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Mental capacity in practice part 2: capacity and the suicidal patient

ARTICLE

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SUMMARY

This article is the second of two looking at assessment of mental capacity in clinical practice. In it, we explore capacity assessments in the context of suicidal thoughts and acts. The laws governing doctors' responsibility to suicidal patients in England and Wales are poorly understood, with tensions at the interface between the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA). Dynamics of the clinical encounter (including the countertransference) further exacerbate uncertainty about how clinicians should balance patients' autonomy with protection of life. We use a case example of a patient presenting with suicidality to describe good practice, based on a balance of legal and clinical principles and up-to-date case law. We discuss the difficulty in applying the MCA in relation to patients who appear to lack a consistent and coherent sense of self and others and consider whether the MCA is fit for purpose in determining whether someone with a personality disorder diagnosis should be permitted to end their own life.

LEARNING OBJECTIVES

After reading this article you will be able to:

- recognise the limitations of the capacity test in capturing the complex factors that affect decision-making in the context of a suicidal patient
- develop a pragmatic clinical approach through the use of principles guided by consideration of the relevant Acts (how they relate to one another, examples of case law), patient factors and clinician factors
- describe how the countertransference may adversely affect decisions on mental capacity.

KEYWORDS

Suicide; consent and capacity; psychiatry and law; self-harm; education and training.

The law surrounding mental capacity and suicide bears scrutiny for a number of reasons. Self-harm and attempted suicide are common presentations to emergency departments (Clements 2016; McManus 2019), estimated to account for up to one-third of all mental health-related emergency presentations (Barratt 2016). Advances in trauma care have increased the likelihood that violent suicide attempts will be survived (Hardwick 2020), raising ensuing treatment issues. Although suicide prevention is recognised as a major public health concern, recognition of autonomy and self-determination is also prominent. There is a groundswell of support for physician-assisted suicide[a] and several high-profile cases draw further attention to the strength of feeling that exists among the general public.

This article focuses on two situations in which psychiatrists may find themselves thinking about mental capacity as it relates to suicide: when a person, having taken active steps to harm themselves or end their life, refuses life-saving medical intervention, and the question of whether someone has the mental capacity to decide whether or not to take those steps in the first place. We use a two-part clinical scenario ('Seeking help' and 'Refusing help') to focus our discussion.

This article assumes familiarity with the principles and application of the Mental Capacity Act 2005 (MCA) and Mental Health Act 1983 (MHA) that would be expected of a mental health clinician in England and Wales, as described in our previous article (Beale 2022). We acknowledge the limits of only focusing on this jurisdiction but hope that the ethical principles and clinical factors will still be relevant to clinicians within other legislative systems.

Clinical scenario: Seeking help

Ms B, a 24-year-old woman, presents to the emergency department on a Saturday night. She is feeling suicidal and asks for a psychiatric admission to keep herself safe. She has attended numerous times over the past few years, sometimes on section 136 of the MHA, having been picked up near railway lines. She has taken several high-risk overdoses in the past but has always sought medical help. She has a diagnosis of emotionally unstable personality disorder and has had numerous psychiatric admissions. She has out-patient follow-up with the community mental health team but has not worked with the specialist personality disorder service. She refuses referral to the crisis and home treatment team and tells you she will end her life if she is not admitted to hospital tonight. The notes from her last consultant review a month ago state she has capacity to decide whether or not to end her life and that hospital admissions should be avoided in favour of positive risk-taking. How will you manage this?

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a There have been several attempts to legislate for this in the UK Parliament; at the time of writing (2022) the latest Assisted Dying Bill is passing through the House of Lords (House of Lords 2021–2022).

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The law and the clinician's obligations

Although there is no blueprint or flowchart for this clinical situation, asking yourself certain questions helps to clarify your obligations and decision-making process.

In this scenario, a patient in crisis is asking for help to prevent her from ending her life.

From the outset, mental capacity should not be the guiding principle when someone is at risk of suicide. Our first legal concern should be that of the European Convention on Human Rights (ECHR) and whether our operational duties under Article 2 are engaged. As clinicians, our duties to act arise from the ECHR – the MCA (and MHA) are the frameworks through which we fulfil those obligations (Fig. 1). This means that we have a positive obligation to take 'operational steps to secure life' in the presence of sufficient risk. This will be different for each patient and does not always mean hospital admission. If you have a patient at real and immediate risk of suicide who is asking for help, what could you reasonably be expected to do, under the circumstances, to alleviate the risk? In this situation, the clinician might be tempted to quantify the risk as 'low' in order to justify not admitting the patient, when a more clinically practical approach (acknowledging the serious limitations of risk assessment) would be to acknowledge the risk and consider what might be done to help mitigate it.

