ARTICLE

Are Psychiatric Patients Disadvantaged in Assessment of Competence to Consent to Treatment?

Natalie Wee BSc
Duke-NUS Graduate Medical School
Singapore

XiaoYun Chong BEng
Duke-NUS Graduate Medical School
Singapore

Abstract

Mental capacity assessment can be challenging, particularly for psychiatric patients. Through a case vignette, we highlight some difficulties in assessing mental capacity of psychiatric patients to consent to treatment, focusing on physician biases. These biases may undermine the reliability of mental capacity assessment and hence disadvantage psychiatric patients by removing their autonomy. We discuss overt and specific biases relating to assessment of appreciation and reasoning in psychiatric patients, relating them to current research findings and Singapore's Mental Capacity Act. Finally, we propose clinical recommendations to help reduce the identified sources of bias.

Key Words: *mental capacity; competence; psychiatric; consent; decision making; bias.*

INTRODUCTION

A 28-year-old woman with a background of generalized anxiety disorder is admitted informally to the psychiatric in-patient ward, due to paranoia and deep mistrust of her mother. Her psychiatrist has diagnosed her with schizophrenia and intends to start her on a course of antipsychotics. In the consultation room, the patient looks extremely anxious. Questioning the doctor's diagnosis and worried about the side effects of her new medications, she refuses the antipsychotics but agrees to continue her medications for anxiety. How should her physician determine if her decision is a competent one? Does her existing anxiety disorder or her new diagnosis of schizophrenia mean that she lacks capacity to make decisions regarding her treatment?

The Clinical Problem

Determining whether a patient is mentally capable of participating in decision-making is conceptually, ethically, and practically challenging, particularly when evaluating psychiatric patients' competence[1] to consent to treatment (Raymont, 2002). Physicians are obligated both ethically and legally to obtain the informed consent of patients before initiating treatment (except in emergencies). Informed consent is only valid when information appropriate to the decision is provided to a *competent* patient, who then makes an autonomous choice. If patients are not deemed competent, a substitute decision-maker who will act in the patient's best interests has to be sought. Therefore, it is crucial for clinicians to determine whether their patients are competent, in order to strike a balance between preserving the autonomy of those who are capable of making informed decisions and providing care in the best interests of those who lack capacity (Appelbaum, 2007).

Despite the importance of accurately assessing competence, data suggests that clinicians' assessment of psychiatric patients' capacity for consent to treatment is suboptimal and may be influenced by overt bias (Shah & Mukherjee, 2003). Even when structured assessment tools are used, physicians may not realize their bias to perceive psychiatric patients as unable to 'appreciate' their illness, or unable to 'reason' rationally about their treatment options. These various sources of bias are discussed below, followed by recommendations for practice.

Inconsistency and overt bias in assessment

Any disease that affects mentation may impair capacity. It is no wonder that there is a natural tendency to judge psychiatric patients as lacking competency. This assumption may lead physicians, without utilizing structured assessment tools, to decide

to evaluate capacity, or may bias their assessment even when such tools are used. In a survey of internists, psychiatrists and surgeons, Markson and colleagues (1994) found that many physicians see the assessment of competence as a medical question, rather than an application of a legal rule. When faced with a situation where they disagreed with the medical decision of the patient, physicians found it difficult to apply the legal standard properly.

Similarly, a systematic review of capacity to consent to treatment in psychiatric patients found low levels of agreement between a clinician's assessment and that made by a clinical researcher using a formal mental capacity assessment tool (Okai, Owen, McGuire, Singh, Churchill & Hotopf, 2007). This physician bias may be exacerbated by the inconsistency in assessment methods. The 37 studies included in the review were highly diverse in their definitions and measurements of capacity, with 29 different capacity assessment tools employed. Despite this, it was found that the majority of psychiatric patients were able to make treatment decisions, with a median of 29% lacking capacity.

Singapore's Mental Capacity Act

Singapore's Mental Capacity Act (MCA) contains statutory principles, emphasizing respect for persons as a tenet undergirding its various provisions. Importantly, it cautions against biased assessments of capacity based on irrelevant criteria (Kua, 2009). Lack of capacity cannot be based solely on a person's age, appearance, physical or intellectual disabilities, behavior and even the quality of his or her decision [Mental Capacity Act, Cap 177A, 2010 Rev Ed, s 4(3)(a),(b) 3(4)].

