

### **Mental Capacity: Is it important in our daily practice?**

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A middle aged man complaining of chest pain walks into the emergency department of a teaching hospital in Karachi. After examination and investigations, he is informed that he has suffered a myocardial infarction and would benefit from a thrombolytic agent. The patient refuses the treatment on the grounds that he will be subjected to the risk of internal bleeding as a side effect and would prefer herbal (hikmat) medication at home. What should be done now? Should he be allowed to go home, knowing the risks associated with his illness? In another real anecdotal experience at Karachi, an elderly lady lies on the bed of a hospital. She is diagnosed with moderate to severe dementia and chronic renal failure. She has now stopped eating. The physician walks in and declares to the family members that he is planning a percutaneous endoscopic gastrostomy (PEG). When the relatives show some reluctance, he further declares, "I am not asking your permission but simply informing you!" and walks out. Is this ethically justified?

In both these cases it is crucial to understand whether the patients had the mental capacity to take a decision or not. What is mental capacity? It is a legal construct. Capacity enables the distinction between the person who is capable of making a decision and whose choice must, therefore, be respected, from one who requires others to make decisions for him or her.<sup>1</sup> The common law definition of capacity was set out by Thorpe J in case of *Re C (Adult: Refusal of Medical Treatment)*:<sup>2</sup> "A person retains capacity, if he is able to understand, remember, believe, weigh in the balance, the necessary information and express a decision." Prior to the enactment of the Mental Capacity Act (2005) in April 2007 there was no legislation in England and Wales relating to capacity and decisions were made with reference to the common law. Incapacitous adults in England and Wales could be treated using a common law defence of 'doctrine of necessity' prior to the introduction of the Mental Capacity Act (MCA) 2005.<sup>2</sup> There were concerns about the arrangements for deciding capacity on the common law basis;<sup>3,4</sup> it included trepidations such as the lack of legal authority for people to act on behalf of anyone lacking capacity and that there was no right for relatives and caretakers to be consulted.

There are three main approaches to the determination of capacity: outcome, status and functional.

The outcome approach uses the results of the patients' decision to determine their capacity. On this account, when the patients' decision appears unwise then this indicates incapacity. The major disadvantage of this view is that it does not respect the decision makers' autonomy. The status approach uses the decision makers' characteristics, such as their IQ or diagnosis as the determinant. Disadvantages of this approach include that it does not recognise that capacity is essentially decision specific — it incorrectly assumes that capacity is an all or nothing concept. There are also problems with borderline cases such as the patient with mild dementia who may or may not be able to decide on treatment. The functional approach involves an assessment of the individuals' cognition in relation to the decision.<sup>5</sup> This approach has the most support in the literature and has the advantage of being decision specific. Disadvantages of the function tests include difficulties with deciding on the appropriate threshold for decision making.<sup>6</sup> On the one hand there is a risk that, if the criteria are too lax then vulnerable people may not be protected and on the other hand if the criteria are too strict then competent peoples' decisions will not be respected.<sup>6</sup>

The MCA employs a two stage test of capacity.<sup>7</sup> The first part involves determining whether the decision maker has an impairment of mind or brain, or whether there is "a disturbance affecting the way their mind or brain works." This may be a permanent or temporary condition. The second part is to determine whether this disturbance or impairment prevents the person making the decision when it needs to be made. It could be argued that the two stage test incorporates elements of status and function tests. The MCA has five statutory principles.<sup>7</sup> These are that a person must be assumed to have capacity unless incapacity is established; a person isn't to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success. Other principles include people not being treated as incapacitous merely because they make an unwise decision and that any treatment done under the MCA must be in the patients' best interests. The final principle relates to always ensuring that any decision made for the incapacitated takes into account the need for it to be done in the least restrictive way.<sup>7</sup>

The decision making mental capacity can be clinically assessed in the following four steps:<sup>7</sup>

- i) To observe if the person is able to understand the information given to them.
- ii) To assess if they can weigh up the information relevant to this decision.
- iii) To see if they are able to retain all this information.
- iv) And finally, whether the person can communicate their decision (by any means) and understand why they need to make it and the likely repercussions of making the decision.

It is the responsibility of every physician to understand the concept and the process of assessing capacity. It is also quite clear that making unwise decisions does not signify the lack of capacity as long as the patient has had access to all the relevant and important information to come to that decision. It should be the onus of the patient to make an informed decision and not of the physician. Doctors around the world in general and Pakistan in particular, at times become so involved in managing their patients that they feel the need to also make decisions for them. It is therefore very important to be aware of one's limitations and ethical responsibilities. On the other hand we have physicians who repulse any attempts of challenge put forth to their treatment plan, even if they are justified. Our patients put a lot of trust in us but this does not mean that we dictate our terms to them. Instead we should make every effort to come to a collaborative plan acceptable to both.

What more can be done to ensure that doctors are more aware of their ethical duties and responsibilities towards their patients? Though the Pakistan Medical and Dental Council (PMDC) guidelines clearly state that medical students must be taught ethics and evaluated,

none of the public or private sector medical colleges in the country have made it a mandatory part of their curricula.<sup>8</sup> It is high time that the PMDC fulfils its role as the sole training body for medical graduates in the country and assert the importance of this subject at undergraduate level. Similarly the post-graduate training authority, College of Physicians and Surgeons Pakistan (CPSP), can play a vital role in dispersing the knowledge of ethics and mental capacity to future consultants. Treating someone who is capcitous and has come to an informed decision, against their will or the will of their caretakers, is and should be considered illegal. Should the general population have more information about their own legal rights through the public domain? Would a law like the MCA of England and Wales help physicians and patients in Pakistan?

### References

1. Wong, J. C., Clare, I. C. H., Gunn, M. J., and Holland, A. J. Capacity to make health care decisions: its importance in clinical practice. *Psychol Med* 1999; 29: 437-46.
2. Zigmond T. A new Mental Health Act for England and Wales: grounds for compulsion. *Adv Psychiat Tr* 2004; 10: 243-6.
3. Lord Chancellor's Department. *Who Decides? Making Decisions on Behalf of Mentally Incapacitated Adults* (Cm 3803). The Stationery Office: London 1997.
4. Law Commission (1995). *Mental Incapacity* (Law Commission Report No. 231). HMSO: London.
5. Appelbaum, P. S., Grisso, T. Assessing Patients' Capacities to Consent To Treatment (1988) *NEJM* 1988; 319: 1635.
6. Jackson, J. Determining Competence: problems with the function test, in *Decision Making and Problems of Incompetence* (ed. Andrew Grubb), Wiley 1994.
7. *Mental Capacity Act 2005. Code of Practice*. Department for Constitutional Affairs, London. The Stationary Office 2007; pp 19-41.
8. Rana TA. Medical ethics in Pakistan: where do we stand? *Pak J Med Ethics* 2004; 3: 1.