Capacity in this scenario is a red herring; there are many more considerations before one gets to this question. Considering first the ECHR, the European Court of Human Rights has held that 'an individual's right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question and acting in consequence, is one of the aspects of the right to respect for private life within the meaning of Article 8' (*Haas v Switzerland* [2011]). Although this point was emphasised in *Rabone* (Box 1) – 'autonomous individuals have the right to take their life if that is what they truly want' – clinicians must wonder at what point those with a mental disorder cease to be autonomous individuals. Indeed, despite the competing interest of Article 8, it was Article 2 that was the guiding principle in *Rabone*; effectively, the right to life was given primacy. Capacity did not enter into this judgment; if Melanie Rabone had been detained under the MHA she would not have left hospital, and the MHA does not require patients to lack capacity. The distinction lies in the fact that, although people are allowed to decide to die, clinicians are not obliged to stand back and let them. As stated in *R (on the application of Nicklinson) v Ministry of Justice; R (on the application of AM) v DPP* [2014], 'a policeman is surely entitled to intervene to prevent a would-be suicide from jumping off Westminster Bridge'.

Ruck Keene (2020) suggests that the 'critical question is whether the person, at that point, is at real and immediate risk of suicide – if they are, then the state's operational duty under Article 2 is very likely to be engaged'.

To put it crudely, it may seem as if people have the right under Article 8 of the ECHR to end their lives, but that is not a right to be abandoned to take their own life in crisis. It is unsurprising that clinicians may grasp onto false reassurances that patients are not 'actively' suicidal and that they can 'guarantee their safety' in order to pronounce patients 'low risk.' Some have come to mistakenly see 'capacity' as a way of absolving themselves of responsibility. It is understandable that clinicians may find themselves confused by the law, as suicide has been treated inconsistently by the courts, with unclear reasoning for such discrepancy (Wicks 2016).

Where is the capacity assessment?

In this scenario, the consultant has documented that Ms B has capacity to end her life; we do not say whether there is an actual assessment of capacity documented. Although the presumption of capacity is a core principle of the MCA, it is important not to conflate the presumption of capacity with the assertion that someone has capacity. If stating that someone does or does not have capacity, there

BOX 1 Case law in detained and voluntary in-patients: *Savage* and *Rabone*

The case of *Savage v South Essex Partnership NHS Foundation Trust* [2008] established that a mental health trust was responsible for the death of a patient who died by suicide while detained under the MHA. There is a duty to protect the ECHR Article 2 right of people detained under the MHA in the same way as there is a duty to prisoners, as they are under state control. The trust had therefore breached Carol Savage's right to life. What of voluntary patients? When Melanie Rabone died by suicide while on leave from a psychiatric hospital where she was a voluntary patient, the Supreme Court found that the right to life principles established in *Savage* extended to voluntary patients (*Rabone and another v Pennine Care NHS Foundation Trust* [2012]). That is to say that there is no legal distinction between detained and voluntary patients when it comes to the duty of hospitals to protect their right to life.

