Personality disorder and competence to refuse treatment

E Winburn,1 R Mullen2

ABSTRACT

The traditional view that having a personality disorder, unlike other mental disorders, is not usually reason enough to consider a person incompetent to make healthcare decisions is challenged. The example of a case in which a woman was treated for a physical disorder without her consent illustrates that personality disorder can render a person incompetent to refuse essential treatment, particularly because it can affect the doctor–patient relationship within which consent is given.

Treatments dilemmas involving consent occur frequently in caring for individuals with personality disorder. Traditionally, personality disorders are viewed as distinct from other mental disorders and are not usually considered to be grounds for judging that a person is incompetent to make healthcare decisions. We report a case in which an individual was treated for a physical disorder without her consent, on the grounds that personality disorder rendered her incompetent to refuse essential treatment. We argue that a close examination of what constitutes competence gives reasonable cause to be concerned that personality disorder may be associated with impairment in competence to consent. Of particular relevance is the idea that personality disorder can affect the doctor–patient relationship within which consent occurs.

CASE REPORT

A 29-year-old single mother with a diagnosis of borderline personality disorder was admitted to hospital after a period of self-cutting. She had declined treatment for her resulting anaemia (haemoglobin 21 mmol/l; normal range 100–130 mmol/l).

The patient repeatedly declined blood transfusion, as she said, "I just don’t know how to say yes." When questioned, she asserted, "It’s not that I don’t want to go without treatment. On one occasion, I might have a morbid fascination with how far she could go without treatment. On one occasion, distressed, she asserted, “It’s not that I don’t want a transfusion, I just don’t know how to say yes.”

The patient was eventually given a transfusion, without physical struggle, on the grounds that she was not competent to refuse treatment for a life-threatening anaemia.

DISCUSSION

Individuals are conventionally presumed competent to consent to or refuse medical treatments. The three components of competence are described as capacity, information and voluntariness.1 Generally, competence is held to be specific to a particular intervention, and to the time at which consent is sought.2 Mental health legislation was developed at a time when psychosis, irrationality and mental illness were held to be virtually synonymous; the mentally ill were presumed to lack competence. Laws typically restrict the authority of clinicians to treatment of mental, as opposed to physical, disorders. In both New Zealand and the UK, mental health law does not include a judgement about competence; rather, treatment is enforced on the basis of a person’s status as “mentally disordered”. In the UK, debate over the fusion of mental health and incapacity law follows concern that the current system disadvantages patients and nihilistic comments about herself and her prospects for treatment, and voiced the idea that she would be “better off dead”. She made vague hints of imminent suicide. Her comments were judged primarily an expression of her personality, rather than of a mood disorder. Indeed, at times she displayed a sharp humour. There was no evidence of psychosis. She was cognitively intact on routine testing. Outside clinical interviews she was often responsive, assertive and articulate and was able to organise care for her son.

The patient repeatedly declined blood transfusion and dietary iron supplements. She could recount being told about the symptomatology and severity of her anaemia, the treatment options and the risks associated with refusing treatment. However, she claimed to be unconvinced and provided unlikely counter-arguments. For example, she stated that her ankles were swollen for lack of exercise rather than as a result of anaemia, and that medical personnel were exaggerating the seriousness of her condition, although she had already been advised, when her haemoglobin was substantially higher, that her anaemia was life-threatening. She claimed at other times to “hate the thought of the blood going inside” and indicated that she might have a morbid fascination with how far she could go without treatment. On one occasion, distressed, she asserted, “It’s not that I don’t want a transfusion, I just don’t know how to say yes.”

The patient was eventually given a transfusion, without physical struggle, on the grounds that she was not competent to refuse treatment for a life-threatening anaemia.

1 Otago District Health Board, Dunedin, New Zealand; 2 Department of Psychological Medicine, Dunedin School of Medicine, Dunedin, New Zealand

Correspondence to:
Dr E Winburn, Otago District Health Board, Private Bag 1921, Dunedin 9054, New Zealand; 1. E.winburn@otagodhb.govt.nz

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Clinical ethics

with mental illness, because it does not require clinicians to make judgements about their competence.

Nonetheless, mental disorders are sometimes associated with impaired competence to make healthcare decisions. A recent review suggested that approximately a third of psychiatric inpatients lacked the capacity to make various treatment decisions, the strongest risk factors being psychosis, severity of symptoms, involuntary admission and treatment refusal.

Personality disorder has always been considered to be at the margins of what constitutes mental disorder, and it is common clinical lore that such individuals should take responsibility for their actions. Consequently, individuals with disturbed personality are not usually considered mentally disordered, or incompetent to consent. Significantly, a recent revision of the UK Mental Health Act has included personality disturbance within the scope of mental disorder.

A closer examination of what is held to constitute competence led us to believe that the patient whose case we have described was incompetent to refuse treatment, on the basis of her personality disturbance. The criteria for capacity can be summarised as understanding and retaining information, weighing up the relative risks and benefits of treatment and arriving at a clear choice.

The patient’s distorted interpretation of the information suggests that she was unable to understand what had been said to her. Furthermore, she was disposed to disbelieve what she had been told, as a consequence of her disturbed relationship with those practitioners who had attempted to inform her. This illustrates that competence to consent depends on adequate interpersonal communication, which in turn is dependent upon an adequate relationship between patient and provider. In personality disorder, a person’s enduring pattern of inner experience and way of relating to others deviates markedly from the norm, so that the doctor–patient relationship, within which consent occurs, is often disrupted. Indeed, personality disorders may be conceived of as disorders of interpersonal life, rather than primarily as disturbances in the mental state of the individual.

Second, it was judged that the patient’s refusal was a manifestation of her tendency to adopt a contrary and self-destructive stance in response to clinical advice. Her claims that she did not want a transfusion were inconsistent and had only a superficial plausibility. As such, they appeared not to be clear decisions about treatment but to be manifestations of her disturbed relationship with clinical staff. The persistence of this kind of interaction with mental health services, frequently observed in those with severe personality disorder, was such that she was considered unable to choose to behave otherwise.

Voluntariness in consenting allows the expression of autonomy. However, autonomy is more than making independent, uncoerced choices: authentic autonomy implies some consistency in expression of a person’s identity, intention, history and elements of their individuality and personal integrity. It has been argued that if the choice to refuse intervention is determined by mental disorder, the choice is not autonomous and thus does not meet the criteria for informed consent.

In the case of this particular patient, it could be argued that her individual choices, statements and personality as a whole pointed to an autonomous decision to decline treatment, her treatment refusal being consistent with her behaviour towards her condition and treatment historically. However, this kind of interaction has typified her contact with the mental health service. Her stated “refusal” of treatment is a part of a familiar range of behaviours by which she brings herself to clinical attention. Her behaviour and personality, as a whole, suggest a disturbed form of engagement with the mental health service, rather than an effort to disengage.

Respect for a patient’s rights is sometimes advocated over what is unfortunately termed “paternalism”. Current practice places a high value on the principles of autonomy. However, the case described illustrates that individuals cannot always best be considered as isolated persons whose relationships, dependencies and obligations can be adequately codified in some form of social contract, with each person assumed able to negotiate their own needs. Most significantly in the case described here, the giving of consent represents an interaction between parties, rather than the activity of a single individual.

Autonomy cannot always be separated from the interpersonal sphere in which it manifests itself.

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