Although the MCA provides legal guiding principles, it lacks specific guidance about who should conduct capacity assessment or how assessment is made. For instance, the assessment can be conducted either informally during consultation with a patient, or formally by a trained specialist, either by applying their professional judgment alone or with the aid of validated tools such as the MacArthur Competence Assessment Tool for Treatment (MacCAT-T). This flexibility in application may allow prejudice to exert undue influence in capacity assessment of psychiatric patients in particular.

Recommendation for practice

Not all patients with psychiatric conditions lack capacity. To reduce the undue influence of physician biases, a formal assessment tool should be utilized in all capacity assessments of psychiatric patients. Based on U.S. case law, mental capacity has been operationalized as four abilities – "understanding", "appreciation", "reasoning" and "expression of a choice" (Berg, Appelbaum & Grisso, 1996). The MacArthur Competence Assessment Tool-Treatment (MacCAT-T) is a semi-structured interview probing these four abilities, which fit with the legal understanding of competence. In combination with a clinical interview, the MacCAT–T has been found to produce highly reliable judgments of capacity (Cairns et al., 2005). Standardizing the use of this structured instrument would lead to greater reliability and validity of capacity assessments, and guide the clinician in assessing capacity as per the legal standard.

Bias in assessing ability to "appreciate" one's illness

A cross sectional study found that in a psychiatric population where psychotic and affective disorders predominated, it was the patients' inability to *appreciate* their illness that contributed most to their lack of capacity. In contrast, the inability to reason was the key determinant of lack of capacity in the sample of medical patients where cognitive impairment was common (Owen, Szmukler, Richardson, Freyenhagen, Martin & Hotopf, 2013). Likewise, a lack of awareness of the illness was found to be the strongest predictor of incapacity in psychiatric patients (Cairns, et al., 2005).

Even when a structured tool such as the MacCAT-T is applied, there may be physician bias in assessing psychiatric patients' ability to *appreciate* their illness. Psychiatric diagnoses are controversial, and physicians may mistake a rejection of a medical opinion as a lack of awareness and the need for treatment. For medical conditions, physicians accept that patients may reject their medical opinion and seek a second opinion. In contrast, psychiatric patients who reject a medical opinion are often seen as being unable to appreciate their illness, labeled as "lacking insight" and henceforth failing capacity tests. This is a form of circular reasoning: treatment refusal is equated with incapacity.

Mental capacity assessment may be biased by a physician's tendency to impose normative judgments on patients' beliefs, values and emotions, especially for psychiatric patients (Banner, 2012). For instance, patients with anorexia nervosa may refuse to accept treatment to gain weight as they value being thin over their health. A physician imposes society's normative beliefs of valuing one's life over body image and judges the patients' value of being thin as pathological. In more subjective cases, a physician's own personal world view may slant his understanding of normative values. The MCA emphasizes the need to respect the person's value system [Mental Capacity Act, Cap 177A, 2010 Rev Ed s 6(7)(b)]. However, physicians may cite provisions in common law which state that health interventions are lawful when there is a necessity to prevent harm (Mental Capacity Act, Cap 177A, 2010 Rev Ed s 7, 8) when these acts are in the best interests of the incapacitated person (Chin, 2009).

Recommendation for practice

Despite the advantages of using a standardized tool, clinical judgment is still an inextricable part of the assessment process. The evaluation of psychiatric patients' ability to appreciate their illness still has a degree of inherent subjectivity, which can introduce bias. It is impossible [and some would argue, undesirable (Banner, 2012)] to entirely eliminate the physician's tendency to impose socially normative judgments in assessing psychiatric patients' ability to appreciate their illness. However, simply acknowledging that the assessment is underpinned by a socially normative judgment, rather than a medical judgment, may in itself enhance clinical judgment, by prompting clinicians to better understand their unconscious assumptions guiding these norms (Banner, 2012).

Bias in assessing ability to "reason" due to one's illness

In addition, there may be bias in assessing psychiatric patients' ability to reason. Amongst psychiatric patients, patients with psychotic disorders in particular have difficulties in the interpretation of reality, and it is tempting to conclude that they have impaired mental capacity. Indeed, a systemic literature review found that 75% of patients with psychotic illnesses were judged to lack capacity (Owen, Richardson, David, Szmukler, Hayward & Hotopf, 2008). Up to 80% of patients with schizophrenia, the prototypic psychotic illness, were found to lack competence. In contrast, only about 31% of patients with depression were found to lack capacity. This is consistent with other studies showing that among psychiatric disorders, schizophrenia has a stronger association with impaired capacity than depression (Grisso & Appelbaum, 1995; Vollmann, Bauer, Danker-Hopfe & Helmchen, 2003), although patients with bipolar disorder may have levels of impairment in decision-making that are similar to those of patients with schizophrenia (Palmer, Dunn, Depp, Eyler & Jeste, 2007). These observed differences in impaired decision-making ability may be a result of bias and are not well studied.