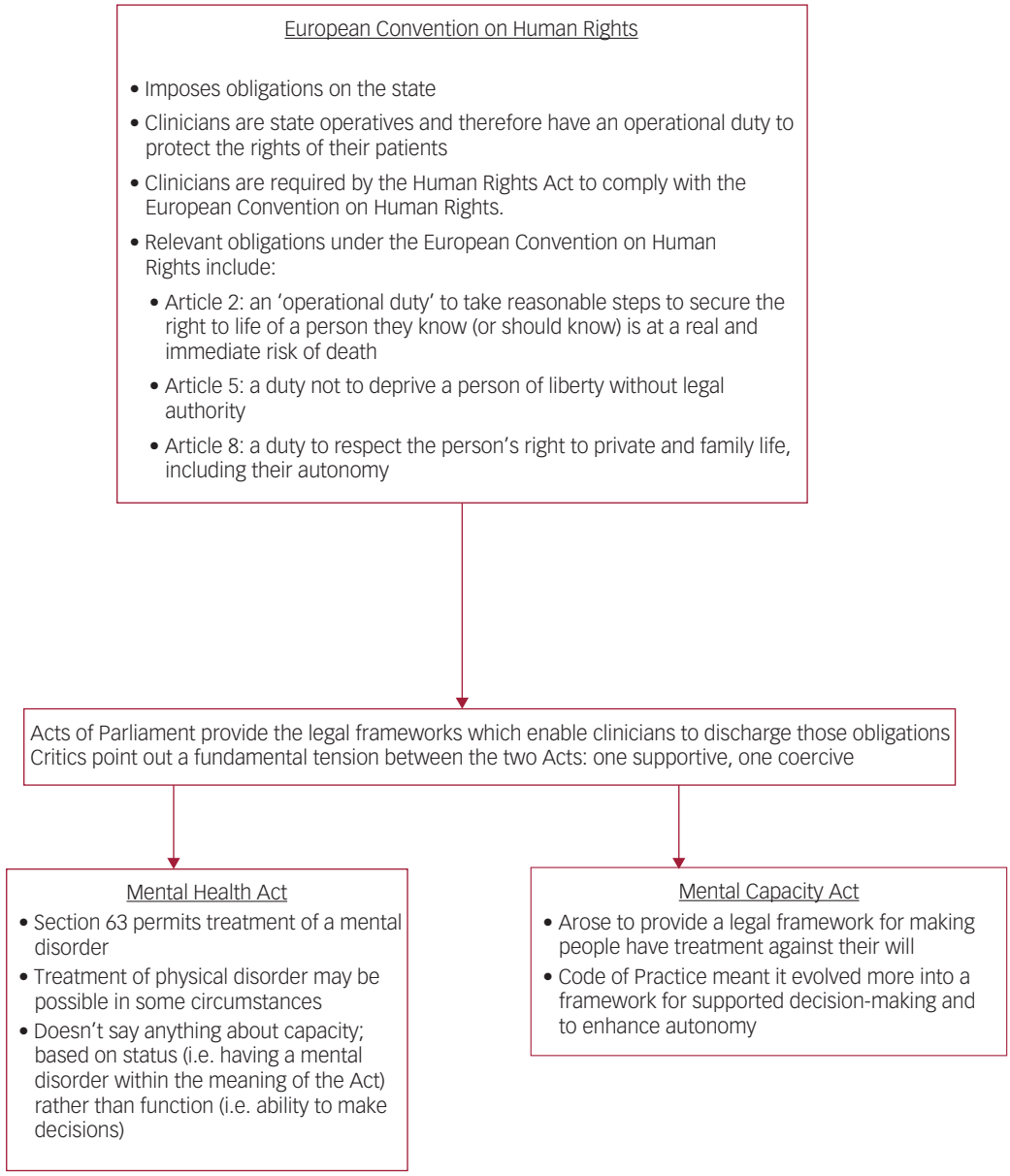

FIG 1 Statutory laws concerning capacity relevant for a mental health clinician practising in England and Wales.

needs to be a proper capacity assessment documented (see our previous article: Beale 2022). This is vital in any situation where documenting an opinion on someone's decision-making capacity, but where the decision is literally one of life or death, it would be inexcusable not to have documented a robust assessment, showing your working and making it clear how you arrived at your conclusion.

The European Court of Human Rights has treated the issue of capacity and suicide with caution, with case law making it clear that a proper assessment of capacity should be carried out where a mentally disordered individual seeks to end their own life (e.g. Arskaya v Ukraine [2013]; *Fernandes v Oliveira v Portugal* [2019]).

Capacity for what decision? Capacity is decision-specific

Clinicians may question whether someone has capacity to make a certain decision, and this is most likely to be a decision connected to care and treatment. If your mind has leapt to capacity when faced with a suicidal patient, it is wise to take a few steps back and ask yourself in what way does suicide fall into the category of decisions about care and treatment? We are not discussing whether or not someone has capacity to consent to an intervention but whether or not they have capacity to take action to end their own life. Assuming that, if the clinician felt this patient lacked capacity, steps would have been taken to assess her for

