

## Competence and decision-making: Ethics and clinical psychiatric practice

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The interface between psychiatry and the law is often unclear and complicated. Ethics in psychiatry is a complex, controversial, often ambiguous topic. Conflicts arise about confidentiality, informed consent, involuntary hospitalisation, right to treatment and right to refuse treatment, among other daily clinical issues. There is an extended responsibility to others as well as to the mentally ill vulnerable person. An overarching departure point would be to address 'competence' with a view to understanding the above issues better. The making of decisions pertaining to health and personal issues is dependent on the ability of the patient to function in various areas. The concept of competence is viewed differently from the clinical as opposed to the legal viewpoint. Some jurisdictions have introduced into legislation more specific legal guidelines for recoding mental capacity.

This discussion takes a practical clinical standpoint and introduces an 'umbrella' concept via a general approach, while also specifically addressing individual ethical issues.

Ethical issues in clinical psychiatry rarely give rise to easy decisions. The application of general ethical issues in psychiatry is more complicated than in other health areas, requiring an assessment of the patient's clinical presentation, community and cultural circumstances as well as legal principles and patient rights. The practising mental health professional must recognise the extent of this responsibility, not only to the patient but to the community as a whole. Lists of guidelines and standards merely provide advice as to procedures, e.g. the Principles of Medical Ethics of the American Medical Association<sup>1</sup> and the Madrid Declaration of the World Psychiatric Association.<sup>2</sup> Often there are conflicting views, and the clinician is required to make a decision by balancing the principles. This is particularly challenging given the extreme vulnerability of the acutely mentally ill patient. These conflicts relate to overall management, treatments and levels of participation in decision-making. The major influences in the clinical arena are the question of the patient's competency (partial, specific to the situation, or complete lack). Competence may be considered as the umbrella under which all other issues are dependent. This is closely related to decision-making capacity in broad approach and among other things relates to beneficence, autonomy, informed consent and confidentiality.

### Clinical applications

Competence has been variously defined depending on point of departure. The public impression of the mentally ill is frequently coloured by this aspect of psychiatric practice and often misguided. Decisions are made with the aim of preventing undesirable outcomes, hence the interaction of psychiatry and the law. Certain specific and circumscribed goals are evident. Persons with mental disorder, mental retardation or organic brain dysfunction require their level of competence in various situations to be considered. In the forensic setting a defendant's competence may change and present status must be considered. In complex cases the pattern and past history are invaluable. Competence is differently defined depending on the approach by either the legal or the psychiatric profession. The understanding of an act and its consequences,

and that there are different legal criteria for different acts, must be considered in addressing different tasks assessed. Total incompetence is rare, so assessment is required in numerous situations. These range from competence to stand trial or be a witness to civil competence as in guardianship and curatorship enquiries. The contractual ability and level of competence required varies for different contracts, e.g. making a will or consenting to treatment. Each of these needs to be individually addressed and further discussed both from a clinical viewpoint and with regard to the essential ethical considerations.

The care of patients without the ability to make decisions remains a daily occurrence in psychiatric practice. Decisions frequently need to be made by 'surrogates' governed by standards that again may differ from those in other branches of medical practice. These decisions are made more specifically in 'best interests' than according to prior known expressed wishes. Associates, usually family members, are defined in the Health Act<sup>3</sup> as well as the Mental Health Care Act:<sup>5</sup> 'Associate means a person with a substantial or material interest in the well-being of a mental health care user or a person who is in substantial contact with the user.' They are called on to make decisions about the health care of acutely mentally ill or cognitively impaired patients which may or may not be their own wish. Clinical practice aims at decision making for the patient's benefit but this may extend further – danger to others (behaviour) or longer-term welfare (care of property).

Family members or other associates are not always fully aware or able to make decisions in what are frequently crisis situations (acute psychosis, suicide or homicidal behaviours). Distressed families seek advice and guidance. Decisions taken by the clinician and the family member/s must be reconciled for the patient's benefit and compatible with bioethics principles and the pertaining law. Personal autonomy poses a dilemma to all role-players, who have to evaluate both medical and non-medical considerations. Family members remain concerned and are frequently distressed due to what is often an unavoidable and urgent choice. At the same time, psychiatrists cannot yield to family demands simply to avoid future stressful encounters. Treatment discussions are often urgent and

situational, and factors such as the nature of the illness may make the relationship between psychiatrist, family and patient complex. Issues of confidentiality arise and create further dilemmas.

The actions of the psychiatrist, the surrogate and to some extent the patient are supported and governed by a legally defined hierarchy (supported by a legal framework) illustrating the above interface. Interaction between ethics, therapeutic needs and the law is evident and in fact stronger here than anywhere else in health care.

## Involuntary treatment

Treatment against 'the will' of a severely mentally ill person may require major judgement calls on the part of the mental health practitioner. The choice of involuntary treatment, with its degree of coercion and legal connotations, is a continuing debate, with related issues of the right to refuse treatment and probably the right to treatment as well.

