

## TAKE-HOME NOTES:

**Competence, capacity and decision-making in mental disorder**

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**Current bioethical debate** is founded on three broad philosophical approaches:

- deontological theory
- utilitarian theory
- Judaeo-Christian tradition.

**Autonomy**

This is a key concept in issues surrounding competence, capacity and decision-making. A modern definition of autonomy is:

*'...critical self-determination in which the agent strives to make decisions which are as little marred by defects in reason, information or control as she can make them.'* Harris (1985)

**Consent has three components:**

- information disclosure
- the patient must be competent/have capacity
- the decision must be voluntary without coercion.

The **Doctrine of Necessity** legitimises non-consensual touching if the resulting benefit outweighs the consequences of strictly adhering to the law. This is providing there is no known objection to the treatment, and the treatment given is no more extensive than the exigencies of the situation, i.e. precludes procedures not necessary to the patient's survival.

**Treatment of incompetent patients**

Currently the judge, not the doctor, has the duty to decide whether treatment is in the best interests of the patient. The judicial decision should incorporate ethical, social, moral and welfare considerations.

**Presumption of 'capacity'**

Treating a patient against their wishes is technically assault if they have capacity. Disputed capacity most often becomes an issue in the context of a patient holding a different view on the medical management proposed and disagreeing with their doctor.

## **Statutory definitions of (in)capacity**

These are included in:

- The Adults with Incapacity (Scotland) Act 2000
- The Mental Capacity Act 2005

## **'Eastman test' of capacity**

- Can the patient comprehend and retain the information given to them about the proposed treatment?
- Does the patient believe the information given to them?
- Can the patient weigh the information in the balance and arrive at a choice?

## **Exceptions to the 'respect for autonomy' model**

Exceptions have been made in cases involving pregnant women, where the best interests of the foetus were considered. Mental health legislation has also been used to legitimise physical treatment in both anorexia and borderline personality disorder.

## **Significantly impaired decision-making ability (SIDMA)**

This is a subcategory of incapacity and refers to the impact of the symptoms of mental disorder on the individual's ability to make decisions about his or her psychiatric treatment. It is associated with:

- **severity of mental illness**
  - formal thought disorder and delusional beliefs
  - manic states
  - lack of insight
  - negative symptoms
- **learning disabilities**
  - deficits in verbal and memory abilities
  - difficulties with problem solving
  - tendency to acquiesce
  - suggestibility
  - problems with concreteness and abstracting from examples
- **dementia**
  - executive dysfunction.

## Decision-making ability

This may be enhanced by:

- taking time over the process
- minimal distraction
- clear communication:
  - information leaflets
  - explaining the pros and cons
  - facilitating reflection, relating and questioning
  - presenting information one part at a time, rather than in an uninterrupted disclosure
  - simplified disclosure format
- giving written information before admission to hospital
- making it clear the decision is the patient's
- attention to communication problems
- modification of the consent setting
- written memory aids, which may help patients stay on task.

## Reflection

(2.3) Think about ways you might determine if a patient is competent or has the capacity to make decisions. What would your criteria be?

(2.12) What do you think was the Judge's decision when this case was presented before the Court?

(2.14) Can you think of any cases where an exception might be made to the model which 'respects autonomy in all circumstances'?

(4.9) How do you think you could help to facilitate decision-making in someone with mental disorder?

(4.11) How do you think you could help to facilitate decision-making in someone with a learning disability?

(5.3) Mr F: Which legislative instruments do you think should be in play here?

(5.6) What do you think would be the role of (in)capacity legislation in this scenario?

(5.9) What are some of the issues that are illustrated in Mr L's case?

(5.12) What do you think is the most appropriate action in this case? Why?

## Further guidance

Further guidance on the background and process of seeking consent is available in the following documents:

[BMA/Law Commission 'joint guidance' \(2004\)](#)

[Consent: patients and doctors making decisions together 2008](#)

[BMA 'consent tool kit' March 2001](#)

[Health Service Circular HSC 2001/023: Good practice in consent. Achieving the NHS Plan commitment to patient-centred consent practice. Department of Health 2001](#)

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#### **Statute**

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Mental Capacity Act 2005, HMSO

Mental Health (Care and Treatment) (Scotland) Act 2003. HMSO