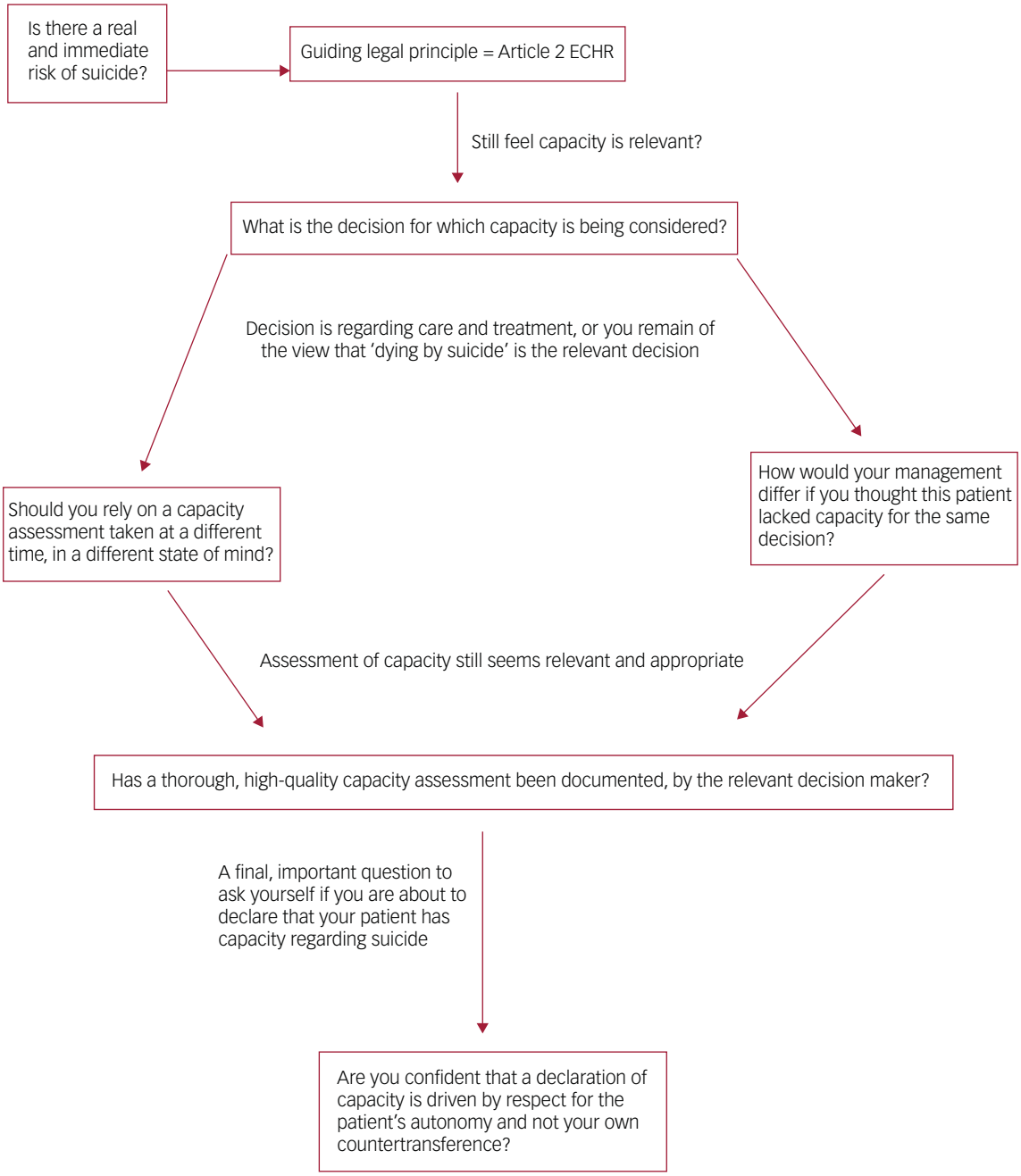

FIG 2 Flowchart for the clinician considering whether a patient has decision-making capacity regarding suicide. ECHR, European Convention on Human Rights.

detention under the MHA, then the implication appears to be that having capacity disqualifies her from even voluntary care.

Ms B is asking for help, albeit a specific intervention which her treating consultant does not think will benefit her. This is not particularly unusual in any branch of medicine, and it is true that the law places no obligation on doctors to perform an intervention that they do not believe to be clinically indicated. Having capacity to make decisions does not permit people to insist on treatment. However, it is also not the reason for denying the treatment in question. In this scenario, the consultant has specified that the decision for which Ms B has capacity is the decision to take her own life, not the capacity to consent to any form of treatment. Their capacity assessment was therefore focused on the wrong decision. It is also important for a clinician faced with this situation to ask themselves how their management would differ if the patient was judged to lack capacity. If the reason for refusing an intervention is the fact they have capacity to ask for it, something may have gone wrong in the understanding and application of the law.

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Fluctuating mental state, fluctuating capacity: capacity is time-specific

There are many situations where decision-making ability might be expected to fluctuate, and a patient with rapidly changing mood states who moves in and out of suicidal crises is surely one whose capacity might be expected to shift accordingly. Although the consultant might have assessed Ms B to have decision-making capacity when she was seen in clinic (leaving aside the holes in this argument as detailed above), she is now presenting to an emergency department in a crisis, where her mental state might be very different. It is not acceptable to take someone else's capacity assessment – from a different time and a different situation – and treat it as persistent or binding. It is not reasonable to make a longitudinal statement that this person always has capacity to end their life, particularly where there is instability of mood, thought and behaviour.

Is capacity relevant at all?

Although the MCA states that 'a person is not to be treated as unable to make a decision merely because he makes an unwise decision', it does not automatically follow that clinicians have no obligation to protect those making objectively 'unwise' decisions. If we are to accept suicide as a decision that falls within the remit of the MCA, then it is probably fair to say that most clinicians would regard this as an 'unwise' decision. However, this 'right' to make such a decision is arguably more complicated when it is the result of a mental disorder and it involves someone taking active steps to end their life.

