

Law, ethics, and medicine

The discrepancy between the legal definition of capacity and the British Medical Association's guidelines

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Differences in guidance from various organisations is preventing uniform standards of practice

The emphasis in medical law and ethics on protecting the patient's right to choose is at an all time high. Apart from circumscribed situations, for instance where the Mental Health Act 1983¹ is applicable, the only justification for medically treating an adult patient against his or her wishes is on the basis of common law, using the principle of best interests, and only when he or she lacks capacity to refuse treatment. As a result, it is important that clinicians should be able to assess capacity to refuse treatment. Given that judgments of incapacity involve deciding that a person does not have the ability to refuse treatment, a great deal of care needs to go into the assessment and characterisation of incapacity.

There is divergence between the characterisation of capacity that is used by the courts and that which is recommended by the British Medical Association (BMA). The BMA usefully expands on the first element of capacity as set out in the standard legal definition of capacity in the Re C judgment² but ignores the other two elements. By doing this, the BMA makes it unclear whether it is rejecting these as relevant to capacity; it also misses the opportunity to expand on these elements in a clinically useful way.

We will begin with a description of the BMA's advice³ and the standard English legal definition of capacity.^{2,4} Then we will show that there are important discrepancies between these two sources of advice. We think that the BMA ought to clarify its position on capacity in order to safeguard the interests of physicians, healthcare workers, and patients.

THE RE C TEST

Mr C was a patient in a psychiatric secure hospital who had chronic paranoid schizophrenia with grandiose delusions of being a world famous doctor. He developed gangrene in his right foot. He refused to consent to amputation of

his right leg below the knee. He sought an injunction to restrain his doctors from amputating the leg without his express consent. In granting the injunction, Justice Thorpe held that C sufficiently understood the nature, purpose, and effects of the proposed amputation, and that he retained capacity to consent to, or refuse, medical treatment. Justice Thorpe laid out the criteria for capacity, which were subsequently cited in other cases, and have become generally known as "the Re C test".⁴

THE BRITISH MEDICAL ASSOCIATION'S GUIDELINES

In 1995 the BMA and the Law Society jointly produced guidelines on the assessment of mental capacity.³ The BMA's guidelines on important issues are generally widely disseminated amongst the medical profession, often influencing medical practitioners in other countries as well.

For these reasons it is important that the BMA gives clear consistent advice that is not open to misinterpretation. Unfortunately, the crucial section of the BMA guidance that outlines the abilities necessary for consent to treatment is inconsistent with the most important common law test of capacity (reference 3 p 66): "The High Court held that an adult has capacity to consent [or refuse consent] to medical treatment if he or she can:

- (a) understand and retain the information relevant to the decision in question
- (b) believe that information, and
- (c) weigh that information in the balance to arrive at a choice.

Therefore to demonstrate capacity, individuals should be able to:

- understand in simple language what the medical treatment is, its purpose and nature and why it is being proposed

- understand its principal benefits, risks and alternatives
- understand in broad terms what will be the consequences of not receiving the proposed treatment
- retain the information for long enough to make an effective decision, and
- make a free choice (ie free from pressure)."

The first three abilities (a, b, and c) are the test for capacity known as the Re C Test.² The five point test that follows the Re C test are abilities that the BMA thinks should follow from this test. In its subsequent condensed guide for clinicians, the *Consent Toolkit*,⁵ the test for capacity is simply given as the five point test listed above, which suggests that the BMA views the five point test as equivalent to the Re C test.

DIFFERENCES BETWEEN THE BMA AND RE C TESTS OF CAPACITY

The five points essentially enlarge on, and put within a clinical setting, the first element of the Re C test. Unfortunately, despite its usefulness, the five point test differs from the Re C test in a number of important ways. The BMA guidelines:

- expand only on the first part of the Re C test
- leave the second and third parts of the Re C test out, and
- appear to add to the Re C test.

We will deal with each of these difficulties in turn.

The BMA guidelines expand only on the first part of the Re C test

The first element of the Re C test focuses on understanding and retaining information. The first four abilities that the BMA recommends focus on this and they give some useful elaboration. The suggestion that patients who possess capacity should be able to understand treatment information in "simple language" is a useful piece of advice. The Re C statement that the patient should understand information "relevant to the decision in question", is helpfully elaborated to specify what types of information would be relevant to the decision.

While the BMA's guidelines are very helpful for clinicians in elaborating what is meant by "relevant information" in the first element of the Re C test, the Re C test is in fact more difficult to interpret and apply with respect to its second and third elements.

The BMA guidelines leave the second and third parts of the Re C test out

The most significant problem is that the BMA's advice is incomplete because it says nothing about the second and third elements of the Re C test, namely believing the information and the ability to weigh information to arrive at a choice. There is no statement about the cognitive abilities that are required to reason about a decision.

The second Re C element requires decision makers to "believe" the information given by the clinician. This not simply a point about understanding or information or believing everything that a clinician says. A naïve reading would be that the patient should simply believe the information given, but in the Re C judgment Justice Thorpe stated that Mr C believed the information "in his own fashion", even though he did not believe that he would die from the gangrene in his foot, as his doctors felt he would. Justice Thorpe found no link between Mr C's beliefs, as relevant to the treatment decision, and his delusional beliefs that were part of his schizophrenia. This suggests that disbelieving the information is acceptable, as much as believing it, so long as either arises from ordinary grounds, as opposed to mental disorder.

