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A practical guide to capacity assessment and patient consent in Hong Kong

如何在香港實踐能力評估與病人同意治療的概念

A person's decision-making capacity is pivotal when a doctor determines whether a person has the ability to make his or her own decisions, and thus it has major clinical, ethical, and legal significance, especially in Hong Kong, where the Mental Health Ordinance has introduced Guardianship provisions and provisions for the treatment of mentally incapacitated persons. This paper examines the legal concept of decision-making capacity and its clinical assessment within the local context. It is important for doctors to be aware of the legal mechanisms under which both urgent and non-urgent treatment can be given to mentally incapacitated persons, provided that the treatment is necessary and given in the best interests of the patient.

醫生在判斷病人是否可以自行作出決定的時候，病人作出決定的能力是最關鍵的考慮因素，所以它不論在臨床上、道德上和法律上都非常重要；特別是香港，現行的《精神健康條例》裏已列明了與監護有關的條文，以及與治療精神上無行為能力成年人有關的各項規定。本文目的在於釐清決定能力這個法律概念，探討怎樣在香港的環境下對病人的決定能力進行臨床評估。醫生必須留意在目前的法律機制下，假如醫生認為一項治療措施是必須而對病人是最有利的話，可以替精神上無行為能力的成年人進行緊急和非緊急治療。

Introduction

The legal requirement for doctors to seek consent from patients before administering any health care intervention reflects their ethical duty to respect a person's right to self-determination. To be able to give valid consent to such intervention, three criteria have to be satisfied. Firstly, the person must be appropriately informed about the nature and the purpose of the treatment, as well as its risks and benefits. Secondly, the patient needs to have the capacity to make that decision, and finally, he or she should be able to make the decision voluntarily and free from coercion. The absence of any of the three components renders a decision invalid.

Although published research examining the concept of mental capacity has been growing, its relevance to Hong Kong is limited because of a difference in statutory legal jurisdiction (our courts are more likely to follow English common law in the absence of a statutory provision). In this article, we aim to clarify the concept of decision-making capacity, its clinical and legal relevance, and how it is assessed within the local context. Although we focus on the capacity to consent to medical treatment, the capacity to make other decisions—for example, to make a will, to choose where to live, or to plead in court—may also be relevant in medical practice.

Why is capacity important?

Capacity is a medico-legal construct that epitomises the delicate ethical balance between respect for the right of self-determination of patients who are capable of making decisions and the mission to act in the best interests of patients who are unable to make decisions for themselves. Under common law, the decision of a person with capacity has to be respected, even if the decision is seen to be unwise, may be detrimental to the person's health, or may even threaten his or her life.

Key words:

Decision making;
Informed consent;
Mental competency

關鍵詞：

作出決定；
知情同意；
精神狀態

Hong Kong Med J 2003;9:284-9

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Acting without a capable person's consent constitutes assault and battery.¹ On the other hand, if a person lacks the capacity to make a health care decision, health care professionals generally have a legal and ethical duty to act in the patient's best interests and to safeguard his or her well-being. Failure to do so constitutes negligence or a failure to perform professional duties.² Capacity is therefore a pivotal concept in determining how a clinician might approach any decision made by a patient: it is the threshold for legal and clinical intervention. In Hong Kong, issues surrounding capacity have become more relevant since the introduction of guardianship provisions in Part IVB of the Mental Health Ordinance,³ and Part IVC, which deals with medical treatment of mentally incapacitated persons.

What is capacity?

The current understanding of capacity points to the adoption of a functional approach to capacity.⁴ This means that capacity depends on the person's decision-making abilities and is thus decision-specific and time-specific. The complexity of a decision may be influenced by the number and variety of consequences of each choice or decision. For example, a patient may be able to make a decision about a chest X-ray for a cough, but may not be able to make a decision about open-chest surgery for a lung tumour. Capacity may also vary between domains—for example, a person may be able to make medical treatment decisions, but not financial decisions. The outcome of a decision (eg if it is likely to harm the patient) or the presence of a particular disorder (eg a psychiatric disorder) may serve as warning signals for impaired decision-making, but they do not themselves determine capacity.

The legal definitions of capacity in Hong Kong

Which abilities are relevant to decision-making depend, to a certain extent, on whether we use common law standards or statutory standards from the Mental Health Ordinance. The statutory standards for capacity relate only to consent to treatment of mentally incapacitated persons, as defined in the Mental Health Ordinance, while the common law standard applies to the capacity of all adults to make treatment decisions (to give consent or to refuse).

Mental Health Ordinance

The Mental Health Ordinance is relevant only to adults who satisfy the criteria of mentally incapacitated persons as defined in the Ordinance—adults with a mental disorder or mental handicap. Mental disorder means:

- (1) a mental illness;
- (2) a state of arrested or incomplete development leading to a significant impairment of intelligence and social functioning that is associated with abnormally aggressive or seriously irresponsible conduct;
- (3) a psychopathic disorder; or
- (4) any other disorder or disability of mind that does not amount to mental handicap.

Mental handicap is defined as subaverage general intellectual functioning and deficiencies in adaptive behaviour. Subaverage general intellectual functioning means "an IQ of 70 or below according to the Wechsler Intelligence Scales for children or for an equivalent scale in a standardized intelligence test."⁵

Part IVC of the Mental Health Ordinance

Incapacity for consent to treatment is defined under section 59ZB(2) of Part IVC of the Mental Health Ordinance as the inability to understand the general nature and effect of the treatment or special treatment. Special treatment is currently limited to sterilisations. Decisions on these can only be made by the Court of First Instance.

