ANALYSIS
A Case Selected for Invited Commentary

"Hey Bill, smoking is bad for you..."

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The case

Bill is a 54 year old man who suffered a sudden cardiac arrest 9 months ago that rendered him unconscious for about 20 minutes before normal cardiac rhythm returned. As a result he now has a marked amnestic disorder as a result of hypoxic encephalopathy, and was admitted to a psychiatric facility for stabilization of behaviours secondary to his memory problems. Prior to his cardiac arrest he had no history of cardiovascular illness, but was a smoker, having smoked a pack a day of cigarettes from age 14. He has no other history of cardiac risk factors.

Currently, he has marked short term memory impairment, being unable to remember having had a meal even a few minutes after he has eaten, or forgetting that he has had his medications only a few minutes later. He has trouble remembering that he is in hospital, and why, and so will attempt to leave the hospital to attend to some responsibility that he remembers from the past. He can be easily re-directed, and understands the explanation as to where he is and why he is there, but after a time will again forget, and will confabulate, coming up with some story explaining where he is and what he has to do. Cognitive assessment two months after his injury showed marked impairment with a Mini Mental State Examination (MMSE) score of 14 out of 30, but his most recent MMSE was 24/30, with the primary deficit being in short term memory. He does have good recall for events prior to his cardiac arrest, and for more distant memories. He does not experience delusions or hallucinations, and there is no evidence of depression or anxiety.

For 6 months after his cardiac arrest, he was hospitalized on a medical ward, with one to one care to prevent wandering, and during that time did not smoke. Upon admission to the psychiatric unit, he informed staff that he did smoke in the past, but had quit. Throughout the time in the previous hospital, he did not have access to cigarettes. Once in a psychiatric facility he was again amongst people who smoked, and thus began borrowing cigarettes from others and then insisting on some of his own.

Bill was asked about smoking and stated that he did not want to smoke much, but wanted to have cigarettes available to him if he decided he wanted one, and anticipated smoking perhaps 6-12 cigarettes a day, less than his previous pack per day habit. He was not spontaneously aware of any risk this would pose to him but when advised that this would increase his risk of another heart attack or stroke, he recognized this was the case, and did ask for help to minimize his use of tobacco, although he still expected that he would want to smoke on an occasional basis. When asked about the impact on his health of smoking on a subsequent day he was unable spontaneously to state what the risk was but with prompting recalled again the risk of another heart attack or stroke.

His next of kin, who is his substitute decision maker, with authority both for medical care decisions and financial decisions, did not want him to smoke due to the risk it entailed with respect to his cardiovascular health, now that he had already experienced an episode of cardiac arrest. His next of kin requested that he be prevented from using his own modest income for this purpose and indicated they would not send any money to him while he was in hospital if cigarettes were going to be purchased for him. He recognized that he could not be kept entirely free from smoking as Bill would still have access to cigarettes given to him by other patients in the hospital.

The staff at the hospital recognized that there was a conflict between the desire on both the part of staff and family to protect Bill from further physical harm caused by smoking, recognizing that an acute medical event like a heart attack or cardiac arrest was often helpful in triggering people to quit smoking, while at the same time wishing to help Bill retain as much autonomy as possible with respect to various aspects of his life. As Bill was felt to be incapable of managing his own finances, his family did have the legal authority to determine what part of his income would be available for day to day use, including purchase of cigarettes. Although he had not previously indicated a desire to quit smoking before his cardiac arrest, and had by his actions indicated a desire to smoke then, his risk factors had changed with his cardiac arrest, such that it could be argued that he had not expressed a prior wish about smoking post heart attack. From a systems perspective in our jurisdiction there has recently been a move to ban smoking in and on the grounds of all health care facilities for patients, staff and visitors, so that staff were quite sensitive to their role in overall health promotion, making this issue feel even more challenging. The question was raised as to whether or not he was capable of making this financial and health related decision, as it was not certain to what degree he could fully appreciate the impact of smoking on his physical health, and his finances.

