COMMENTARY

INVITED SUBMISSION

Commentary on "Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders"

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Commentary in Response to: "Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders" by Charland, Lemmens, & Wada

I am grateful to the *Journal of Ethics in Mental Health* for the invitation to comment on the article "Decision-making capacity to consent to medical assistance in dying for persons with mental disorders" by Charland, Lemmens, and Wada (2016). In their thorough and thought-provoking paper, they critically consider the new federal legislation regarding medical assistance in dying (MAID). According to Charland et al., assessing a patient's decision-making capacity is "a matter of considerable controversy" among both researchers and clinicians. Their central claim is that it is "doubtful that our current knowledge and practices governing the determination of decision-making capacity will be able to bear the weight of the new federal legislation." In other words, they raise serious concerns that the reliability and quality of competency assessments does not meet the standard required for the context of MAID. Their qualms specifically regard assessments in patients with mental illness. They warn that, given the nature of current competency theory and assessments, "the right to MAID will be open to arbitrary abuses and challenges." Even though I agree with most of their statements, my perspective on the matter of competency is somewhat different.

Decisions are the most important things we make: by making decisions we shape our lives. In our society, respecting people's choices is a core value, also in health care. There are exceptions, though. The most relevant exception in clinical practice concerns situations of patient incompetency. Even though incompetency is rare in the general population, it is considerably more prevalent in health care settings. In a recent review, Lepping et al. (2015) observed that the weighted average proportion of patients with incapacity was 45 percent in psychiatric settings and 34 percent in medical settings, adding that the two groups did not differ significantly. Incapacity is a common phenomenon in health care, and assessments of patient competency are frequently performed in hospitals.

If patients are deemed incompetent, their incompetence will usually be due to a psychiatric or neurological condition. The reason is that it is *mental* dysfunction that can jeopardize decision-making competency, rather than dysfunction of the bowel, joints, kidneys, etcetera. Consequently, assessing competency in mental illness is not at all rare: mental disorders are the *standard* type of illnesses (together with some neurological conditions, in particular dementia) that may result in incompetency. Mental disorders are thus, in general, highly relevant to competency assessments. In fact, as Appelbaum (2007) notes: "Between 3 and 25% of requests for psychiatric consultation in hospital settings involve questions about patients' competence to make treatment-related decisions." Still, we have to remind ourselves that, as Appelbaum puts it, "no diagnosis in which consciousness is retained is invariably predictive of incapacity."

To sum up, incompetency is a prevalent phenomenon in health care, and competency assessments are anything but rare. Consequently, the outcome of competency assessments is already influencing numerous medical decisions in hospitals all over the world. Moreover, even at present, assessing decision-making competency in people suffering from a mental or neurological disorder is typical rather than atypical; it is daily practice. These assessments are necessary safeguards to ensure that patients' decisions are not *blindly* followed. Patient autonomy is respected in our health care system; doctors therefore need to consider whether the choice is *autonomously made*. Otherwise, "patient autonomy" would be a dogma, a hollow phrase, rather than something real – and respecting such "autonomy" would actually be harmful.

Yet, we may feel that even though such assessments are a valuable component of current health care practices, there is still something new and disconcerting about the legal developments in Canada: under the new legislation, the patient's decision could result in that patient's death by MAID. One could argue – which appears to be the basic line of reasoning in Charland et al. – that even though competency assessments are acceptable in current medical practice, they cannot be used in situations where the decision at hand may result in the patient's death, as is the case regarding MAID and euthanasia.

Patients may have to make very different decisions, for example, concerning antibiotic treatment for acne, ultrasound testing during pregnancy, switching to another antidepressant, undergoing cardiac surgery – the list has no end. Some choices are less serious in nature; some are at the most serious end of the spectrum. The latter type of decisions refers to situations where the patient's choice may result in that patient's death: a patient may refuse urgently required life-saving treatment. In such a case, an assessment of that patient's competency may be performed. This is a weighty assessment: if the patient is considered competent, the decision not to undergo treatment will – most probably – result in his or her death.

