

Correspondence

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Contents

- Avoiding hard capacity assessments will not help
- Authors' reply
- A contextual approach to routinely elicit a trauma-oriented history
- Conclusions in Gryglewski et al may not be warranted
- Response letter to the article by Killackey et al (2019) 'Individual placement and support for vocational recovery in first-episode psychosis: randomised controlled trial'

Avoiding hard capacity assessments will not help

We read with interest Zhong et al's editorial outlining a 'pragmatist's guide' to assessment of decision-making capacity.¹ The authors argue that a subset of 'grey area' capacity cases cause 'moral distress' in clinicians and propose that 'capacity is only practically important when the treatment team is willing to proceed with forced treatment. Absent this condition, the outcome would be the same as simply honouring the patient's choice, and there is no need (apart from intellectual satisfaction) to assess capacity'. In our view, this is problematic advice.

Some capacity assessments are easily resolved, and Zhong et al give helpful examples of cases where time, education, treating illness and negotiating with the person negate capacity questions. Indeed, in England and Wales, the Mental Capacity Act (MCA) lays out the imperative to do this.² Yet to collapse all hard capacity questions into a coercion test fails to grapple with the range of clinical sources of 'moral distress' and the legal doctrine of informed consent.

First, the question 'would we force treatment?' is not necessarily an easy one. Decisions about coercion generated moral discomfort in clinicians long before capacity emerged as a legal construct,³ and discomfort can arise when forced treatment is not at issue: consider a person with depression assenting to electroconvulsive therapy because she feels that she deserves punishment. Furthermore, the question 'would we force treatment?' is all too easily reduced to its sibling: 'can we force treatment?' The authors raise the issue of whether adequate resources are available to restrain a person who refuses antibiotic treatment, arguing that if not, the capacity question is moot. However, even with such resources readily available, the ethical question persists: is forcing treatment the right thing to do in this case? This holds in all capacity cases, not merely grey area cases.

Several Court of Protection determinations have upheld the wishes of a person found to lack capacity, ruling out coercion, through a careful 'Best Interests' process (see for example *Wye Valley NHS Trust v B*).⁴ This involves recognition of current and prior wishes of the person, advance directives and views of family. Zhong et al's alternative model is a risk-benefit analysis carried out by clinicians. It is telling that they consider medical risks only (pressure sores, prolonged hospital stay) and pay little import to the perspective and lived experience of the person facing coercion. The MCA also provides a defensible process for clinicians, with

capacity assessments providing legal clarity on where decisional authority lies.

The authors contrast a scenario in which a patient who is hypomanic faces imminent death by sepsis with a scenario in which the infection is mild and out-patient antibiotics will suffice. Yet such vastly different facts, contexts and consequences of a decision can be legitimately incorporated into a capacity assessment as a component of the 'relevant information' that a person must 'understand, retain, use or weigh' under the MCA.

Avoidance is not the best approach to moral distress. More research on hard capacity cases and on education and training to improve approaches to them is a healthier path.⁵

Declaration of interest

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- 1 Zhong R, Sisti DA, Karlawish JH. A pragmatist's guide to the assessment of decision-making capacity. *Br J Psychiatry* 2019; **214**: 183–5.
- 2 Department of Health. *The Mental Capacity Act 2005, Section 1(3)*. Stationary Office, 2015.
- 3 Austin WJ, Kagan L, Rankel M, Bergum V. The balancing act: psychiatrists' experience of moral distress. *Med Health Care Philosophy* 2008; **11**: 89.
- 4 *Wye Valley NHS Trust v B* [2015] EWCOP 60.
- 5 Mental Health and Justice Project. Contested assessment [Internet]. London UK: Mental Health and Justice Project; 2019. Available from: <https://mhj.org.uk/workstreams/6-contested-assessment/>

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Authors' reply

Kane et al claim that we 'collapse all hard capacity questions into a coercion test [which] fails to grapple with the range of clinical sources of "moral distress" and the legal doctrine of informed consent.' We do not take this position. We identify a narrow set of circumstances that permit capacity evaluators to look past the overt question – does this patient have capacity? – and address the covert but more practically meaningful question – what should clinicians do when the patient declines the treatment recommendation? If it turns out that all parties actually agree that involuntary treatment is not available, feasible or appropriate, then the apparent conflict dissolves.

Nevertheless, Kane and colleagues rightly point out that the determination of whether a treatment is available or 'medically indicated' can itself pose an ethical dilemma. Forced treatment is almost always contentious, as it infringes upon people's liberty and autonomy interests. But even voluntary treatments can provoke moral distress if the validity of consent is in doubt or if clinicians regard a requested intervention as futile. Kane et al. seem to suggest that our approach avoids these issues.

On the contrary, we believe that our method puts the focus right where it belongs: on the practical problem of providing involuntary treatment. Capacity status can be an important consideration, but in the most difficult cases, it is seldom determinative on its own. In proposing that capacity evaluators 'collaborate closely with treatment providers', we do not advocate that evaluators should abdicate their responsibility to engage in moral discussion about a patient's situation. Nor do we encourage practitioners to make unilateral