

Capacity to consent: issues and controversies

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Capacity to consent has major ethical and legal implications, but it is often poorly understood and inadequately practiced. Varied literature on the subject is reviewed with a view to discuss the legal and clinical aspects and strategies to improve current practice.

Clinical practice in recent times has witnessed several developments in the ethical and legal aspects of patient care. One of the most important of these is the issue of capacity to consent for treatment. Unfortunately, despite increasing emphasis, relatively little research has been done in this country on these issues, and most of the available literature is based on the ethical and legal framework of the USA. This review will critically examine issues relevant to capacity to consent to treatment.

CONSENT

The principle of autonomy is a fundamental component of English law and ethics. Any treatment (except certain treatments under the framework of the Mental Health Act 1983) without valid consent amounts to battery or assault. This could be perceived as a criminal offence that may lead to prosecution (McIlwain, 1999).

There are three components of a valid consent — the patient should have adequate information, the consent must be voluntary and the patient must have capacity to give or withhold consent. The phrase ‘informed consent’ is often used in this context. However, it is a term used in American legal doctrine since 1957 and has no actual definition in English law (McIlwain, 1999). The three components of valid consent obviously have overlapping considerations, but assessment of capacity to give or withhold consent remains the cornerstone of the whole process and will be the focus of this discussion.

COMPETENCY VS CAPACITY

The terms ‘competency’ and ‘capacity’ are often used interchangeably. Competence is a legal concept. Every adult is presumed competent unless a court of law determines that they are

incompetent. Although legal standards vary among jurisdictions, deeming an individual incompetent may require legal proceedings.

‘Decision-making capacity’ is a more pragmatic concept related to the clinical setting where a clinician determines the patient’s ability to make informed decision about his or her health care. It is obviously important because a determination of ‘incapacity’ strips the patient of his or her basic right of autonomy (Miller and Marin, 2000).

RESEARCH IN PRACTICE

Capacity to consent is often neglected in clinical practice and also often poorly recorded, specifically in conditions where it may fluctuate (Auerswald et al, 1997). Marson et al (1997) found significant disagreement between experienced physicians in judging the capacity of mild Alzheimer’s disease patients. Markson et al (1994) observed that physicians in general and psychiatrists in particular know the standard for capacity but may apply it incorrectly. This suggests that relying on expert opinion may introduce bias and produce inaccurate results that undermine patient autonomy. The authors’ recent study, assessing the capacity of psychogeriatric inpatients to consent to hospital admission, found only modest correlation between the views of the research psychiatrist and the treating clinician (Mukherjee and Shah, 2001). These findings indicate a difficulty in assessments and a potential lack of knowledge and understanding.

CAPACITY: THE BASIC FACTS

There are several views about what constitutes capacity and how to assess it, although there is no universal gold standard. In the UK, every adult is presumed to have the capacity to make treatment decisions unless proved otherwise.

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There are two main guidelines for the assessment of capacity. The High Court judgment in the case of *Re C* (adult: refusal of medical treatment) [1994] stated that capacity is present if the patient can fulfil the following criteria:

- They can comprehend and retain the treatment information
- They believe that information
- They weigh that information in the balance to arrive at a choice.

Further guidance has been published jointly by the British Medical Association (BMA) and The Law Society (1995). This states that the patient should be able to:

- Understand, in simple language, what the medical treatment is, its purpose and why it is being proposed
- Understand its principal benefits, risks and alternatives
- Understand, in broad terms, what the consequences would be of not receiving the proposed treatment
- Retain the information long enough to make an effective decision
- Make a free choice (i.e. free from pressure).

The BMA has published a report of its consent working party and produced a toolkit for doctors (BMA, 2001). The Department of Health has also published a reference guide to consent for examination or treatment (Department of Health, 2001). These guidelines are similar enough, and they provide a valuable framework for day-to-day clinical procedures, but they do not necessarily provide a standardized procedure.

Challenging the validity of a unitary standard for capacity determination, Drane (1984) proposed a 'sliding scale' model in which the patient's capacity is judged through three progressive levels of stringency as the decision becomes more potentially harmful. There are also various other issues related to consent in minors and other specific circumstances that are beyond the scope of this article but have been discussed elsewhere (Medical Defence Union, 1997).

CAPACITY: CLINICAL CORRELATES

There is no absolute or single clinical correlate of capacity. However, several researchers have focused on the effect of cognitive functions on capacity. Marson et al (1995, 1997) demonstrated that impairment of verbal fluency, conceptualization, semantic memory, verbal recall, executive dysfunction and receptive aphasia may adversely affect decision-making capacity. However, despite being helpful, simple cognitive assessment scales, such as the Mini Mental State Examination (Folstein et al, 1975), have a limited role, and

there is no agreed cut-off score. It is also worth remembering that capacity is decision-specific, and one should not presume incapacity based on someone's cognitive assessment, especially in cases of mild to moderate impairment.

The presence of a concurrent psychiatric condition, apart from cognitive impairment, may pose a different set of problems. Presence of thought disorder may affect communication, and psychotic thinking may influence decisions. Extreme phobia or panic, anxiety, depressive negative thinking, euphoria or profound anger may all impair rational thinking (Appelbaum and Grisso, 1988), although the presence of a psychiatric illness, however serious, does not make someone automatically incapable of making health-care decisions.