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Thinking about this case, initially in a legalistic way (and using the Mental Capacity Act 2005 (MCA), which governs England and Wales), the first question is whether Bill has capacity to make decisions about his smoking. He certainly has a disorder of his brain that puts his decision-making abilities in jeopardy, which is the first stage required under the MCA in order to say someone lacks capacity.

The second stage is to consider recall, understanding, the ability to weigh up and to communicate. He can communicate. He can also recall relevant information. The Code of Practice for the MCA states that the person need only recall for a short time. It also suggests that people should be helped to make decisions if at all possible. Therefore, the fact that 'with prompting' he again recalls the risk of another heart attack or stroke suggests that, to this extent, his recall is sufficient. And there is nothing here to suggest that he does not understand. Indeed, his MMSE of 24/30 is reassuring. The main deficit is in 'short term memory', so again it is not obvious that he cannot 'weigh up' the information; at least, if prompted, he should be able to overcome difficulties. In fact, when the various risks are discussed, he asks that attempts should be made 'to minimise his use of tobacco'. In itself this seems to suggest some weighing up of the pros and cons involved in the decision. Hence, on the basis that he can recall, understand, weigh up and communicate sufficiently, I would be inclined to judge that Bill has capacity to make the decision about smoking.

His decision is that he would wish to smoke 6-12 cigarettes per day. The staff may wish to write down this decision as an agreement, which could be given to Bill and produced when staff feel they need to limit his smoking, given that he is likely to forget the limit himself. All of this would seem to be to honour the spirit of the MCA, which is all about trying to allow people to make decisions for themselves insofar as they are able. One of the basic principles of the MCA is that capacity should be presumed. In making the judgment that Bill has this capacity we are taking that presumption seriously and trying to be on his side.

In which case, his family should let him have money to purchase cigarettes. If they do not, he is likely to borrow cigarettes in any case and may thereby become unpopular if he cannot reciprocate. Presuming that Bill lacks the capacity to make decisions about his financial affairs, his family still need to act in his best interests and his capacitous decision to smoke about 10 cigarettes a day must be given very significant weight. Indeed, for the family to use their control of the finances to block his decision would seem to be an illicit use of their power. They would need to argue that the risks attached to smoking were so great that, when they entered this fact into the check list for determining best interests (see box 1), it completely outweighed Bill's own capacitous wishes.

There are several complicating factors. First there is an issue to do with 'lacking capacity to make decisions about financial matters'. It should be, after all, that Bill is encouraged and helped to make decisions about those matters within his competence. Bill might not have capacity to make a decision about buying a new house, but buying a packet of cigarettes would not seem to require the same level of capacity. For practical and legal reasons it may be that Bill has to be declared to lack the capacity to manage his financial affairs tout court. Even so, he should be helped and encouraged to participate as much as possible in these decisions (even in the decision to buy a house). So, on the face of it, since he probably does have capacity to make the decision to buy cigarettes, his decision should be supported.

Secondly, if we presume he lacks financial competence completely, is it the case that this lack of capacity should be allowed to block the exercise of an alternative capacity, namely the capacity to make a decision about smoking? The spirit of the MCA, it seems to me, is that he should be allowed to make those decisions that he is able to make. Hence, he should be allowed to make the decision to smoke a restricted number of cigarettes a day.

Thirdly, although he has no other cardiac risk factors beyond smoking, having suffered a cardiac arrest, he is undoubtedly now on some form(s) of treatment. If the family wish to argue that the risks of minimal smoking are so great as to outweigh his capacitous wish, there would need to be some clarity about what these risks actually are in numerical terms. There would need to be an estimation of the risk of further cardio-(or cerebro-) vascular insults as things now are with or without the risk of smoking 10 cigarettes a day. My guess is that the increased risk would not be overwhelming, even if it were significant. (Ignoring the previous history of cardiac arrest and any current medication, the risk of a 54 year old man with healthy cholesterol levels and normal blood pressure having a heart attack in the next 10 years changes from 4% to 8% if he smokes [http://hp2010.nhlbihin.net/atpiii/calculator.asp (accessed on 4 December 2007)].) If it were overwhelming, then it is not obvious why this could not be put to Bill, who could (presumably) make a capacitous decision with this information to hand.

