

# Consenting adults: assessing mental capacity

The concept of informed consent is based on an individual's basic human right to make their own decisions and pursue their own goals. However, a diagnosis of dementia or other form of cognitive impairment can jeopardise a patient's ability to give informed consent. **Dr Premila Fade** looks at how mental capacity should be assessed and how patients who lack capacity should be managed.

**T**he concept of informed consent derives from the principle of autonomy. Autonomy means self rule – the freedom of the individual to make their own decisions and pursue their own goals. Autonomy is valuable because freedom to choose one's own destiny is essential for human happiness. Society places many limits on autonomy but the freedom to decline medical intervention (if one is of sound mind) remains absolute.

Unfortunately not all human beings are capable of autonomy. However, civilised society is built on the notion that all human life is of equal worth and therefore all persons regardless of their capacity for autonomy have an equal right to protection by the state and are equally worthy of life sustaining medical treatment.

All persons also deserve respect and dignity. Although society has a duty to protect the vulnerable from danger, it also has a duty to respect their independence as far as is possible. Thus doctors must balance protection of life and well being against freedom and liberty.

## Informed consent

A patient of sound mind has a right to decline medical intervention for any reason<sup>1</sup>. If a doctor proceeds without consent then a criminal charge

of assault or battery may be brought. If the doctor gains consent to the 'nature and purpose' of the treatment then he may proceed; however, he may still be liable for a charge of negligence if the patient has not been adequately informed of the risks of the procedure. Information given must specify significant risks and answer the patient's particular concerns.

In order for consent to be valid, the patient must have capacity to make the decision, must be given sufficient information to make the decision and must be free from coercion or undue influence from family, friends or healthcare professionals.

## Assessing capacity

A person must be presumed to be capable of giving consent unless proved otherwise and lack of capacity cannot be established just because the person has dementia or a mental illness<sup>2</sup>. Capacity is not assessed by cognitive assessment or by disease severity scales. Capacity is decision-specific, as a person may be able to make some decisions for themselves but not others. For example, a patient with severe dementia may be able to decide for himself where he wants to live or when he wants to take a bath. The legal test for capacity is based on the case of *Re C*<sup>3</sup>. This concerned a paranoid schizophrenic who

**Table 1.** Assessment of capacity

Is the patient suffering from a disorder of the mind or brain that interferes with thinking and/or communication?  
 Can the patient:

- > Understand and retain information relevant to the decision?
- > Use or weigh the information as part of the process of arriving at a decision?
- > Communicate the decision by any means?

was refusing an amputation for gangrene. The patient was certainly delusional but the judge was convinced by his reasons for refusing the amputation and felt he did understand the danger to his life of his refusal – the patient stated clearly that he had come into the world with four limbs and he intended to depart the same way. The so called ‘re C’ test has now received statutory endorsement in the Mental Capacity Act 2005<sup>2</sup> (*Table 1*).

Capacity may fluctuate, but a person’s decision made when he has capacity cannot be overridden when he does not have capacity. If a decision can wait and it is possible that the patient may regain capacity, then the decision should be deferred. If the decision to be made is minor and does not have significant consequences for health or safety then the capacity required to make that decision is lower than for a decision that has major health or safety implications.

The professional (the decision maker need not necessarily be a doctor or even a healthcare professional – eg, a social worker) deciding capacity must do everything possible to present the information in a way the patient can comprehend and must facilitate communication with the patient by all available means (eg, using a translator, writing information down or using a speech and language therapist to help).

In coming to a decision regarding capacity, the professional should assess the patient’s understanding by asking questions about the information given and explore the patient’s reasoning. If the patient can understand the risks/benefits of the treatment proposed and can give valid reason(s) for refusing or accepting the proposed treatment, then the patient should be judged to have capacity to make that decision

**Table 2.** Mental capacity act: best interests

The decision maker must:

- > Balance the risks and benefits of the treatment/procedure
- > Involve the person who lacks capacity
- > Have regard for past and present wishes and feelings, especially written statements
- > Show respect for religious/cultural beliefs
- > Consult with others who are involved in the care of the person
- > Not make assumptions based solely on the person’s age, appearance, condition or behaviour
- > Choose the least restrictive option.

even if the decision seems unwise or even reckless to the professional.

The decision need not be logical from the perspective of the professional as long as it makes sense to the patient (as in the Re C case). This is the most difficult stage of the test to assess.

### **Making a best interests decision**

If the medical team decide a patient does not have capacity, then they must act in the patient’s best interests. The best interests test is derived from case law and professional guidelines<sup>2</sup>. It has now received statutory confirmation in the Mental Capacity Act 2005 (*Table 2*). The Act places particular importance on choosing the least restrictive option possible in terms of the patient’s rights and freedoms<sup>2</sup>.

Although the decision on best interests rests with the medical team, the patient’s family/friends must be consulted<sup>1,2</sup>. If the patient’s family disagree with the decision made by the medical team then further discussion to find a solution acceptable to all parties should take place<sup>3</sup>. If there is still conflict an application to the Courts can be made but this should be a last resort. Effective empathic communication is extremely important in this process.