This particular situation may not really be about capacity at all. Capacity may be seen as a sort of 'get out of jail free card', a way of saying that if a patient dies it will not be our responsibility. Although we cannot stop everyone from dying by suicide, the term 'capacity' does not erase clinical responsibility or lessen the need for compassion. Although 'positive risk-taking' may be appropriate at times (e.g. the decision to discharge someone even if there is a possibility of suicide – something which we are very poor at predicting (Appleby 2018; Graney 2020)), it is possible for clinician and patient to make a plan without capacity for suicide being a consideration. As with a robust assessment of capacity, a management plan needs to show your working. Instead of claiming to be able to predict that the risk is low or justifying your decision on the basis of capacity for suicide, explain the reasoning behind your decision, acknowledge the risk that may exist and explain what you are doing to mitigate that risk. The patient and their care need to remain your central consideration in the face of considerable anxiety regarding scrutiny of clinical practice, rather than self-interest.

Although *Savage* and *Rabone* have clarified our legal obligations towards in-patients, it is difficult to know to what extent that applies to out-patients, including in the emergency department, or those who come to harm in unforeseen circumstances such as an accidental overdose (*Morahan, R (on the application of) v HM Assistant Coroner for West London* [2021]).

All cases turn on their own facts. The point is that these are complex processes that deserve time and careful thought, including the need to attend to one's own countertransference responses, discussed later in this article. 'Capacity' might be being misused in this situation and legislation intended to support decision-making misappropriated.

Clinical scenario continued: Refusing help

Several weeks later, Ms B presents again to the emergency department. She has taken a large, staggered overdose of paracetamol and has deranged liver function tests. She is conscious and not confused or intoxicated. She called the ambulance herself and says this is because she was afraid of dying in pain and alone but refuses treatment to counter the effects of the overdose, asking instead for palliative care. She says she is frustrated that nothing ever changes and that her life will never improve. She is aware that her consultant has said she has capacity for suicide and states that this means she cannot be treated against her will. She does not think anyone will ever be able to help her, so wants to be allowed to die.

The law and the clinician's obligations

It is well established that a competent adult refusing medical treatment cannot be treated against their will (e.g. *Airedale NHS Trust v Bland* [1993]); also 'this right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent' (*Re T (Adult: Refusal of Treatment)* [1993]: para. 201). When a person refusing treatment for a physical disorder also has a mental disorder (a broadly defined term that may extend to so-called 'organic' conditions such as brain injury, delirium and dementia) their capacity to make the decision may be called into question. A key difference between the MCA and the MHA is that a patient who retains decision-making capacity may still be treated against their will for a mental disorder under the MHA. This introduces a tension at the interface between the two Acts, with further difficulties arising as a result of the arguably artificial distinction between physical and mental health. Section 63 of the MHA provides the authority to treat patients with a mental disorder without their consent, although which treatment falls into the

category of physical or mental becomes blurred when physical treatment may be seen as part of the treatment for that disorder, therefore falling within the scope of the MHA. The MHA Code of Practice (Department of Health 2015: para. 13.37) states that treatment for a physical disorder cannot be given under the Act unless the physical treatment is 'intended to alleviate or prevent a worsening of symptoms or a manifestation of the mental disorder (eg a clozapine blood test) or where the treatment is otherwise part of, or ancillary to, treatment for mental disorder'. Therefore, treatment to mitigate a suicide attempt could conceivably be given under section 63 of the MHA without mental capacity being considered, although this is probably not ideal practice.

As per the previous scenario ('Seeking help'), the clinician's Article 2 obligations are engaged here, perhaps even more clearly so, because the risk to life is not hypothetical but definite and imminent. As above, the MCA says that a competent patient has the right to refuse treatment, but determining competence in this situation may be complex and challenging (Box 2).

Against the clock

This is clearly a time-critical situation: the longer Ms B goes without treatment, the greater danger she is in. Physical effects of the overdose may further affect her decision-making ability. You will need to establish how urgently a decision needs to be made and you should not unnecessarily delay life-saving treatment. The MCA Code of Practice (which is currently under review) advises:

> 'Sometimes people who lack capacity to consent will require emergency medical treatment to save their life or prevent them from serious harm. In these situations, what steps are "reasonable" will differ to those in non-urgent cases. In emergencies, it will almost always be in the person's best interests to give urgent treatment without delay' (Department for Constitutional Affairs 2007: para. 6.35).

That said, you will usually have some time to assess and, as in the previous scenario, your first question in the face of suicidality – even with refusal of treatment – should not usually be about capacity. Set aside the question of capacity to begin with, in favour of finding out what you can about Ms B and who she might allow to be contacted. In many cases, therapeutic engagement will mean that patients agree to treatment, negating the immediate question of enforcing it.