Some patients lacking capacity could pass all of the BMA's understanding requirements yet not be able to satisfy the third Re C criterion. It is likely that the third Re C element, which requires that a person should be able to "weigh things in the balance" is an attempt to capture the complicated processes that take place when reasoning about a treatment decision. This requires consideration of risks, benefits, short term outcomes, long term outcomes, assigning relative weights to each, and making a decision based on all the relevant factors,⁶ including consideration of other salient factors such as individual values and priorities.

The BMA guidelines appear to add to the Re C test

The final point in the BMA's five point test is quite confusing. "Make a free choice (ie free from pressure)" is not usually included in tests of competence or capacity. "Voluntariness", or having choice free from external pressure, is one of the preconditions of valid consent, along with capacity and having sufficient information.^{4 7}

There is an alternative reading of the final point of the five point test, which is that the patient should be capable of making a free choice, for instance, he or she is not impaired by any psychiatric factor that might render it impossible to decide in a certain way. Examples of this

found in case law are a person with severe needle phobia being incapable of choosing to have a necessary operation because of the strength of her fear of needles, or a patient with a mental disorder such as anorexia nervosa in which she feels compelled to lose weight.⁴ This reading would concern internal restrictions or pressures, to which one might add a requirement that it must be pathological in origin, as opposed to cultural or subcultural (for example, as a consequence of a religious belief). However, the parenthesis elaborating upon the element of "free choice" by making an explicit link to coercive forces renders this reading implausible.

THE IMPLICATIONS OF THE GUIDELINES DIVERGING FROM THE LEGAL DEFINITIONS

Taken at face value, the divergence of the BMA's five point test from case law of Re C might appear to be trivial and of no consequence. However, looking at the Re C case itself, it is likely that Mr C would have easily passed the five point test, as the difficulties surrounding the determination of capacity by the three elements listed by Justice Thorpe centred around the second element, with some disagreement on this point among the expert and professional witnesses involved. The issue hinged on whether Mr C in fact believed the information given to him about his condition, and whether his disagreement with the recommendations of the surgeons arose from ordinary causes, or his delusional belief that he was a world renowned surgeon. The BMA's guidelines, in failing to mention the second element of the Re C test, do not identify the crux of the issue of whether or not a patient such as Mr C is competent to make a decision regarding their treatment.

THE LIKELY IMPACT OF THE BMA'S ADVICE

The BMA is the largest association of medical doctors in the UK and its advice has significant influence over the medical profession. It is likely that the majority of the medical profession will read advice from the BMA. The General Medical Council, in its *Guidance on Good Practice*,⁸ refers doctors to their own professional bodies for guidelines of assessing capacity, referring explicitly to the BMA's guidelines as an example of this. This lends these guidelines added weight, for the General Medical Council is the regulatory body of the British medical profession and its recommendations have the status of being statements of best practice, against which doctors may be measured if issues or complaints of medical negligence or malpractice arise.

THE RE C TEST OF CAPACITY AND ITS STATUS

Scotland has enacted statute law on capacity in the form of the Adults with Incapacity (Scotland) Act 2000 which includes a definition of incapacity.⁹ Because there is no definition of capacity to refuse treatment in English and Welsh statute law, the test of capacity as outlined in the case of Re C is taken as being the standard English and Welsh legal test of capacity. This view is supported by Kennedy and Grubb⁴ and the Medical Defence Union.¹⁰ The Re C definition has been quoted in subsequent legal judgments involving consent and capacity,^{11 12} making it likely that in future court cases involving issues of treatment refusal, the Re C test will remain the standard by which capacity is determined in the courts.

The Department of Health has published guidance for clinicians concerning issues of consent and capacity. In its summary of the law in England, it reflects the first and third elements of the Re C test, in its *12 Key Points on Consent*¹³ and *Reference Guide to Consent in Treatment or Examination*.¹⁴

CONCLUSION

Given the influence of the BMA's guidance and the General Medical Council's reference to it, the five point test is likely to become the established definition for capacity among the medical profession, and thereby affect both standard clinical practice and the Bolam test.¹⁵ However, given that the legal definition of capacity has already been set out in Re C and has been cited and used in subsequent legal cases, it is equally likely that capacity will continue to be determined by judges according to the three Re C elements. There is, therefore, the potential for a gap to appear between the practice of doctors and the judgments that will be handed down in courts for contentious clinical cases. This is a situation which is at best highly undesirable for the welfare and best interests of patients in terms of inconsistencies in definitions and practice; and at worst a flagrant dismissal of the wisdom of the courts by the medical profession.

Although it usefully elaborates on the first element of the Re C test, the BMA's guidance does not reflect all the elements of the Re C test, and also adds a new factor to it without explanation. Given the growing importance of this issue and the influence of this guidance, the BMA should clarify and develop its position with regard to whether it wishes its members to follow the legal test for incapacity as outlined in Re C or the hybrid five point test suggested in its guidance. This is particularly the case as

the General Medical Council explicitly refers members to the BMA's guidance, whereas the Department of Health appears to follow more closely the Re C elements in its guidance. These discrepancies in guidance from various sources are not trivial and can lead to disagreements and variation in clinical practice and standards. The irony is that variation in practice and standards is precisely what all the organisations involved are trying to prevent with their guidance in the first place.

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