Although the prevalence of incapacity amongst patients with schizophrenia is relatively high, some patients with psychotic disorders have preserved decision-making capacity. Owen et al. (2007) studied the ability of schizophrenic patients to reason using practical rationality and theoretical rationality. Practical rationality or "common sense" is shared knowledge within a culture, such as the fact that the sun rises in the east. Theoretical rationality is the ability to make a logical conclusion from a set of rules. A simplified example would be the conclusion that not all four legged animals are dogs, if all dogs have four legs. Interestingly, although schizophrenia causes impairment in practical rationality, theoretical rationality is intact or even enhanced in patients with schizophrenia (Owen, Cutting & David, 2007). Taken together, these findings caution against assuming that patients with schizophrenia cannot make rational decisions simply because they experience an altered reality.

Notably, the MCA states that the test for capacity is a *functional* one, assessed according to the ability of the person to make a particular decision at a particular time, rather than in general [Mental Capacity Act, Cap 177A, 2010 Rev Ed s 4(1)]. Therefore, even if a patient is suffering from an impairment or disturbance that affects the function of the brain or mind which impairs the ability to make *some* decisions (as is indeed the case in most schizophrenic patients), it does not automatically mean that he or she lacks the ability to make decisions regarding consent to treatment.

Recommendation for practice

For schizophrenic patients, the additional use of a structured cognitive test such as the Mini Mental State Examination may help to come to a more accurate assessment of capacity. In a study of middle-aged and older outpatients with schizophrenia, the patients' level of capacity was strongly associated with cognitive test performance but not with severity of psychopathology (Palmer, Dunn & Appelbaum, 2004). This is consistent with overall findings in functional outcome studies of schizophrenia that neuropsychological test performance tends to be a better predictor of everyday functioning than severity of psychopathology alone (Green, Kern & Braff, 2000; Evans, Heaton & Paulsen, 2003). However, more research is required to discover which aspects of cognitive impairment are most predictive of mental incapacity.

Further recommendations

When fear or anxiety appears to be interfering with a patient's ability to attend to and process information, introducing a known and trusted confidant or advisor to the consent process may permit the patient to make competent judgments (Appelbaum, 2007). Also, simply repeating information missed by patients or explaining it in a different way may improve understanding and restore capacity. One study found that during enrolment of bipolar patients in research, redisclosure of information improved informed consent (Palmer, Dunn, Depp, Eyler & Jeste, 2007). Another study found that patients understood treatment information better if the physicians explained the information in stages at the second meeting (Grisso & Appelbaum, 1995). In our case vignette, the doctor or pharmacist is obligated to explain the side effects of the antipsychotics to the patient and clarify any misconceptions.

Conclusion

Mental capacity assessment is a complex decision influenced by multiple factors. In the psychiatric setting, physician experience and extant opinions play a larger role in assessment outcomes as compared to the medical setting. The lack of consistency between physicians highlights the fact that psychiatric patients may be disadvantaged due to overt prejudice as well as biases in assessing patients' ability to appreciate their illness and reason about treatment.

With regards to the patient in our vignette, her existing anxiety disorder should not lead her physician to automatically presume that she lacks competence, nor should her new diagnosis of schizophrenia mean that she is unable to assess the benefits and disadvantages of her medication. To the extent that she can understand the information about her condition, appreciate the consequences of her treatment, weigh her options rationally and communicate her decision, her decision should be considered a competent one regardless of whether it agrees with the clinician's opinion.

Footnotes

1. The term "competence" is often used in judicial contexts and "capacity" in clinical contexts. In this article, the terms "competence" and "capacity" are used interchangeably as they are largely used synonymously in both the legal and medical literatures (Appelbaum, 2007).

References

Appelbaum, P.S. (2007). Assessment of patients' competence to consent to treatment. *New England Journal of Medicine, 357*, 1834-40.

Banner, N.F. (2012). Unreasonable reasons: normative judgements in the assessment of mental capacity. *Journal of Evaluation in Clinical Practice, 18,* 1038-1044.

Berg, J., Appelbaum, P. & Grisso, T. (1996). Constructing competence: formulating standards of legal competence to make medical decisions. *Rutgers Law Review, 48,* 345-96.

