Ethico-legal considerations in the assessment of capacity

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Abstract

The right of an autonomous person to make decisions about their care is central to the practice of medicine. However, we are often faced with situations where someone is unable to make those decisions because of their medical status, mental health or intellectual ability. Here we consider the legal framework for the treatment of individuals who lack the capacity to decide for themselves, and some of the ethical issues that inform how such decisions are made.

Keywords Best interests; mental capacity; mental disorder

Key points

- The Mental Capacity Act 2005 outlines a framework for the assessment of capacity
- Capacity needs to be considered in all decisions not limited to those that are counter to medical advice
- A psychiatric opinion may be helpful where capacity is impaired as the result of a mental disorder

Introduction

Mental capacity is defined as lacking when an individual is unable to make a *specific* decision at a *specific* time because of an impairment of, or disturbance in, the functioning of the mind or brain.[1]

Up until 2005, patients who lacked capacity were treated under 'common law', which had evolved over time through a series of legal precedents and court rulings. The Mental Capacity Act 2005 (MCA) replaced common law and set out to ensure that an individual's right to autonomy was enshrined in law, alongside a framework for protecting the interests of those unable to do this for themselves.[1] Five key principles are outlined in the MCA (Table 1), along with a functional test of capacity divided into four parts, namely, that the individual cannot: (1) understand the information relevant to the decision; (2) retain; (3) use and weigh the information; and (4) communicate their decision.

Capacity is only deemed lacking if there is evidence of impairment or disturbance in functioning of mind or brain and functional tests of capacity are not met. In individuals who lack capacity treatment can proceed providing it is in their best interests.

Ethical implications

The evaluation of an individual's capacity typically arises in response to a patient's rejection of medical treatment and is frequently swayed by the perceived risks associated with such a refusal. This suggests that not all self-determined choices are regarded with the same weight. In the case of individuals grappling with mental disorders or learning disabilities, their capacity is more prone to scrutiny than that of others; this implies that the assessment of capacity may exert a disproportionately significant influence on certain segments of society compared with others.

The right of the capacitous individual to choose can directly conflict with a doctor's duty to care for that individual, for example when a patient refuses life-saving treatment. This can provoke difficult situations in which fears of litigation, reputational damage and moral distress arise. In such instances, assessments may lean towards the patient being deemed lacking in capacity. The converse is also true — that a presumption of capacity could be inappropriately applied in order to justify non-intervention.[2]

The tendency for refusal of treatment to trigger capacity assessments also means that many people who, nonetheless, express wishes congruent with clinical recommendations are not afforded the protections of the MCA.

Best interests

Best interests as a concept is not defined in the MCA on the basis that the diversity of decisions to which the MCA might apply would make it too difficult to do so. In determining a person's best interests decision-makers must consider that person's past and present wishes, feelings values and beliefs. They must consult with family and others involved in the welfare of the individual concerned.

The five principles of the MCA

- Capacity is presumed unless it is established otherwise
- All practicable steps must be taken to optimize capacity
- An unwise decision is not sufficient grounds for deeming someone lacks capacity
- If someone lacks capacity, a decision must be made in their best interests
- Care must be taken to avoid unnecessary restriction of right or freedom of action

Table 1

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Ethical implications of best interests decisions

Ascertaining an individual's past and present wishes presumes that the individual had the requisite capacity at the relevant times to make informed decisions. In decisions involving, for example, newborns or individuals with severe mental disorder this is more challenging.

The temporal specificity of best interests decisions is also challenging given that a person's wishes may have changed over time. The UK National Institute for Health and Care Excellence recommends that the restrictions and freedoms associated with the different options should be considered, along with the likely risks, including the potential negative effects on the person who lacks capacity, such as disempowerment or trauma.[3]

'Best interests' extend beyond medical interests and should encompass medical, emotional and all other welfare issues.[4] However, the manner in which these various interests are balanced remains ambiguous and is likely to be influenced by the values, beliefs and inherent biases of the parties involved.

The MCA does not recommend substituted judgement (where the aim is to make the decision that the person would have made were they able to); instead a 'balance sheet' approach is applied where the likely advantages and disadvantages are weighed up against each other. The decision-maker is ultimately responsible for deciding which course of action is in the person's best interests. This can mean that the eventual decision is not consistent with the person's wishes and feelings.

There are a number of mechanisms through which people can try to ensure that, when they lose capacity, their wishes are upheld. A Lasting Power of Attorney (LPA) allows someone to choose who makes decisions about their care and welfare in the event that they are unable to. An LPA has to be registered with the Office of the Public Guardian in order to be legally binding.

