CASE REPORT

Reflections on mental capacity assessments in general hospitals

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SUMMARY

Research suggests that a significant proportion of inpatients in general medical wards may lack capacity to make treatment decisions, a situation that often goes unrecognised by clinicians. We would like to briefly discuss two cases from a non-psychiatric setting, where a mental disorder served to inhibit the individual's ability to weigh-up associated risks when deciding to refuse potentially life-sustaining healthcare interventions. In both cases the history of mental disorder was well established yet, for markedly different reasons, the respective presentation was such that the influence of the disorder on decision-making was not evident to the treating teams.

BACKGROUND

A person's right to determine whether to consent to or decline medical treatment is long established and forms the cornerstone of the relationship between healthcare practitioners and their patients.¹⁻⁴ Outwith certain treatment decisions made under the auspices of the Mental Health Act 1983, this fundamental right extends to patients with a mental disorder who have the mental capacity to make such decisions.^{5 6} The law protects a person's decisional autonomy from the arbitrary or prejudicial judgments that they cannot make a decision for themselves merely by virtue of their disability, or by characteristics or concerns about the wisdom of the choices they make.⁷ Nevertheless, there are occasions where a mental disorder will render an individual unable to make a decision about treatment¹ because it impairs that person's ability to understand, retain or use the relevant information, or to communicate their wishes.⁸ In this sense it is important to emphasise that not all people with a mental illness will lack decision-making capacity and, conversely, not all people who lack capacity to make decisions will have a mental illness; capacity is not just 'a mental health issue'.

Capacity assessment can be an inherently complex endeavour.⁹ Assessments resting on an appraisal that the person is unable to weigh-up the consequences of making a particular decision are generally more complex¹⁰ and potentially more controversial than assessments determined on the other elements of the functional test such as comprehension or retention of relevant information; particularly where the subsequent best interests decision conflicts with the person's expressed wishes.¹¹ Moreover, recent court decisions stress the importance of ensuring assessments carefully distinguish the different decisions a person might

face¹² and the need to avoid any temptation to 'conflate a capacity assessment with a best interests analysis'.¹³ All of which perhaps testifies that the current 'mood music' of the Court of Protection is an emphasis on the rights of the individual in the face of any apparent over-protective bias of involved professionals. Of course, such a stance is not an altogether new phenomenon. The cases of *Re C* [1994]⁵ and *Re MB*[1997]¹⁴ established that, to be deemed unable to make a healthcare decision, there must be a clear correlation between the person's mental disorder and the process of weighing up the relevant information for the particular decision; it is not enough for the person to be evidently disordered if the disordered thinking is not pertinent to the decision in question.

Despite such cautions, evidence suggests that many healthcare practitioners operate in relative ignorance of their responsibilities under the Mental Capacity Act 2005.^{15 16} Where a mental disorder is evident our experience suggests that clinicians are inclined to decide that incapacity exists, often without informed, considered assessment. That said, on other occasions, mental disorder either goes unrecognised or its impact on decision-making is not always adequately recognised.² The cases we highlight represent examples of these scenarios in situations that had potentially profound implications for the individuals concerned.

CASE PRESENTATION

Patient A is a 67-year-old gentleman with a long-standing diagnosis of treatment resistant schizophrenia who was seen by a surgeon in relation to suspected caecal cancer. Patient A's past experiences with mental health services had led him to try to shield his paranoid thinking from healthcare professionals. When CT colonography showed a suspicious caecal polyp, the patient declined the surgeon's suggested need for a diagnostic colonoscopy, while concealing his rationale for this refusal. The patient's mental capacity was assessed and, initially, the treating team believed that he possessed the necessary capacity to refuse further investigations for his suspected cancer.

During an unconnected routine assessment of his mental state by the patient's psychiatrist he eventually disclosed the paranoid thinking underlying his decision. He was convinced that the surgeon had put a metal chain in the barium suspension that he had ingested prior to the colonography in order to prove on the scan that there was something inside the patient's bowels. The patient firmly held the belief that his surgeon had done this with the sole

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intention of justifying an invasive procedure with an ulterior motive to kill him while undergoing surgery. It was subsequently accepted that the patient's paranoia was affecting his ability to make a decision regarding the proposed colonoscopy and the psychiatrist arranged a multidisciplinary meeting involving an Independent Mental Capacity Advocate, Patient A and the surgical team to review the management plan. A subsequent CT scan demonstrated no abnormalities and no further involvement from the surgical team was required.

Patient B is a 58-year-old, highly intelligent gentleman with a history of depression, chronic alcohol abuse with associated liver damage, and Ca mandible which had been surgically excised. He had experienced numerous past admissions to hospital with his most recent admission being prompted by his general poor health and a desire to repair his percutaneous endoscopic gastrostomy (PEG) site which he had been damaging through self-harm. On the ward patient B either refused or persistently postponed a multitude of medical and nursing interventions such as blood tests, medication, wound dressing for chronic ulcers, care of his personal hygiene (including episodes of double incontinence), repair of the PEG site and cosmetic surgery to repair the hole in his cheek caused by surgical treatment of the cancer to his mandible.