Finally, it is simply not clear why on any grounds Bill's capacitous decision-making should be blocked. It would seem to be a straight forward infringement of a basic human liberty. Of course, for other reasons (to do with the risk of passive smoking and the importance of health promotion) the state (or the hospital) might insist that smoking is banned in certain places. In which case, however, this law must be applied equally and fairly. The rationale for such a ban would need to be couched in terms of broader considerations of democratic justice: that the state has a duty to protect its citizens from certain harms in a fair way and based upon rational evidence where the justification for such a policy is broadly accepted within the body politic. But all of this is by-the-by as far as Bill is concerned. At present there is no such law, so he should be allowed to smoke in a controlled manner.

All of the above comments reflect the legal context in two countries (England and Wales) and are based on the judgment that Bill has capacity. To my mind these judgments also reflect an ethical approach. But what if he lacks capacity? We are then thrown back

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upon determinations of best interests and in the same jurisdiction we must use the best interest check list (Box 1). Again, this seems to me to be an ethical way of approaching matters. But now let's dig below the legal approach. After all, determining best interests might just lead to deadlock, with the family arguing against cigarettes and Bill still wishing to smoke.

Below the legal surface we come across different, conflicting values. The job then becomes one of negotiating between these values, which requires that they are aired explicitly. This is to engage in values-based practice (Fulford 2004), which should complement the facts (evidence-based practice). It should recognise that weight needs to be given to the views of the family, but values-based practice places Bill's views centre stage.

There has been a debate, in the context of dementia, concerning whether we should pay more attention to a person's previous views or to their present views. In this debate, Jaworska (1999) suggested it was important to continue to recognise the extent to which the person was still a valuer, able to express his or her own values. Rightly or wrongly, Bill still values cigarettes. He is sensible enough to seek to have his desire limited by staff. If we are to value Bill as a person, we must value his values. To take this stance is to make a statement about the importance of values. Of course, we are never fully autonomous, so our values cannot run riot and rough shod over the values of others. That might be the reason for banning smoking altogether in a hospital. But short of this step, it is an argument in favour of supporting Bill in his desire to smoke, in a controlled way and in a way that does not upset other people. To override this value is to undermine his standing as a person. Whichever way we look at it, therefore, and whatever our personal views about smoking, with all the caveats in place, if we are to respect Bill he should be allowed to smoke.

Competing Interests: *None*

Acknowledgements: *None*

References:

Fulford KWM (Bill). (2004). Facts/Values. Ten principles of values-based medicine. In: Radden J, ed. The philosophy of psychiatry: a companion. Oxford: Oxford University Press: 205-234.

Jaworska A. (1999). Respecting the margins of agency: Alzheimer's patients and the capacity to value. Philosophy and Public Affairs, 28: 105-138.

Box 1

Determining best interests: The checklist from the Mental Capacity Act 2005 governing England and Wales