CAPACITY: WIDER CONSIDERATIONS

Assessment of capacity sometimes involves a wider consideration than the guidelines. Appelbaum and Roth (1981) argue that a clinician should take into account psychodynamic aspects of a patient's personality in his or her assessment. A patient's refusal or consent to a treatment decision may stem from past experience, emotional trauma, his/her interaction with or perceived reaction of his/her carers or the treating team. It is also important to ensure that the information that a patient receives is uniform and optimized to his or her ability. The patient may be confused by partial or conflicting information provided by different health-care professionals or overwhelmed by too much information. The authors stress that occasionally more than one assessment may be necessary, as capacity is not a fixed state but may fluctuate with changes in the patient's physiological, psychodynamic and mental state.

Capacity is also not absolute. A person may be able to make one health-care decision but not another. This understanding enables the patient to participate in decision making to the extent of their ability (Fleming et al, 1995).

It is also important to be culturally sensitive and aware of possible effects of difference in race, religion and social class between the patient and the assessor on the process of assessment of capacity. According to Lidz et al (1988), assessment of capacity should be a process rather than an event and should be an important part in the doctor-patient relationship and the joint decision-making process. They suggest that doctors should be aware that the patient may have a very different value system and that their role is to help the patient make decisions rather than to impose their own value structure.

CAPACITY: IN EMERGENCY

Clinicians in acute medical and surgical situations face a more difficult task in assessment of capacity because of time constraints and possible risk to life. The situation may be more complicated by the illness or trauma, the effects of any medication, acute stress of the situation and, at times, lack of information. Some situations may be obvious, e.g. an unconscious patient or someone who is very confused, and if the patient clearly does not have the capacity, duty of care should guide the course of treatment with a presumption that the patient would consent if he or she had the capacity to do so. However, conflict may arise between a doctor who considers a particular treatment vital and the patient who refuses consent to it. Here the issue of capacity is crucial (Hassan et al, 1999). A competent adult patient has the right to withhold consent to examination, investigation or treatment, even if such a decision is likely to result in death. It is also worth remembering that the common law doctrine of necessity and duty of care are only applicable if the patient clearly does not have the capacity to consent (Hassan et al, 1999).

WHO SHOULD MAKE THE ASSESSMENT?

It is the primary responsibility of the treating clinician to assess capacity (Department of Health, 2001), and a psychiatric opinion is seldom necessary. All doctors should be familiar with the principles of assessment of capacity, and it should be an important learning for all trainees, who should be supervised appropriately.

THE ROLE OF THE PSYCHIATRIST

Psychiatrists can play a crucial but selective role in assessment of capacity, but often they are consulted for wrong reasons (Guthiel and Duckworth, 1992). If the psychiatrist is asked to take part in the assessment, a joint assessment by the psychiatrist and the treating physician should be the norm. A psychiatrist on his or her own may not be able to give the necessary details of a proposed treatment or alternatives, and the eventual judgment on capacity may be flawed. If a psychiatric condition is responsible for incapacity, the psychiatrist may be able to treat the patient, making him capable again. Under the Mental Health Act 1983, medical treatment may be offered in life-saving circumstances where the patient's refusal of a treatment is a direct effect of their mental state, resulting in incapacity.

Psychiatric consultation may also be helpful for patients who are refusing treatment, particularly if the refusal does not appear to be a well-thoughtout decision based on previously expressed values or wishes. In this situation, the

purpose of the psychiatric consultation is not to assess capacity, but rather to address potentially remediable factors that may be contributing to the treatment refusal, such as poor communication, anxiety, hostility or anger, resulting in the breakdown of the therapeutic relationship (Katz et al, 1995). In certain situations, it may also help to resolve an angry response or countertransference from the staff that may prejudice their judgment of a patient's capacity.

STRATEGIES TO IMPROVE QUALITY OF ASSESSMENTS

Grisso and Appelbaum (1995) noted improved comprehension in patients when they were given treatment information 'part by part' rather than 'as a whole the first time'. The authors believe that some patients' understanding may improve with additional explanation, and a fixed inability to understand should not automatically be presumed on the basis of a patient's apparent lack of comprehension. One should also not assume a patient's lack of capacity simply because they lacked decisional capacity in the past. Re-evaluation is necessary whenever a significant decision needs to be made (Fleming et al, 1995). A patient's capacity may fluctuate throughout the course of illness and, at times, even throughout the course of the day, e.g. some patients may be relatively lucid in the early hours of the day but grow more confused as they tire.

Since there is a consistent period of lucidity, this type of individual could still participate in decision making about health care (Derse, 1999). Furthermore, it may be possible to remove barriers to decision-making capacity. These barriers may include language difference, low intelligence, limited education, impairment of speech, hearing or sight impairment, severe pain, sleep deprivation or, at times, treatment modalities, such as mind-altering medication or a respirator. More time needs to be spent with such patients, and appropriate specialist help should be sought whenever possible. Even a temporary removal of such a barrier may permit the patient who is capable to remain involved in making health-care decisions (Fleming et al, 1995).

CONCLUSION

Assessment of capacity is a cornerstone of good clinical practice and has immense ethical and legal implications. Universal good practice still appears to be lacking. Clinicians should be aware of the various issues involved in the assessment and, when working under pressure of time, should not put this important aspect of patient care at the bottom of their list of priorities. **HM**

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KEY POINTS

- Assessment of capacity is the cornerstone of ethical and legal clinical practice.
- Every adult is presumed to have capacity.
- Evaluation of capacity should be objective.
- Capacity is decision-specific.
- The more serious the decision, the greater the degree of capacity that is required.
- Cognitive impairment or a psychiatric condition does not automatically remove capacity.
- Assessment of capacity is primarily the responsibility of the treating clinician, and psychiatrists are of help only in certain circumstances.
- Wider considerations are necessary to ensure good practice, and every attempt should be made to find out the patient's true potential in the decision-making process.

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