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Correspondence

Decision-making capacity and consent to treatment

We read with interest the article in the July 2001 issue of *APT* (Bellhouse *et al*, 2001) regarding decision-making capacity in adults. The authors have summarised leading legal cases in the area of consent to treatment, and then focused on the practical assessment of capacity. In doing so they have illustrated the ongoing ethical dilemma between patient autonomy (the right to self-determination) and the paternalistic outlook of the medical profession. The authors make reference to the report of the Expert Committee on Reform of the Mental Health Act 1983 (Department of Health, 1999*a*). However, recently there have been a number of other documents published focusing upon consent to treatment and we feel that a consideration of these would add a further dimension to this topic.

Bournewood (R *v*. Bournewood Community and Mental Health NHS Trust ex parte L, 1998) highlighted the need for safeguards to be put in place for incapacitated patients. Subsequently, the Government published a number of documents describing the way in which they intend to take forward policy on incapacity. Despite the Expert Committee's recommendation for a capacity-based approach to consent, the Green Paper (Department of Health, 1999*b*) and subsequent White Paper (Department of Health, 2000) reject this, and do not see patient autonomy as a priority.

More recently there have been a number of publications from the General Medical Council (1998), British Medical Association (2001) and Department of Health (2001) concerning consent to treatment and capacity. These aim to provide clarification for clinicians dealing with these ethical considerations.

The Reference Guide to Consent for Examination or Treatment (Department of Health, 2001) provides a comprehensive overview of the subject. Guidance is provided to deal with difficult clinical situations; however, this does not clarify all issues. The document emphasises 'consent must be given voluntarily: not under any form of duress or undue influence' (paragraph 3.0, p. 5). Within psychiatric practice, professionals are often aware that coercion plays a part in consent. Examples include a patient agreeing to be admitted informally, stating that otherwise he or she would be sectioned. This also applies to the administration of medication. Furthermore, supervised discharge enables patients to be conveyed to hospital if they do not comply with elements of their treatment. This does not officially allow administration of medication without consent in the community. It has, however, been recognised that the element of coercion in supervised discharge has contributed to a successful outcome, improving patient compliance. A survey of supervised discharge orders (Knight *et al*, 1998) found that one-third of respondents had stipulated that patients accept medication as a condition of the order. The authors comment 'it is a matter of concern that patients are complying with medication under such duress'. This has been described elsewhere (Eastman, 1997) as 'fudged pseudo-coercion'.

The issue of consent remains contentious in the areas of force-feeding and deliberate self-harm. The Department of Health document states 'the courts have recognised that a competent individual has the right to choose to go on a hunger strike' (paragraph 19.3, p. 11). It further notes that towards the end of a hunger strike capacity may be lost. However, if while competent he or she expressed the desire to starve him- or herself to death, he or she cannot be force-fed. Conversely, if the patient is refusing food as a result of a mental disorder, different considerations may apply, and specialist guidance should be consulted. Since starvation is likely to lead to mental disorder, in addition to loss of capacity, this does little to clarify the situation for professionals.

Similar ambiguity is found in the case of self-harm, which often presents a particular difficulty for health professionals. The document states that if practitioners have good reason to believe that a competent patient genuinely intended to end his or her life when he or she took that decision, and the practitioner is not satisfied that the Mental Health Act is not applicable, then treatment should not be forced upon the patient. There is not consensus as to whether it is appropriate to use the Mental Health Act in such circumstances. Again this requires clarification.

The article by Bellhouse *et al* has provided a useful practical aid to clinicians in the assessment of capacity. However, we now look to the Government for a legislative framework within which to practice these skills.

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Psychiatry and treatment adherence in the renal unit

Phipps & Turkington (2001) gave a good overview of the range of psychological difficulties experienced by patients in a renal unit. However, there was one important omission; non-adherence to treatment. Non-adherence to dietary and fluid restrictions by patients receiving dialysis is well recognised and non-adherence to immunosupressant medication following transplantation is now being seen as a major problem. There are several studies showing that at least 20% of all transplant recipients omit some of their immunosuppressants and that non-adherence is a leading cause of premature transplant failure (Schweizer *et al*, 1990). Adherence research in patients with renal and other chronic conditions has indicated the importance of health beliefs (Horne, 1998) and mental state (Bunzel & Laederach-Hofmann, 2000) in determining adherence, yet renal staff are likely to have received little, if any, training in the assessment of such areas. Non-adherence to treatment is thus a field in which psychological intervention is likely to make a positive impact and is therefore an area that requires further attention by liaison psychiatrists.

Bunzel, B. & Laederach-Hofmann, K. (2000) Solid organ transplantation: are there predictors for posttransplant non-complicance? A literature overview. *Transplantation*, **70**, 711–716.
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Authors' reply: We thank Janet Butler for her correspondence regarding our recent article. She highlights the importance of non-adherence both for dialysis and transplant patients, with the potential consequences that may arise from this. This issue was discussed in our paper in relation to psychological adjustment and denial (De-Nour & Czaczkes, 1972), and the impact of adjustment disorder on physical outcome (House, 1989). The references given by the author give readers the opportunity to focus in more detail on the research relating to adherence and we are grateful to her for this. In relation to improving adherence in renal patients we would stress the importance of a fully informed, collaborative relationship between patient and physician in relation to the emergence and monitoring of medication side-effects. This can be supplemented by cognitive-behavioural therapy techniques aimed at ameliorating dysfunctional attitudes in relation to excessive needs for control, entitlement and achievement. Such strategies could be taught to renal staff on a workshop basis.

De-Nour, A. K. & Czaczkes, J. (1972) Personality factors in chronic haemodialysis patients causing non-compliance with medical regimen. *Psychosomatic Medicine*, **34**, 333–344.
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