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Editorial

Overestimating patients' capacity

Peter Lepping

Summary
Clinicians regularly overestimate patients' capacity to make decisions. This may jeopardise their autonomous decision-making. It may lead to poor clinical outcomes for patients and has potential adverse legal consequences for clinicians. There is a need to use the legal principles of the Mental Capacity Act more rigorously.

Declaration of interest
None.

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The full implementation of the Mental Capacity Act 2005 in England and Wales in 2007 increased the importance of correct and appropriate capacity assessments across medical specialties. In psychiatry, detention under the Mental Health Act 1983 does not require a lack of capacity, but nonetheless capacity assessments are increasingly common in psychiatric practice. This may be to determine best interest or in order to provide non-psychiatric treatment to a patient who is admitted to a psychiatric unit. Furthermore, psychiatrists are increasingly asked to perform assessments of capacity for other specialties. The Mental Capacity Act requires clinicians to empower patients to make decisions and to make an assumption of capacity until proven otherwise. However, if patients who lack capacity are allowed to make decisions, these may not reflect their true wishes. The consequence may be poor outcome and inadequate protection of the patient. There is good evidence to suggest that doctors routinely overestimate their patients' capacity, and that this is true in psychiatry as well as in other specialties.

Evidence

Raymont *et al* investigated the prevalence of mental incapacity in medical in-patients in a cross-sectional study of 159 patients in London. They tried to identify risk factors associated with mental incapacity. They estimated that at least 40% of medical in-patients did not have capacity to make decisions about their treatment, and found a strong association between the lack of capacity and increasing age, as well as diminishing cognitive function. More worryingly, they came to the conclusion that incapacity was rarely detected by clinicians or relatives.[1] However, the authors noted that there was little conflict between patients and treating physicians with regard to treatment decisions, in contrast to psychiatric settings where such conflict is more common. The researchers used the MacArthur competence assessment tool for treatment (MacCAT-T), which has shown good interrater reliability. Kahn *et al* published a prospective observational study in an academic medical centre in California. In a sample of 100 patients they found that 70% of patients lacked some type of decisional capacity. A Mini-Mental State Examination score of below 21 was found to be 100% specific in identifying patients without capacity.[2] The high proportion of patients lacking capacity in this study may reflect the fact that it was conducted in a university hospital, with a high proportion of severely ill patients.

In psychiatry, Owen *et al* found that 60% of a cohort of psychiatric in-patients showed a lack of capacity to make treatment decisions. The sample size was large, 350 consecutive UK in-patients. Mania and schizophrenia were highly associated with mental incapacity, while only a minority of patients with depression and personality disorder lacked capacity. The study suggested that 39% of informally admitted patients on psychiatric wards lacked capacity, while 14% of detained patients had capacity.[3] In a study published in this *Journal*, Cairns *et al* confirmed that a lack of decisional capacity with regard to treatment is common, but by no means inevitable, in psychiatric in-patients. In another study of 112 UK patients, mania and psychosis were associated with mental incapacity, as were poor insight, delusions and Black and minority ethnicity if born outside the UK.[4]

In a systematic review, Okai *et al* found 37 papers on mental capacity. Most of these evaluated tools to test capacity and showed high interrater reliability. Psychosis, severity of symptoms, involuntary admission, and treatment refusal were the factors most strongly associated with incapacity in psychiatric in-patient populations.[5] Hotopf emphasises that mental capacity assessments have, up to a point, good construct validity. He does, however, identify problems in defining capacity in particular illnesses, such as anorexia nervosa and personality disorder.[6] In a recent study, my colleagues and I investigated 688 in-patients in North Wales. We asked senior nurses on all wards in an acute hospital trust to judge the capacity of their patients to make basic, as well as complex, decisions. We included medical, surgical, gynaecological, psychiatric and community hospital patients. Overall, 8% of patients lacked capacity to make either basic or complex decisions, and a further 5% lacked capacity to make complex decisions. Lack of capacity, as judged by senior nurses, was most pronounced in medicine (21% of patients), followed by psychiatry (20%). It was least judged to be a problem in surgery (6%). The proportion of patients identified as lacking capacity was much lower than the proportion identified in previous studies where more stringent criteria were used to assess capacity.[7] This suggests a persistent underestimation of incapacity by senior ward staff and clinicians, confirming Raymont *et al*'s findings back in 2004. It would appear that the introduction of the Mental Capacity Act 2005 has not thus far changed the situation significantly.

Ethical and legal implications

There is good evidence that medical and psychiatric patients usually give approval of their treatment once they regain capacity, even if their initial wishes were overridden.[1,8] In psychiatry, the retrospective approval rates are no different between patients admitted voluntarily or involuntarily. The only factor that is

significantly associated with retrospective approval is regaining capacity. Owen *et al* concluded that their findings 'moderate concerns about surrogate decision-making by psychiatrists'.[8] It seems that despite relatively good construct validity of capacity assessments, clinicians overestimate patients' capacity to make treatment decisions. It is unclear whether this leads to worse outcomes. However, we may compromise good outcome by allowing patients who lack capacity to make decisions about their care. This would tend to suggest that the Mental Capacity Act provisions should be used more frequently.

Beauchamp & Childress state that 'society has a legitimate interest in good outcomes'.[9] They consider it ethically desirable to have systems in place that promote good outcome. The other important question is the purpose of focusing on capacity. The concept of capacity primarily aims to protect autonomous decision-making.[10] We therefore have to ask whether autonomous decision-making is being jeopardised if we allow decisions to be made by people while they lack capacity to do so. This has clear ethical implications as doing so may fail to protect autonomous decision-making, thus violating the very principles that we are trying to protect. In order to avoid more paternalistic practice as a consequence it will be important to emphasise the need to work with patients to optimise their capacity as much as possible. There may be legal implications of accepting decisions made without capacity. There is a risk of accusations of neglect if outcome is undesirable.

Conclusions

It seems highly likely that clinicians in all fields of medicine overestimate their patients' capacity to make decisions. This has important legal and ethical implications. We should be willing to consider lack of capacity far more assertively than we do in current routine clinical practice. There is a need to apply the legal principles of the Mental Capacity Act 2005 to more regularly assess capacity and to make appropriate best-interest decisions. This is likely to protect autonomous decision-making rather than disempowering patients.

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