1. There is a reasonable belief, following assessment, that the person lacks capacity
2. Avoid discrimination
3. Consider all the relevant circumstances (medical, psychological, social, spiritual and so forth)
4. Put off the decision if the person is likely to regain capacity
5. Encourage the person to participate as fully as possible (e.g. by using communication aids, pictures etc., or by improving sight, hearing or language, and by consulting with appropriate experts)
6. If the decision is about life-sustaining treatment, ensure it is not motivated by a desire to bring about the person's death
7. So far as is reasonably ascertainable consider the person's past wishes and feelings
8. So far as is reasonably ascertainable consider the person's present wishes and feelings
9. So far as is reasonably ascertainable consider the person's values and beliefs likely to influence the decision
10. So far as is reasonably ascertainable consider other factors the person might consider, e.g. cultural background, religious beliefs, political convictions, past behaviour or habits and any effects on others that might be relevant to the person
11. If it is practicable and appropriate consult anyone named by the person
12. If it is practicable and appropriate consult anyone engaged in caring for the person
13. If it is practicable and appropriate consult anyone interested in the person's welfare
14. If it is practicable and appropriate consult anyone with power to act as an attorney
15. If it is practicable and appropriate consult any deputy appointed by the court
16. Decide on the least restrictive measure if at all possible in the person's best interests
17. Seek a way to balance the concerns of all involved
18. Settle any disputes
19. Reach a decision in the person's best interests

Note: of course, not every one of the provisions covered by this checklist needs to be relevant in every case; but the checklist forms a framework for deciding on a person's best interests. In addition, differences in legal systems might make some of the items less relevant. Still, from an ethical perspective, the framework of broad thought and consultation seems likely to apply widely.

Commentary by:

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Issues in this case

- Autonomy vs. welfare
- Capacity on a sliding scale
- Consent vs. lack of dissent
- Status of advanced directive
- Paternalism or the tyranny of health

The issues in this case can be summarized simply as the perennial conflict of autonomy as a principle versus the other principle of bio-ethics, welfare. The principles of beneficence and non-maleficence can be subsumed under the broad umbrella of welfare and under this umbrella, often in psychiatric cases, comes welfare of the society. In this case, the welfare of society is not that apparent although it can be argued tenuously that a healthy citizenry can only be beneficial to the whole society. The competing interest, or the countervailing argument in these types of cases will be that the society also benefits from allowing people to act in autonomous ways, often in irrational ways, with certain caveats. The most obvious of those caveats would be that in exercising one's autonomy, one is not encroaching on somebody else's welfare or autonomy. All of the above is true under the assumption that it is a capacitous (or competent) person exercising his right to be autonomous, or for that matter, the right to act foolishly.

The equation changes slightly in favour of the society when the player is not competent or incompletely competent to decide or exercise his autonomy. Society has by convention, usurped the role of a parent to protect not only the well-being of the incompetent (parens patriae power) but also to prevent harm to its citizens through the actions of another, competent or not. This is loosely called the police power. In this particular case, the police power does not seem to be an issue but capacity is. Capacity (or competence) is roughly tested through a 4-stage test that is used in legal settings but remains an essentially clinical test: can a person understand information given to him, can he retain the information so given, can he manipulate (cognitively) that information to come to a choice, and finally, can he register his wishes based on the above three. It is not required that he exercises or expresses a choice which is correct, or agreeable to others, or even rational. At the very least it requires to be shown that a choice (however irrational) has been made through all of the four stages. A capacitous or competent decision is thus inviolable save certain circumstances.

In this case, clearly there are areas that will give rise to doubts in the mind of the assessing clinicians. It is agreed that Bill has an amnestic disorder secondary to the hypoxic encephalopathy howsoever caused. How it was caused has relevance in the later stages. The amnestic disorder manifests itself at the very least by Bill's inability to remember having a meal only a few minutes ago. So clearly, in absence of the ability to retain new information (as evidenced by the scores of MMSE and the deficit areas in short term memory), he fails the first test. A capacity test is 'all or none' i.e. all fourth limbs have to be satisfied. So for all practical purposes, Bill is judged to be incompetent. Following on from the foregoing, Bill is likely to fail the second limb, the third limb, and by extension the fourth limb, that is, ability to express a choice based on the first three criteria. For any decision based on retention of new information, he would be deemed globally incompetent.

The issue of remaining in hospital thus merits further analysis. Although it would appear that Bill is in hospital voluntarily, it can be best described as being in hospital without dissent (assent) rather than true consent. A 'nod' rather than a shake of the head. A true consent must be a competent decision based on the tests above, plus certain other factors such as lack of duress or coercion. This lack of consent to remain in hospital is not an immediate problem, but will become crucial in later stage of our analysis.