Note that the physician who performs the assessment takes the weight of the decision into account. If the decision is more serious (death being the most serious consequence), the stringency of the assessment is increased. As Appelbaum writes, "In practice, the stringency of the test applied varies directly with the seriousness of the likely consequences of patients' decisions." This is the "sliding scale" approach.

Charland et al. appear to recognize that decision-making competency is already being assessed regarding decisions that may have the gravest of consequences. They write: "When patients refuse treatment in standard medical care situations, the decision is most often not immediately final, and further communication with the patient can result in a reversal of the treatment refusal." True, such a refusal may not be immediately final, but it could be, and in some cases, it will be. And even if it is not immediately final, it could still be ultimately final, and in some cases, it will be. This is true for only a small percentage of the competency assessments, but since there are so many assessments of competency, their actual number is still significant. If we accept this situation, it is not clear to me why there would suddenly be an insurmountable problem regarding MAID or euthanasia contexts (see also Parker 2013). Note that, in such cases, based on the "sliding scale" principle, the stringency will reflect the gravity of the decision, just like today when a patient refuses life-saving treatment. The stringency will be adjusted irrespective of other clinical, procedural, and legal safeguards, such as a second opinion.

Does all of this mean that competency assessments are never complicated, that there are no "borderline cases", that there is never disagreement between the evaluators, and that there is an objective algorithm that will always lead doctors to the right conclusion? Obviously not. If one wishes to avoid making complicated decisions, or to avoid grey areas and borderline cases, medicine is not an easy field in which to work. Medical decision-making is often "subjective", as doctors and patients try to find answers to the most important and hardest questions life may pose, even if there is a great deal of objective evidence to inform the decision-making. The uniqueness of every individual's situation, hopes, and preferences – together with a lot of stress and sometimes exhaustion – often makes healthcare decisions challenging, to say the least. And it is true that competency assessments are probably among the more complicated judgments doctors, and in particular psychiatrists – who may be consulted in difficult cases – have to make.

Let us briefly look at two points of criticism Charland et al. formulate regarding the MacArthur Treatment Competence Assessment Tool, or MacCAT (Appelbaum & Grisso, 1995). They claim that it is "legally biased" in that "it focuses on the cognitive abilities that underlie decision-making and reasoning." In fact, in his paper "Is Mr. Spock mentally competent? Competence to consent and emotion", Charland (1998) has already emphasized the relevance of emotions to competent decision-making and argued that the framework developed by Appelbaum and Grisso is overly "cognitivistic". Later, observations in patients with anorexia nervosa pointed to the fact that values may be affected by mental illness, possibly leading to incompetence in a way that is not "detected" by the MacCAT (Tan et al., 2006). Both are valid critiques (Meynen & Widdershoven, 2012). Still, I have never considered these points as undermining the entire practice and relevance of competency assessments, but rather as calls for improvements through research, awareness in clinical practice, and perhaps some tailoring of these assessments to the specific types of disorders the patient may suffer from. To be sure, it is not the case that emotions and values have no place at all in the MacCAT; as Charland et al. recognize, the MacCAT-component of appreciation is "tied to affectivity and values". Still, it is true that the MacCAT, just like many other instruments, is not infallible.

Meanwhile, there are many more issues to be considered regarding MAID and euthanasia other than the accuracy of competency assessments, as has also been made clear in recent contributions to this journal (Maher, 2016; Gupta, 2016).

In conclusion, doctors evaluate competency in people with mental disorders on a daily basis in hospitals, presumably all over the world. In some cases, the stakes are as high as they can get: refusal of life-saving treatment that may immediately lead to the patient's death. Some assessments are complicated; in these cases, psychiatrists may be consulted. The "sliding scale" principle ensures that the gravity of the probable consequences of respecting the patient's decision is reflected in the stringency of the evaluation. Are competency assessments infallible? No. Will they sometimes result in tragic consequences and unfavorable outcomes? Yes. Is it better to perform them instead of declaring every patient categorically competent (or incompetent)? Yes. Whereas Charland et al. express serious doubts that current competency assessments "can bear the weight" of decisions regarding MAID, I suggest that, if these assessments can bear the weight of present-day medical decisions, there is at least a good chance that they can bear the weight of the new legislation as well.

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