If a patient lacks capacity and does not have anyone to speak on his behalf (no next of kin or friend), then an Independent Mental Capacity

## Case studies

### Case study one

A GP is called to Mr B at home by his son who has found him on the floor unable to get up. The patient is upset that the GP has been called, he says he does not need any help but he is clearly short of breath and the GP decides he needs admission to hospital for appropriate assessment. However, the patient does not agree and refuses to go with the ambulance crew. The patient has a diagnosis of vascular dementia made three years previously by a psychiatrist but there has been no recent medical contact except with the district nurses who have been dressing a leg ulcer. The house is untidy and dirty, Mr B has lived alone since his wife died a year ago. Mr B's son has noticed a significant decline in his father's memory and cognition over the last year and he is worried about his father's ability to live independently and manage his own affairs. What should the GP do?

The first issue is does the patient have capacity? Just because the patient has a diagnosis of dementia does not mean he lacks capacity. The GP should explore with the patient why he does not wish to go into hospital. If the patient understands the reasons why the GP wishes to admit him to hospital, can give an explanation for his refusal and has insight into the risks he faces if he remains at home then he has capacity to make this decision.

Secondly the GP should explore alternative assessment and treatment options with the patient – is there a local intermediate care service that can treat and support Mr B at home? If possible patients with dementia should be treated at home because disruption of normal routine and removal from familiar surroundings may cause a significant decline in cognitive abilities that then impacts on ability to live independently on discharge from hospital. Finally the GP could contact the district nurse who knows the patient better than the GP and may be able to persuade him to accept medical intervention.

### Case study two

Mrs A is 78 years old; she suffers from moderately severe dementia and lives in a rest home. She is admitted to hospital with severe community acquired pneumonia. She is very confused but assents to all interventions. The admitting team commence treatment with antibiotics, fluid resuscitation and oxygen therapy. The rest home report that she has declined in health generally over the last few months; they were struggling to cope and feel she will need placement in a nursing home on discharge from hospital. They report that the patient is generally happy, she engages with staff and other residents but her language is limited and she does not recognise carers or her daughter who visits regularly. The medical team feel a resuscitation decision should be made so they consult the patient's daughter. The daughter says her mother always said that she would not want to be kept alive if she was going to be a 'vegetable' or a 'burden'. The daughter feels that her mother would not want resuscitation, antibiotics or any other medical treatment that would prolong her life. What should the medical team do?

Where there is doubt about what is in the patient's best interests life prolonging medical treatment should be given if clinically indicated. If there has been improvement in the patient's clinical condition then capacity should be reassessed.

The medical evidence suggests that the treatment is working. If active treatment is discontinued it is not certain that the patient will die imminently.

The meaning of 'burden' and 'vegetable' need to be explored with the daughter. Evidence from the rest home suggests her mother does still get some enjoyment from her life. More background information may be useful; contact should be made with the patient's GP and any other family members or close friends. Nursing staff should be consulted as they may have valuable information to impart regarding the benefits/burdens of the medical treatments being given. If after further discussion with the daughter agreement cannot be reached about the patient's best interests then a second independent medical opinion should be sought.

## Key points

- The concept of informed consent derives from the ethical principle of autonomy.
- In order for consent to be valid a person must have capacity to make the decision.
- Capacity is decision specific and is not predetermined by a diagnosis of cognitive impairment or mental illness.
- A person has capacity if they can: understand and retain the information necessary to make a decision, use and weigh up the information to reach a decision and, communicate that decision.
- If a person lacks capacity the medical team must make a decision in the person's best interests, taking into account not only the medical facts but also the patient's wishes and evidence from family about the patient's previously expressed values, beliefs and wishes.

Advocate (IMCA) should be appointed and consulted if the decision concerns serious medical treatment or change of residence<sup>2</sup>. All healthcare organisations should now have access to an IMCA service.

The IMCA is there to act on the patient's behalf and ensure their voice is heard. The IMCA's opinion is not binding on the medical

## References

1. General Medical Council. Seeking patient's consent: the ethical considerations. London GMC 1998. Re C (Adult: refusal of medical treatment) [1994] 1 WLR 290
2. Mental Capacity Act 2005. [http://www.opsi.gov.uk/acts/acts2005/ukpga\\_20050009\\_en\\_1](http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1) (date last accessed: 10/09/07)
3. British Medical Association. Withdrawing and withholding life prolonging medical treatment. London BMJ publishing 1999

team but must be given careful consideration when deciding on best interests.

## Conclusion

A diagnosis of dementia does not preclude the ability to consent to medical intervention. Capacity is decision specific and every effort must be made to enhance the patient's understanding and communication. Even if the patient cannot give informed consent they must still be at the centre of the decision making process.

Any decision made on best interests should respect the beliefs and values of the patient and his family, preserve the patient's dignity and be the least restrictive of his liberty.

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