Bill's choices could be executed even in this stage when he has lost capacity, if either he had an advanced directive registering his wishes when he was capacitous or if a substitute decision maker properly appointed makes that choice on his behalf. It would appear that Bill does not have an advanced directive informing the team what shall be done to him, or with him, in the event of his losing capacity. Therefore this decision falls on the substitute decision maker, be it his next of kin or the Court. In both these circumstances, the substitute decision maker will have to express a choice which will not only be in his best interest, but something that is consistent with what Bill would have wanted when competent. It would appear that Bill never wished to stop smoking when he was autonomous. But then he never had a heart attack before either. So there is no way of knowing what Bill would have done in the event of him having a heart attack (but retaining autonomy) with respect to a desire to stop smoking. A reasonable construction would be that if Bill was competent, given the new risk factor that has developed since (the heart attack), he might have been minded to quit. Bill now says that he wants to smoke much less, would like help with minimizing his use of tobacco but should retain the option of having a cigarette (or two) as and when he desires.

And here is where paternalism comes into play. At its most benevolent (and benign form) it is making substitute decisions for Bill by his carers, which would be in his best interest. Reduced tobacco intake may decrease his chances of another heart attack but no one can be sure by how much, assuming that there may be other factors in the causation of a heart attack. However, best interest is not merely 'best medical interest' that doubtless will be served by him quitting smoking, but also in retaining his autonomy and dignity, as much is possible. Just like Bill could not be forcibly stopped from smoking in his pre-heart attack days, he can not now be stopped forcibly, just because it is good for him, unless it is documented that the chance of harm is statistically so great that it is imperative that he be prevented and there are no countervailing interests, such as loss of dignity, operating. Best interest should also take into account his financial interests in so far as he should not be allowed to blow all his money on something

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harmful. A difficulty then emerges if he is smoking all his money away (although in this case it would appear he is not).

All things considered, it can be argued that Bill ought to give up smoking for his own health and finances (and should have done long ago), and now is the best time to do it. The timing is crucial because now Bill faces at least three more hindrances: 1) he is in a hospital that, although it does not have a no-smoking policy, is moving towards it for greater good; 2) he has lost his capacity to do as he pleases with both his money and his health; 3) a substitute decision maker has made a decision not to allow him to smoke based on an assumption of what Bill might have done if he had the new information. Law requires the substitute decision maker to decide what Bill would have done rather than what a reasonable man in his situation would have done. In this situation, without any concrete indication of what Bill would have done (actually, there is some evidence he might have decided to the contrary), the substitute's decision is suspect, although clearly the decision has been taken in good faith and with very good intentions.

A further caveat to complicate the whole matter is whether Bill's previous position on smoking was autonomous given he was suffering from an addiction and perhaps was powerless to do otherwise. But that's a matter for another day.

Competing Interests: *None*

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References:

Fulford KWM (Bill). (2004). Facts/Values. Ten principles of values-based medicine. In: Radden J, ed. The philosophy of psychiatry: a companion. Oxford: Oxford University Press: 205-234.

Jaworska A. (1999). Respecting the margins of agency: Alzheimer's patients and the capacity to value. Philosophy and Public Affairs, 28: 105-138.

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Actual Case Outcome:

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What we did:

The team worked with Bill first to develop a plan to help him reduce his smoking by prescribing bupropion, and offering him nicotine gum when he requested a cigarette as an alternative, but providing a cigarette if he insisted on one. His family continued to refuse to send money to purchase cigarettes. We anticipated at some point being unable to continue to provide him with cigarettes unless the family relented and sent money. We advised Bill of this situation. To complicate things further, Bill will require placement in residential care as his behaviours have settled significantly and many of those facilities are non-smoking which will either force him to stop, or limit his placement options, prolonging his hospitalization

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