Opposing ethical points of view on involuntary treatment are acknowledged, vary (depending on legislation) between countries, and are revised over time.

There is agreement that the presence of severe mental illness which removes the capacity to make a treatment decision becomes a clinical decision based on an assessment of psychiatric state and thus of competence. A second consideration that always runs parallel to this is the risk of harm to self or others. Meeting these criteria requires consideration of ethical and legal criteria, both with potentially significant consequences. It is argued that temporarily depriving the patient of freedom of movement and choice is justified by the objective of eventual return to improved health. Mental hospitalisation does not automatically imply incompetence and is a legal and not a medical concept. Coercive treatment situations must be carefully considered and adhere to 'the least restrictive' process, used appropriately and reviewed and monitored (Mental Health Care Act). Coercive treatment must be for as short a period as possible and consideration must be taken of individual circumstances in each case and the level of competence or decision-making capacity of the patient.

It is important that all clinicians remain aware of recent developments, the extent of the current legislation and any ongoing changes. In the current situation a 'dangerousness' alert due to publicised incidents has become a determinant for involuntary hospitalisation, but should be specifically reserved for those cases in which restoring mental health is the reason for use of legislation to detain the patient. Beneficence requires the provision of care for those patients incapable of caring for themselves. Argument opposing the above also relate to autonomy and the infringement of the person's liberty.

## Competency assessments

These form part of various aspects of psychiatric practice and are formally addressed variously in relation to treatment, forensics and civil issues. The clinical assessment focuses on the present state of the patient's mental capacity.

Does the patient have a rational and factual understanding of the situation? Proposals by the patient are influenced by abnormal thought processes that affect the ability to negotiate and co-operate. Competence may be defined as the capacity to function in a particular way, to process and understand information and to make relevant well-circumscribed decisions based on that understanding (Weisstubb<sup>6</sup>). In some situations competence may be suggested as just another word for 'acceptable' behaviour, and this opens up many potential difficulties. It is shaped in part by the context and

consequences of the decision concerned. Can mental illness in this context be understood in the framework of what is considered to be socially acceptable behaviour? In many cases the latter is used as a means to justify legal decisions, e.g. in guardianship applications for cognitively impaired patients. If a competent person is a whole, rational agent, free to assert self determination and autonomy, is it the ability to perform certain cognitive acts or is it a process of self determination? There is a tendency to describe competency in terms of cognition, judgement and insight.

## Decision-making capacity

Tests of decision-making capacity typically require a subject to be able to understand the subject matter of the decision and appreciate the consequence of making the decision. Individuals may be assessed as either globally competent or incompetent. Marginal decision-making capacity in various situations is addressed. These include treatment decisions (e.g. electroconvulsive therapy, decisions about property, care for self, consent to treatment, etc.) The mental state is not consistent or stable and variation over time is common.

An individual's capacity can vary for a variety of physiological or psychological reasons and also in relation to familiarity with the subject matter of the decision. Every effort should be made to help maximise an individual's performance, e.g. by providing an unthreatening environment and assessing the patient in his/her language of preference. Is the situation different when assessing whether a patient is competent to make a single decision or a series of decisions? This is important in informed consent or decisions relating to care of the patient's property in complicated estates or contexts. It becomes evident that there is a range of possibilities based on the patient's clinical condition and level functioning in tasks to assess his or her abilities to make decisions. However, abilities are not an all-or-nothing matter, and it must be stressed that ability does not necessarily mean 'ability to make the current or wisest choice'. Decisions do not fit into a single standard. They are affected by a spectrum of patient mental states and must be considered in the context of the individual patient in his or her individual situation.

At no point in the continuum is there a specific or appropriate process to be followed.

Cultural norms are important and must be considered. Substituting judgement/best interest in the hierarchy above advance directives is an important consideration. The process has become complex, dynamic and personalised and tends to de-emphasise other ethical considerations. This area must remain one of sensitisation by the psychiatrist.

The psychiatrist must ensure that respect for the patient's genuine interests underlies all clinical decisions, so as to bring to the highest possible level the care these vulnerable patients receive.

## Conclusion

Ability to make decisions is foremost in this area of clinical assessment. Psychiatry has been given the clinical responsibility for determining which individuals may on the basis of mental illness need to be deprived of autonomy and dignity by involuntary commitment to protect and attempt to treat them. This burden of responsibility and exercise of judgement is a significant one, often criticised by society as well as the patient whose rights may be compromised. A clear role has been defined, with concepts and assessment procedures to meet legal, clinical and ethics standards and based on principles of safety and therapeutic advantage. Patients are considered to be legally competent unless they are

judged legally incompetent or temporarily incapacitated. Competence is an element of every aspect of decision-making and especially important in mental health systems. Mental competence is the capacity to make acceptable decisions. Often the phrase 'decision-making capacity' is preferred.

The concept must be consistent with medical ethics and law and interpreted in its relationship to medical and psychological concepts. There are implications for a range of situations and assessments, and whether they recognise it or not, most clinicians assess their patient's decision-making abilities as part of every encounter.

## References

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