Individuals can also make an advance decision to refuse treatment (ADRT), which allows them to inform their family, carers and health professionals of their wishes should they lose capacity to make those decisions in future. ADRTs are legally binding providing they are written down and have been signed and witnessed. Individuals can also appoint someone to make decisions about their care.

Mental capacity and the Mental Health Act (MHA)

The other Act of Parliament that legally protects compulsory treatment is the Mental Health Act 1983/2007.[5] This provides for the treatment of mental disorder providing the individual has a mental disorder of a nature or degree that warrants treatment, poses a risk to themselves or others and is unwilling or unable to consent to treatment. The MCA is explicit in stating that, in the treatment of mental disorder, the MHA cannot be overridden by any aspect of the MCA.[1]

This raises an interesting dilemma as the MHA makes little mention of capacity other than in three specific instances (psychosurgery or implantation of hormones, electroconvulsive therapy and after 3 months of compulsory treatment). Thus, it is legal for a patient with a mental disorder to be treated against their will for their mental disorder, irrespective of whether they have capacity to refuse that treatment. A recent review of the MHA has highlighted the need for patients to have much greater control over treatment decisions as well as earlier access to a second opinion for those who are detained.

In Scotland the Mental Health (Scotland) Act 2003/2015 makes more specific reference to the ability of the patient to make a decision about their disorder whereby doctors have to evidence that, as a result of a mental disorder, the patient's ability to make decisions about medical treatment is significantly impaired.[6]

In Northern Ireland, the Mental Capacity Act (Northern Ireland) 2016, when fully commenced, will fuse together within a single piece of legislation mental capacity and mental health law for individuals aged ≥16 years.[7]

When to seek psychiatric opinion

It is the role of all doctors to adequately assess capacity. However, in a number of instances it can be necessary to seek a psychiatric opinion. In instances where capacity is in question as a direct result of a mental disorder a psychiatrist may be required to determine the extent to which capacity could be optimized via treatment of the underlying condition. Where the MHA may also be relevant (e.g. the hospitalization of someone with dementia) or where an individual is already liable to detention under the MHA, psychiatry involvement is advised. In determining best interests psychiatric input may also inform a consideration of any emotional ramifications of a patient being given a treatment against their will. ◆

KEY REFERENCES

1 Mental Capacity Act 2005. http://www.legislation.gov.uk/ukpga/2005/9/contents (accessed 8 January 2024).
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3 National Institute for Health and Care Excellence. Decision-making and mental capacity. NG108. 2018. https://www.nice.org.uk/guidance/ng108/chapter/Recommendations#best-interests-decision-making (accessed 8 January 2024).
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5 Mental Health Act 1983/2007. http://www.legislation.gov.uk/ukpga/2007/12/contents (accessed 8 January 2024).
6 Mental Health (Scotland) Act 2003/2015.
7 Mental Capacity Act (Northern Ireland) 2016. https://www.legislation.gov.uk/nia/2016/18/contents/enacted (accessed 27 October 2023).

FURTHER READING

Taylor HJ. What are 'best interests'? A critical evaluation of 'best interests' decision-making in clinical practice. *Med Law Rev* 2016; **24:** 176–205.

TEST YOURSELF

To test your knowledge based on the article you have just read, please complete the questions below. The answers can be found at the end of the issue or online here.

Question 1

A 90-year-old woman presented with chest pain and shortness of breath. The ECG revealed ST elevation consistent with myocardial infarction. She appeared confused and when the medical team inform her that she needs to remain in hospital for urgent treatment she says no and asks to go home. She referred to one of the nursing staff as her husband and on being asked 'what year' answers 1999. She had no advanced decision to refuse treatment.

What is the next best step?

A. Do nothing as they are refusing treatment
B. Arrange a best interests meeting
C. Proceed with planned treatment
D. Request a Mental Health Act 1983/2007 assessment
E. Offer them supportive treatment

Question 2

A 39-year-old woman presented to the emergency department having been found wandering in the streets. She had pneumonia although her observations were stable. She refused treatment and wanted to leave. She said that she was being followed by MI6 and that some of the hospital staff were working for them. She had a history of treatment-resistant schizophrenia.

What is the next best step?

A. Use the Mental Health Act 1983/2007 to treat her
B. Transfer her to a psychiatric ward
C. Request a psychiatric assessment before commencing treatment
D. Use the Mental Capacity Act 2005 to keep her in hospital
E. Allow her to leave

Question 3

A 78-year-old man was awaiting discharge from hospital. The occupational therapy team believe that he could manage at home with three times a day care. His family were keen for him to go into a nursing home. He wanted to go home to live independently but was deemed not to have capacity to take this decision.

What is the next best step?

A. Arrange a best interests meeting
B. Discharge him to a nursing home
C. Discharge him home with regular support
D. Discharge to his home with no support
E. Arrange a safeguarding meeting