Which legal framework?

As discussed above, treatment for the consequences of an overdose could fall within the remit of the MHA, so you might consider making an application for detention. Treatment for an overdose could fall within the remit of section 63, but this is a legal framework with which acute clinicians may be unfamiliar. To treat under the MHA will require close collaboration and a shared understanding between psychiatric and acute medical teams. Ruck Keene & Burnell (2014) outlined the position in law with regard to non-consensual medical treatment for people who have taken an overdose. They note that 'very considerable caution should be exercised before detaining a patient simply for purposes of using Section 63', yet this is often precisely the reason for which patients are detained. If not with a view to treatment, there are less convincing grounds to detain. This is an example of how the black and white nature of law is not always a good fit for the complexities of clinical reality.

Assessing capacity

Before assessing capacity, remember that you need to take 'reasonable steps' to arrive at a 'reasonable belief' as to the patient's capacity (Department for Constitutional Affairs 2007); in an emergency, what constitutes 'reasonable steps' is likely to be different from when you have the luxury of time. It is not possible to dictate the definition of 'reasonable', as this will depend on the person and situation in

BOX 2 The case of Kerrie Wooltorton

In 2007, Kerrie Wooltorton, a young woman with a diagnosis of personality disorder, ingested antifreeze before calling an ambulance to take her to hospital. This was something she had done on eight previous occasions, each time consenting to life-saving treatment. On this occasion, however, she had written a 'living will' refusing life-saving treatment but asking that measures be taken to keep her comfortable. Doctors assessing her found her to have capacity to refuse treatment (despite her unwillingness to engage in assessment beyond indicating her letter) and no steps were taken to reverse the effect of the poisoning, which was fatal. This controversial case has been subject to much discussion in the academic and popular press (e.g. Doughty 2009; Muzaffar 2011; Richardson 2013; Sarkar 2013; Szawarski 2013) and Ms Wooltorton should arguably now be left to rest in peace. Her case never came before the courts (who may well have formed a different conclusion to that of the coroner) and neither yet has any comparable case; therefore there is not yet any case law to confirm or counter that someone refusing treatment in the immediate aftermath of a suicide attempt may be permitted to die if found to have mental capacity to make this decision.

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question; however, you must ask yourself whether your belief as to the person's capacity is reasonable given the risk, nature of the decision, time and the information available.

We explored the 'how to' of capacity assessment in our previous article (Beale 2022) and readers can review this with the current situation in mind. When a patient is seemingly rational and able to understand the dire consequences of refusing treatment, pay particular attention to how they weigh their decision in the balance. You might wonder whether there is a degree of ambivalence in someone who opted to come to hospital, knowing that staff might try to change their mind or even act against their will. This is not to say that seeking medical care is proof of the wish to be saved; however, Ms B's presence in the emergency department may indicate ambivalence regarding suicidal wishes. From the initial scenario, she has previously asked for help to stay alive on several occasions and has often sought the safety of the hospital. This might suggest that current choices are not in keeping with her usual beliefs and values. Is her view – that life can never be improved and there is no hope remaining – appropriate when applied to the reality of her situation? The interplay of pain, fear and distress may even render the test for mental capacity inadequate for decisions of this magnitude, particularly in urgent care (Casey 2016). Until we have an alternative, clinicians are advised to exercise considerable caution in assessing capacity when someone has made an attempt on their life. Suicide is no longer a crime in the UK, although under certain circumstances, being involved in the suicide of another person might be: see Box 3.

Case law: King's College Hospital NHS Foundation Trust v C and V *[2015]*

The refusal of treatment for a suicide attempt in the acute setting has not yet been tested in the courts. However, capacity to refuse longer-term treatment and therefore, in effect, to die by extended suicide was considered in *King's College Hospital NHS Foundation Trust v C and V* [2015]. In this case, C had taken an overdose and needed renal dialysis, which was expected to be temporary and offer a positive prognosis. She refused and wished to be allowed to die, a life devoid of 'sparkle' being one that was, to her, not worth living. Expert opinion was divided as to whether a personality disorder caused her to lack capacity to refuse treatment but, ultimately, the court held that she had capacity to make this objectively 'unwise' decision. There are comparisons to be drawn with our case: both concern a woman with a personality disorder diagnosis who, having already attempted to take her own life, refused the treatment required to save her. C was found to have decision-making capacity and was allowed to die. Perhaps the key difference is one of time. With the luxury of time, those involved in the case of C were able to make multiple assessments with the involvement of psychiatrists, the opinions of family taken into account and, ultimately, the court acting as final arbiter. C had plenty of time to make clear her case; Ms B does not. She has arrived at hospital in an emergency scenario, already suffering the physical effects of poisoning, and we have limited time in which to assess her capacity and make a decision about whether or not to save her life. To put it crudely, if the situation seems to demand that the clinician prioritises either Article 2 or Article 8 of the ECHR, it might be most sensible to err on the side of preservation of life.