Cairns, R., Maddock, C., Buchanan, A., David, A., Hayward, P., Richardson, G., Szmukler, G. & Hotopf, M. (2005a). Prevalence and predictors of mental incapacity in psychiatric in-patients. *British Journal of Psychiatry, 187,* 379-385.

Cairns, R., Maddock, C., Buchanan, A., David, A., Hayward, P., Richardson, G., Szmukler, G. & Hotopf, M.. (2005b). Reliability of mental capacity assessments in psychiatric in-patients. *British Journal of Psychiatry, 187,* 372-378.

Chin, J. J. (2009). Ethical issues related to mental capacity act. The *Singapore Family Physician, 35*(3), 22-25.

Evans, J. D., Heaton, R. K. & Paulsen, J. S. (2003). The relationship of neuropsychiatric abilities to specific domains of functional capacity in older schizophrenia patients. *Biological Psychiatry, 53*, 422-430.

Green, M. F., Kern, R. S. & Braff, D. L. (2000). Neurocognitive deficits and functional outcome in schizophrenia: are we measuring the "right stuff"? *Schizophrenia Bulletin, 26,* 119-136.

Grisso, T. & Appelbaum, P. (1998). *Assessing competence to consent to treatment: a guide for physicians and other health professionals.* New York: Oxford University Press.

Grisso, T., & Appelbaum, P.S. (1995). The MacArther Treatment Competence Study. III: Abilities of patients to consent to psychiatric and medical treatments. *Law and Human Behavior, 19*(2), 149.

Kua, E.H. (2009). Psychiatric assessment of mental capacity. *The Singapore Family Physician, 35*(3), 19-21.

Markson, L.J., Kern, D.C., Annas, G.J., & Glantz, L.H. (1994). Physician assessment of patient competence. *Journal of the American Geriatrics Society, 42*(10), 1074-1080.

Mental Capacity Act (Cap 177a, 2010 Rev Ed). Singapore Attorney General. http://statutes.agc.gov.sg/aol/search/display/view.w3p;query=DocId%3A7f933c47-8a34-47d1-8d0a-0a457d6fa1c2%20%20Status%3Ainforce%20Depth%3A0;rec=0;whole=yes

Okai, D., Owen, G., McGuire, H., Singh, S., Churchill, R. & Hotopf, M. (2007). Mental capacity in psychiatric patients - systematic review. *British Journal of Psychiatry, 191,* 291-297.

Owen, G.S., Cutting, J. & David, A.S. (2007). Are people with schizophrenia more logical than healthy volunteers? *British Journal of Psychiatry, 191,* 453-454.

Owen, G.S., Richardson, G., David, A.S., Szmukler, G., Hayward, P. & Hotopf, M. (2008). Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross-sectional study. *British Medical Journal, 337,* 40-42.

Owen, G.S., Szmukler, G., Richardson, G., Freyenhagen, F., Martin, W. & Hotopf, M. (2013). Decision-making capacity for treatment in psychiatric and medical in-patients: cross-sectional, comparative study. *The British Journal of Psychiatry, 203,* 461-467.

Palmer, B., Dunn, L.B. & Appelbaum, P.S. (2004). Correlates of treatment-related decision-making capacity amongst middle-aged and older patients with capacity amongst middle-aged and older patients with schizophrenia. *Archives of General Psychiatry, 61,* 230-236.

Palmer, B., Dunn, L., Depp, C., Eyler, L. & Jeste, D. (2007). Decisional capacity to consent to research among patients with bipolar disorder: comparison with schizophrenia patients and healthy subjects. *Journal of Clinical Psychiatry, 68,* 689-696.

Raymont, V. (2002). 'Not in perfect mind' – the complexity of clinical capacity assessment. *Psychiatric Bulletin, 26,* 201-204.

Shah, A. & Mukherjee, S. (2003). Ascertaining capacity to consent: a survey of approaches used by psychiatrists. *Medicine, Science and the Law, 43*(3), 231-235.

Vollmann, J., Bauer, A., Danker-Hopfe, H. & Helmchen, H. (2003). Competence of mentally ill patients: a comparative empirical study. *Psychological Medicine, 33*(8), 1463-1471.

Acknowledgements: *We would like to acknowledge the contributions of Dr. Wong Kok Seng and Dr. Geoffrey Tan. Our thanks for their helpful comments and suggestions.*

Competing Interests: *We would like to declare that no financial support was provided for the preparation of this manuscript.*

Address for Correspondence:

e-mail: *natalie.wee@u.duke.nus.edu*

e-mail: *chongxiaoyun@u.duke.nus.edu*

Date of Publication: *March 18, 2015*