Patient B presented as an eloquent and assertive self-advocate who forcefully expressed his right to determine his care and treatment with threats to take legal action against any clinicians who did not respect his wishes. The treating team viewed that the patient possessed the capacity to refuse these various nursing and medical interventions but, because of the potentially serious consequences associated with his refusals and a sense of considerable desperation, asked for a second opinion from mental health services. Once a relationship was established and it proved possible to delve beyond his initially assertive denial of any difficulties, the assessing psychiatrist found that the patient was depressed and that negative cognitions such as hopelessness significantly impaired his ability to adequately weigh-up the consequences of refusing healthcare decisions.

The interface between Mental Capacity Act and Mental Health Act is a complex one and beyond the remit of this article to fully explore. However, in general, if the mental disorder is of a nature or a degree which poses significant risks to the individual or others, the Mental Health Act can be used to impose treatment of that mental disorder.¹⁷ In contrast, the use of the Mental Capacity Act applies to all the decisions taken in the best interests of people who permanently or temporarily lack capacity, including decisions relating to medical treatment.

DISCUSSION

When a patient refuses an important healthcare intervention their decision is questioned if an impairment or disturbance in the functioning of the mind or brain causes the treating clinician to doubt that patient's capacity.¹⁸ Despite the caution implicit to the judgment in *Re C*, there have been a number of cases where delusional beliefs have been found to impair a person's ability to weigh-up relevant information for a treatment decision.^{19 20} In the case of our first patient the overt impact of mental disorder was not obvious to the surgeon during his assessment as the patient was discrete with the information he imparted to the surgeon owing to paranoia. If the impact of paranoid thought processes on treatment decisions can go unrecognised in a patient diagnosed with a functional mental illness, it might be speculated that the risks of such occurrences are considerably higher in the less familiar context of physical conditions, such as delirium.²¹

Learning points

- ▶ All healthcare professionals have a responsibility to have regard to the Mental Capacity Act Code of Practice and should understand the Act's basic principles. Any healthcare professional who seeks consent for a form of treatment or intervention must be able to undertake an assessment of decision-making capacity. The treating clinician is usually best placed to undertake this assessment as they have the requisite knowledge of the clinical intervention and the related risks and benefits to be considered. If that assessment is inconclusive, or proves to be particularly complex, it is a good practice to seek a second opinion.
- ▶ Where a patient has a history of mental illness we advise a comparatively low threshold before seeking a second opinion in relation to capacity to make important healthcare decisions, not least because the effects of mental disorder on decision-making can be as difficult to recognise as it can be decisive in its impact.
- ▶ An apparent desire to be left alone can give rise to a risk that the wrong conclusions may be drawn about capacity. Enquiring about a patient's mental health symptoms with compassionate demeanour, using empathic communication, may serve to facilitate greater accuracy in assessments of capacity while also building the relationship necessary to move forward with greater cooperation.
- ▶ Provision of a mental health liaison service (which includes a psychiatrist involvement) in general hospitals is likely to improve the quality of capacity assessments in a broader context of improving overall patient care.²¹
- ▶ Where a patient is assessed as having the necessary mental capacity for a particular decision, the person is able to make that decision autonomously, even if healthcare professionals consider their choice unwise.⁷ Conversely, where a person is found to lack capacity, a decision must then be made in his/her best interests. This is a statutory process which considers the person's wishes, in conjunction with a consultation of people involved in their care and interested in their welfare. Valuable guidance and information can be found in Chapter 5 of the Mental Capacity Act Code of Practice. Alternatively, seek advice from your organisation's Mental Capacity Act Lead.

The correlation between physical ill health and depression is a commonplace phenomenon, recognised to inhibit a patient's motivation to participate in their care and treatment, and yet often goes unrecognised.²² With patient B the evidence of mental disorder was vested in his self-defeating behaviours which arose owing to depressive symptomatology, including a lack of motivation, hopelessness and helplessness, although this was masked by his eloquent presentation and since the predominant emotion he displayed was anger. Despite the administration of high doses of analgesia in varying forms, patient B expressed a concern that personal care interventions caused him pain. Patients like B, who are highly intelligent and can articulate good reasons for their decisions may still lack capacity for significant treatment decisions^{8 23} and, as such, are no less deserving of being protected, where this is in their best interests, from their own inclinations.

Patient B had multiple healthcare needs, ranging from basic nursing care to potential surgical intervention. The disturbance

in his mental functioning caused by his depressive state was further complicated and fluctuated because of organic problems, including electrolyte imbalance. The requirement for capacity assessments to be both time and decision²⁴ specific posed considerable challenges to the treating team as different interventions needed to be offered to the patient on a daily basis. Equally, as is so often the case, the determinations in respect of capacity were only the beginning of the care journey, as clinicians then faced the ethical dilemmas implicit to the provision of care and treatment to an individual against his wishes, with the possibility of his active resistance. In the event, some cooperation and considerable acquiescence was achieved, reflecting in part the good relationships that were built up between B and his care team but also, sadly, since his physical health swiftly deteriorated despite their best efforts.

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