The clinical encounter from a psychodynamic perspective

Presumes capacity as an excuse for inaction

Respondents to both the House of Lords post-legislative scrutiny of the MCA (Select Committee on the Mental Capacity Act 2005 2014) and the independent review of the MHA (Wessely 2018) gave evidence that the notion of capacity is sometimes used to justify inaction. In short, if we believe a person has capacity to make an objectively unwise decision, we interpret this to mean we need not take action to protect them.

First-person testimony of this disturbing phenomenon is available in abundance (Aves 2022; Hibbins 2020; JL 2017), with a growing body of

BOX 3 The Suicide Act 1961

Although the Suicide Act 1961 abolished the crime of suicide in England and Wales, to 'aid, abet, counsel or procure the suicide of another' remains a criminal offence. Indeed, the Mental Capacity Act states 'For the avoidance of doubt, it is hereby declared that nothing in this Act is to be taken to affect the law relating to murder or manslaughter or the operation of section 2 of the Suicide Act 1961 (c. 60) (assisting suicide)'.

In law, there is a distinction between killing and allowing to die, although where one becomes the other might not necessarily be clear. Although an omission is not lawfully the same as an act, would a clinician (who has an operational duty to protect the patient's right to life) who chooses not to save the life of a suicidal patient be considered 'aiding and abetting'?

academic commentary (Brown 2021; Ruck Keene 2020; Series 2022) supporting these findings of the MHA review (Wessely 2018: p. 224):

> 'During our engagement processes we heard a number of service users outlining a key concern about a capacity-based mental health system, or full fusion. We heard examples of people in distress being told that nothing could be done because "you have capacity, and it's your choice what you do." […] However, service users will have to decide that being able to make their own decisions about admission is worth the risk of being refused treatment, or being left to do something that is harmful to themselves or others. At the moment we are not convinced that most service users would think this way.'

Independent empirical research (incisively titled 'If you are not a patient they like, then you have capacity') explored this experience in 211 current or former patients of psychiatric services; findings suggest the practice is widespread and harmful (Aves 2022). This theme has also emerged in inquest reports. To think about mental capacity is understandable when someone is declining an intervention; in fact, we should probably think more about capacity to consent in the 'compliant' patient than we do in practice. However, to use the concept of capacity to deny care when someone is asking for it might be considered perverse. At its worst, the concept of capacity can become weaponised to punish patients who are disliked (Chartonos 2017) or viewed as challenging to deal with or beyond help: 'well meaning legislation that legitimises non-treatment may be dangerous, especially in a group of patients who some clinicians may regard as wasteful of healthcare resources and undeserving of care' (Kapur 2010).

Countertransference reactions

In the above scenarios, the clinician is under considerable pressure. Faced with a patient who is stating an intent to kill herself, these pressures can result in an intense countertransference. The countertransference comprises the psychiatrist's emotional response to the way the patient is relating to them and to the transference that the clinician forms in relation to their patient. The patient's projections (e.g. anger, hopelessness) and the clinician's own feeling that they are failing expectations – both internal and external – may combine to form what has been termed 'countertransference hate' (Winnicott 1949). This combination of aversion (the impulse to abandon the patient) and malice (Maltsberger 1974) may be a factor in a doctor's decision to 'let the patient decide', all under the rational guise of implementing the MCA. By the very nature of the countertransference, this decision-making process may be unconscious and in the service of the clinician's negative feelings, but carry all the trappings of a rational, 'following the guidance' plan. It is beyond the scope of this article to explore systemic factors in detail, but worth noting that countertransference does not occur in a vacuum. Social injustice, stigma and bias all play a role in how patients are treated by individual clinicians and the wider system.

Effect of patient suicide on the clinician

The death of a patient by suicide often has profound and lasting effects on the clinician (Gibbons 2021). Post-traumatic stress disorder symptoms, shame, guilt, anxiety and isolation have all been described, associated with significant effects on personal and professional life (Gibbons 2019). There is evidence that these can result in negative changes to clinical practice, including avoidance of clinical contact, loss of confidence and excessive preoccupation with medico-legal considerations (Alexander 2000; Courtney 2001). Fear of future adverse outcomes, along with countertransference reactions as described, may therefore powerfully influence the assessment process.

Conclusions

A suicidal patient may lead to such acute anxiety in the clinician that it is difficult to think. However, by retaining our bearing as clinicians – thinking of our patient's welfare, recognising the time specificity of mental state examinations, not rushing decisions unnecessarily, attending to our countertransference and seeking support from colleagues – we can manage these situations appropriately.

