to them? Say they only remember one or two things out of ten?

GQ interviewing doesn't depend on quantity but rather quality of information. There may be obvious reasons why someone produces only a small amount of recall – problems with receptive or expressive language problems for instance. In that case, it is the type of information that the individual recalls or their body language when they report it that will give clues as to their understanding. If all the person offers about an impending surgical procedure is a series of single words with nothing qualifying them to indicate understanding, ('doctors, nurses, hospital') then this is qualitatively different from a response that contains more elements such as 'pain, hurt, doctor, injection, go to sleep, feel better'. Observation of the individual's emotional state can add further information to an assessment. If the mood 'fits' with what is being reported then this can also be an indication of their understanding and feelings about the issue being assessed. In short, words alone don't say enough about understanding. But even a very few words, if accompanied by emotional indicators such as facial expression, tone of voice, and gesture, can be clearly indicative.

[See 'Davy's abdominal surgery' in the Case Illustrations document.]

What if somebody doesn't say anything at when you ask them to recall or if you ask them questions?

In this instance you should try to determine if the interviewee was unable to talk or simply unwilling. The people who know them best will be able to help and they can probably tell you about the individual's usual style and level of communication. If the person doesn't usually communicate verbally then find out what method they normally use – do they gesture, use sign language, draw, have a specific communication aid? And how do they usually respond? Convert the information to be communicated into a medium that is most accessible to the individual and allow time for the information in the new medium to be processed. Then re-assess using the most effective medium for the individual.

[See 'Sandra who wanted to eat biscuits' in the Case Illustrations document.]

If the individual is usually able to talk but may be choosing not to do so then unfortunately the assumption would have to be that they lack capacity. This is because the final requirement in the process is that they communicate their decision, so if they choose not to communicate at all, this will be impossible. Where this is the case, it's worth letting the person know that, unless they engage with the process, other people will have to make the decision for them. If they are feeling angry or powerless then a reflection of their position might result in a different response. Sometimes though vulnerable individuals might choose to withhold a

response because they are used to being ignored or misunderstood. As an interviewer, you need then to acknowledge this with them, help them understand that you take their views seriously and tell them how much it matters that they talk to you about their decision.

What if the individual's capacity can be different on different days, for example someone with dementia or chronic mental health problems?

Dementia can be problematic because memory fluctuates. The best strategy is to try to interview the person on a good day so that the information you get can be used as their baseline. An assessment when the person is experiencing confusion and disorder is not valid. Your job in this instance is to establish from those who know the person best if this is 'as good as it gets' and if it is, to do the best you can with the tools you have. What is certain is that using closed and leading questions will give you answers while the GQ might not. But any GQ answers you obtain will be the person's own, and less likely to be one word acquiescent answers. Don't forget that to give no answer at all is also a response.

This applies equally to people with fluctuating mental health problems who may be functioning rationally on one day and experiencing distressing and confusing delusions on another. In the UK, people are increasingly making Advance Directives when they are functioning well that outline how they should be treated when their illness interferes with their judgment. These can be used in Court to support a person's decision at a time when they are no longer able to communicate that decision.

What if different members of the team have assessed and there is disagreement between them as to whether capacity is present?

The most persuasive element of the GQ is that the interviewee's own words are recorded and reported and the conclusion about capacity is based on direct evidence, not speculation derived from diagnosis or assumptions. This is why it's important to write down what people say, to make contemporaneous notes that you can refer to in order to ask more questions, and to use the interviewees own words when you do that. You can always make an audio recording for back-up – especially if there might be Court proceedings. Where there are disagreements, this evidence can help give everyone a different perspective and it's a good thing for members of the team to meet and discuss their reasons for their views. If this does not lead to agreement then independent facilitation of the team's decision process might be helpful.

What if I get it wrong?

First, if you have followed the procedure and asked the questions in the right way then, while it may not be perfect, it will not be wrong. Second, the assessment of

capacity does not rest with one assessor, it is designed so that the evidence gathered will give a good indication as to whether decisional capacity is present or not.

Finally, no harm comes to the individual from offering them the best opportunity to understand a situation and give their consent. It is far more 'wrong' to guess at capacity or assume it. Using the GQ, you will gather evidence and record it systematically and so your judgment is transparent and accountable. You will decide by weighing up the information available at the time and if you have undertaken this process fairly on behalf of the individual then an answer will not be wrong.

What if I don't think the information that has been shared with the individual is very good?

The quality and appropriateness of the information shared with the individual is extremely important. If any doubt exists about any aspect of the information then you should discuss this with the person who provided it. Booklets detailing the required information can be usually be obtained from GP surgeries, hospital departments and increasingly from patient-led web sites although you always have to be clear about their accuracy. Translations into different languages are usually also available, and carers are often more than willing to adapt them with images and symbols to accommodate people with literacy problems. In the UK, we are obliged to give the necessary information in the way that is best suited to the needs of the patient, and to allow them to communicate their decision in the way that suits them best also. If this basic requirement is not met, an assessment of capacity is invalid.

The whole process seems to leave too much responsibility with the person assessing. Is all the responsibility ours?

Quite often the person responsible for making the final decision about a procedure is not the person assessing for capacity. Surgical and medical specialists frequently don't have the time, and they are permitted in the UK to take advice from other people about this. So it's more likely that you are assessing on behalf of that specialist, whether medical, legal, social care, police service, or the Courts. That means your role is not to make a final decision but to present your evidence about capacity to the person who will. Although you guide the decision maker in their final judgement, you are not wholly responsible.

What if an individual seems to have capacity but their decision is obviously irrational?

Some irrational decisions are driven by a mental health difficulty although it would be wrong to use the irrationality *per se* as an indication of disorder. For example, if an individual with anorexia nervosa refuses to accept that they need to eat or be hospitalised to help them recover from a medical condition, or a mother whose unborn child has died refuses medical intervention to end the pregnancy, then an opinion about a more pervasive mental disorder would be appropriate. Irrationality

itself is not a reason to infer lack of capacity, but irrationality driven by depression, delusions, thought disorders, or cognitive distortions probably is and you will need a specialist's opinion to support your own findings. People whose impairments are quite focused may be entirely rationale in making other decisions and it's worth remembering that, in the UK at least, assessments of capacity refer to a given decision at a given time. They are not blanket judgments that last a lifetime.

What if the person's family keep interrupting and either disagreeing with the individual or coercing them?

Consent obtained under coercion is not valid. Family members are sometimes challenged by the process of the consent interview, often believing that their family member is not being encouraged to give the right answers because they are not being asked direct (usually closed) questions. They may be used to speaking for the individual and might be surprised to hear them express their own opinion - particularly if it doesn't agree with theirs. Explaining clearly how the interview works and that the individual must be able to give their own answers in their own way usually does the trick. But if families are unable to cooperate then you may need to ask them to leave so that you can conduct the interview without contamination or coercion.

What if something changes about the very thing that you are seeking consent for, like some new drug trial or procedure that means that surgery may not be the first choice?

People must be told about any changes in the information they need to make a valid choice and given time to absorb this. You will need to conduct another interview in the light of the new information, whether this is of a positive nature - fewer invasive or distressing procedures are indicated, or negative - new risks have been identified, to see if it has influenced either their capacity or their decision. If a significant amount of time has elapsed while new information is researched it is good practice to re-affirm the feelings of the individual anyway.