Capacity to consent for treatment: who decides?

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Introduction

This article presents the case of a 71-year-old woman who was admitted after having taken an intentional overdose of rivaroxaban in the absence of an established mental health disorder. The patient had a hereditary, debilitating physical health disorder, the impact of which led to a desire to take her own life. The various teams involved in her care had different views about the patient's capacity to refuse treatment for a catheter-associated infection and questions were raised about how to approach similar cases in the future. This case describes an important learning experience for clinicians in dealing with the challenges posed by the effects of infection on decision making, physical health conditions affecting mood and multidisciplinary team disagreement regarding the assessment of a patient's capacity. Ultimately, independent experts or a court of protection order should be sought in similar cases.

Case report

A 71-year-old woman presented to the emergency department from a care home following an impulsive and intentional overdose of 28 tablets of rivaroxaban 20 mg with clear suicidal ideation. This was following a breakdown in trust and communication at her nursing home and frustration at her lack of independence. The patient had a past medical history of hereditary spastic paraplegia, recurrent venous thromboembolism, recurrent urinary tract infections following long-term catheter placement and bilateral foot ulcers. She also had a significant history of allergy to a range of broad and narrow spectrum antibiotics as documented in her medical records. She had not prepared an advanced directive or sought legal advice about ending her life before admission to hospital. There were no medical concerns following the overdose and she was not treated with the antidote. She was initially deemed medically fit following close monitoring in relation to her overdose and was awaiting an appropriate placement that would meet her needs in the community.

A catheter change was performed at the request of the patient because of concerns about the consequences of visible sedimentation, and her temperature spiked to 39.3°C 2 days later, accompanied by a burning sensation and pain in the left flank and suprapubic region. At this time the patient refused all investigations, including blood tests, blood cultures and antibiotic therapy. Given her deterioration and concerns about her behaviour on the ward round, which included statements about wishing she could stab herself, an urgent mental health assessment was sought.

The medical team determined that the patient did not have the capacity to understand the consequences of refusing investigations and treatment. She had made it clear that she wished to die without pain or discomfort which, as had been described to her, would not be the case if sepsis developed and remained untreated. She was additionally not able to communicate an understanding of this aspect of her likely future deterioration back to the medical team. However, the mental health team concluded that the patient had the capacity to make decisions and therefore refuse treatment.

As the patient's infection developed, she became more clinically unwell with associated nausea, headache, rigours and significant discomfort. After much discussion, she was initially adamant that she did not want intravenous antibiotics but was willing to take oral trimethoprim and allow blood tests to be taken for biochemical evidence of the seriousness of her infection. Following microbiology discussions about the ineffectiveness of this option, given the progression of her infection, she consented to intravenous meropenem in the presence of junior doctors and senior nursing staff. This was administered, the infection subsequently resolved and she was discharged from hospital to a nursing home in the community.

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Case report (continued)

The mental health team called a meeting citing concerns that the medical team had treated the patient against her will, despite their view that she had capacity to refuse treatment. A multidisciplinary team meeting was arranged involving both teams, the safeguarding leads, mental health capacity lead and senior nursing staff. Based on the subsequent discussion, it was agreed that in the event of two consultants disagreeing about a patient's capacity assessment, an independent expert should be consulted, or a court of protection order should be sought.

Discussion

The Mental Capacity Act 2005 requires clinicians to assess a patient's capacity within the four domains of understanding information, retaining it, using and weighing up the information and communicating a decision. Unwise decisions do not by default render the patient to be lacking capacity and should be respected (Johnston and Liddle, 2007).

This case presented some ethical challenges that require recognition. First, this patient presented to hospital with an intentional overdose but in the absence of any history of mental health problems. It is quite common for physicians to label such patients as requiring psychiatric assessment, without thinking carefully about the circumstances around such a presentation. This patient had a rare, untreatable hereditary disorder causing progressive impairment to both her mobility and independence with associated ongoing pain. Therefore, her wish to die may seem very reasonable.

A second important consideration is the degree to which the patient's decision-making process might be affected as a result of being systemically unwell and clinically septic – a condition known to affect brain functions including memory, level of consciousness and higher functions (Ehlenbach et al, 2019; Giridharan et al, 2022; Pan et al, 2022). What if the patient was just making an unwise decision or perhaps the infection was impairing her judgement? Furthermore, do clinicians have a responsibility to inform patients of capacity assessments in real time and how might that affect the outcome (Schneiderman and Teetzel, 1995)? These questions are faced regularly in the hospital setting, requiring clear guidance for clinicians to ensure best advocacy for the patient's needs and interests (Talukdar, 2021).

Individual trusts have mental capacity leads who can advise on how best to approach cases with questions about capacity, and independent experts can be sought to provide an advanced directive for future treatment. An application to the court of protection for a deprivation of liberty safeguarding request is advisable in the rare circumstances when clinicians disagree about capacity, and decisions cannot be reached at the multidisciplinary level.

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Learning points

- Always document a formal assessment of capacity.
- When two consultants disagree about the assessment of capacity an independent expert should be consulted, or a court of protection order sought.
- A multidisciplinary approach should be encouraged at an early stage when complicated cases arise.
- Every effort should be made to respect the wishes of the patient.
- A collaborative dialogue between the medical and mental health teams will help provide the best possible care for the patient.

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