When faced with a suicidal patient, whether they have already taken steps to harm themselves or not, consideration of mental capacity should not be top of a clinician's list of priorities. First and foremost, the clinician must do all they can to help the patient feel safe and supported, learning as much as possible about this person and the circumstances that led them to this point.

Understanding of the legal frameworks in which they practise is of vital importance for all clinicians, and for those in England and Wales the most important of these is the European Convention on Human Rights. Best practice would be to consider the relevant aspects of the ECHR before thinking about how to use the MHA and/or MCA to uphold those rights. This sharpens our focus on what we should be doing for the good of our patients rather than for self-preservation.

Although the law technically does allow for a capacitous individual to choose to die by suicide and for the clinician to respect that decision, the clinician who feels able to declare their patient as having

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capacity for suicide is advised to ensure that their capacity assessment is extremely robust and documented to the same level accordingly. In addition, clinicians are advised to question their own judgement and examine their countertransference (Fig. 2). The law is undoubtedly unsatisfactory and confusing, even seemingly contradictory. It may be the case that the MCA does not currently provide an appropriate framework for determining whether a mentally disordered, suicidal individual has the capacity to take their own life.

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C.B. drafted the article and J.-L.D., T.L. and A.R.K. made written contributions. All authors agreed the final content.

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MCQ answers
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MCQs

Select the single best option for each question stem

1 Regarding the law and clinicians' obligations in relation to the scenario 'Seeking help':

a mental capacity should be the first guiding principle when someone is at risk of suicide
b the psychiatrist's duties to act as a clinician primarily arise from the Mental Capacity Act (MCA) and the Mental Health Act (MHA), rather than the European Convention on Human Rights (ECHR)
c the clinicians involved have a positive obligation to take 'operational steps to secure life' in the presence of sufficient risk
d the extent of previous use of mental health services in this patient suggests that the psychiatrist should prioritise use of the MHA
e given the extreme complexity of this case, the clinician is excluded from the operational duty to protect the patient's rights.

2 Regarding the law and clinicians' obligations in relation to the scenario 'Seeking help':

a as the ECHR suggests that an individual has autonomy over their lives, including the decision to die, clinicians are bound to not intervene
b the finding that a patient has capacity to make a decision to end her life means that the clinician is absolved of clinical responsibility
c the written statement by the consultant psychiatrist that the patient 'has capacity' is sufficient and implies that a robust assessment has been performed
d as capacity is decision-specific, in this case the more appropriate capacity assessment relates to Ms B's consent to an admission rather than her decision to take her own life
e in this patient, an assessment made a month ago is acceptable to apply to this presentation as it is acknowledged that fluctuations in capacity can be disregarded at times, particularly in as difficult a clinical condition as emotionally unstable personality disorder.

3 Regarding the scenario 'Refusing help':

a in a time-critical situation such as this, it is regarded as acceptable to not consider capacity
b as in this case there is the issue of suicidality worsened by refusal of treatment, the clinicians need to address capacity as an urgent first step
c in cases like this, it is accepted as routine and legally unproblematic that the first step is to organise detention of the patient under the MHA so that section 63 can be used to treat the overdose
d as this is a time-critical situation, the clinicians should establish how urgently a decision needs to be made and not unnecessarily delay life-saving treatment
e when assessing capacity in this time-critical situation, it is recommended practice to omit taking 'reasonable steps' in order to arrive at a 'reasonable belief'.

4 As regards countertransference reactions in relation to the scenario 'Refusing help':

a the urgency of the situation renders consideration of the countertransference superfluous
b although the countertransference may exist in this difficult situation, the professional and rational bearing of the psychiatrist will ensure appropriate decision-making
c the acknowledgement that the psychiatrist may be influenced by the countertransference is in itself sufficient to prevent any acting out by the psychiatrist
d the countertransference excludes the presence of positive feelings the psychiatrist may feel towards the patient
e a negative countertransference reaction (sometimes with the intensity of 'countertransference hate') may be a factor in the doctor's decision to 'let the patient decide' on a course that is adverse to health.

5 When faced with a suicidal patient:

a assessment of mental capacity is the first priority
b considering the relevant aspects of the ECHR before thinking about how to use the MHA and/or MCA sharpens the clinician's focus on what they should be doing for the good of the patient rather than for self-preservation
c the clinician should consider the MHA and MCA as priority – the ECHR can be considered at leisure when there is less clinical urgency
d the clinician can be reassured that the law is clear and can be used as a helpful decision-making tool
e as the law does allow for a capacitous individual to choose to die by suicide and for the clinician to respect that decision, the clinician is advised to declare the patient as having capacity for suicide.

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