Part IVC of the Mental Health Ordinance gives a doctor the power to provide urgent or non-urgent medical treatment to a mentally incapacitated patient without consent, provided that the patient does not understand the nature and effect of the treatment. The treatment must also be necessary and in the patient's best interests. Part IVC does not explicitly refer to refusal of treatment. One possible reason is that these provisions primarily aim to ensure that the mentally incapacitated person is not deprived of necessary treatment, merely because he or she lacks the capacity to consent to the treatment (section 59ZB[2a]). However, the omission to deal specifically with the capacity test for refusal of treatment in the Ordinance is, as will be discussed below, the source of some confusion to practitioners in the application of these legal provisions.

Common law on capacity

The common law presumes that a person has mental capacity to make a decision unless there is evidence that he or she lacks this capacity. The key decision of the English court in *Re C (Adult: refusal of treatment)*⁶ determined this common law. The judge said that the question to be decided was whether C's capacity was so reduced by his chronic mental illness that he did not sufficiently understand the nature, purposes, and effects of the proposed amputation of his leg. It adopted a three-stage test to establish a patient's decision-making capacity:

- (1) Could the patient understand and retain information relevant to the decision in question;
- (2) Did he believe that information; and
- (3) Did he weigh that information in the balance to arrive at a choice?

The principles in considering refusal of treatment had also been elaborated in *Re T (Adult: refusal of treatment)*.⁷ The Court of Appeal held that when the patient is refusing treatment, doctors have a duty to give him or her appropriately full information as to the nature of the treatment proposed and the likely risks, including any special risks. Withholding information on the consequences of refusal or misinforming a patient may make a refusal invalid. The court said that the doctor should consider whether, at the time of refusal of treatment, the patient had a capacity that was

commensurate with the gravity of the decision that the patient purported to make. The graver the consequences of the decision (eg if the decision leads to grave risks to health or life), the greater the level of competence is required to make the decision. The further the person's capacity is reduced by illness, the lighter the principle of autonomy weighs. For a refusal of treatment to be effective, the doctor has to be satisfied that the capacity to decide has not been diminished by illness, medication, false assumptions, misinformation (eg misleading or inadequate information on alternative treatment, or a lack of information about the risks to health or life caused by refusal), or overbearing influence by another person. Furthermore, the patient's decision to refuse needs to be relevant to the treatment situation he or she is in. The presumption of capacity may also be rebutted by long-term conditions that may impair decision-making, such as mental handicap or mental illness.

A discrepancy exists between the *Re C* standard for capacity and the simpler standard in Part IVC of the Mental Health Ordinance about the general nature and effect of capacity. The Part IVC standard applies only in considering consent to treatment by mentally incapacitated persons, as defined in the Ordinance, while the common law standards apply to (1) treatment refusals by mentally incapacitated persons and possibly (2) both treatment consent and refusals among persons whose decision-making abilities may be compromised but who do not fall within the strict definition of mentally incapacitated persons. The latter interpretation is controversial, because the definition of mental disorder in the Mental Health Ordinance includes persons with "any other disorder or disability of mind other than mental handicap." This definition is potentially wide enough to include persons with any mental incapacity that is long-term (eg brain injury) or temporary (eg acute intoxication with illicit drugs). However, the inclusion of diagnostic categories not 'classically' considered in mental health legislation may lead to misunderstanding and underuse of Part IVC of the Mental Health Ordinance.

Moreover, this discrepancy between common law and statute may suggest a 'double standard', which is confusing to frontline staff because there seems to be a higher standard for capacity to refuse treatment compared with capacity to consent. Critics would argue that this procedure uses an 'outcome approach' to capacity, in which judgement of capacity and incapacity depends on the outcome of the decision (one is capable if treatment is agreed to, but incapable if it is refused). Nevertheless, it is understandable that the gravity of the consequences of the decision clearly has a part to play in considering capacity. There is a delicate balance between preservation of life and the patient's right to self-determination.

We have designed a flowchart to illustrate the doctor's evaluation of whether he or she should provide medical or dental treatment to a mentally incapacitated adult (Fig.). If a person is considered capable of making a treatment decision,

his or her wishes would prevail. On the other hand, if a person is incapable of making a treatment decision (including inability to consent or refuse a treatment and inability to communicate a choice), both Part IVC of the Mental Health Ordinance and common law follow the principle of acting in the patient's best interests. Treatment can be given either without consent or with proxy consent from a guardian who has appropriate powers.

Assessment of decision-making abilities

All clinicians should be familiar with how to assess capacity, which requires an assessment of the specific abilities deemed important in the Hong Kong legal setting. A brief guide will be provided below. For further information, a joint publication by the British Medical Association and the Law Society in Great Britain is a good resource on general issues about capacity and its assessment.⁸ If there are conflicting medical opinions on the patient's capacity, the court (or Guardianship Board) is the final arbiter.⁹ A fundamental difficulty is that capacity determination for legal purposes is dichotomous (ie the patient is either capable or not), whereas from a medical perspective, abilities are on a continuum.

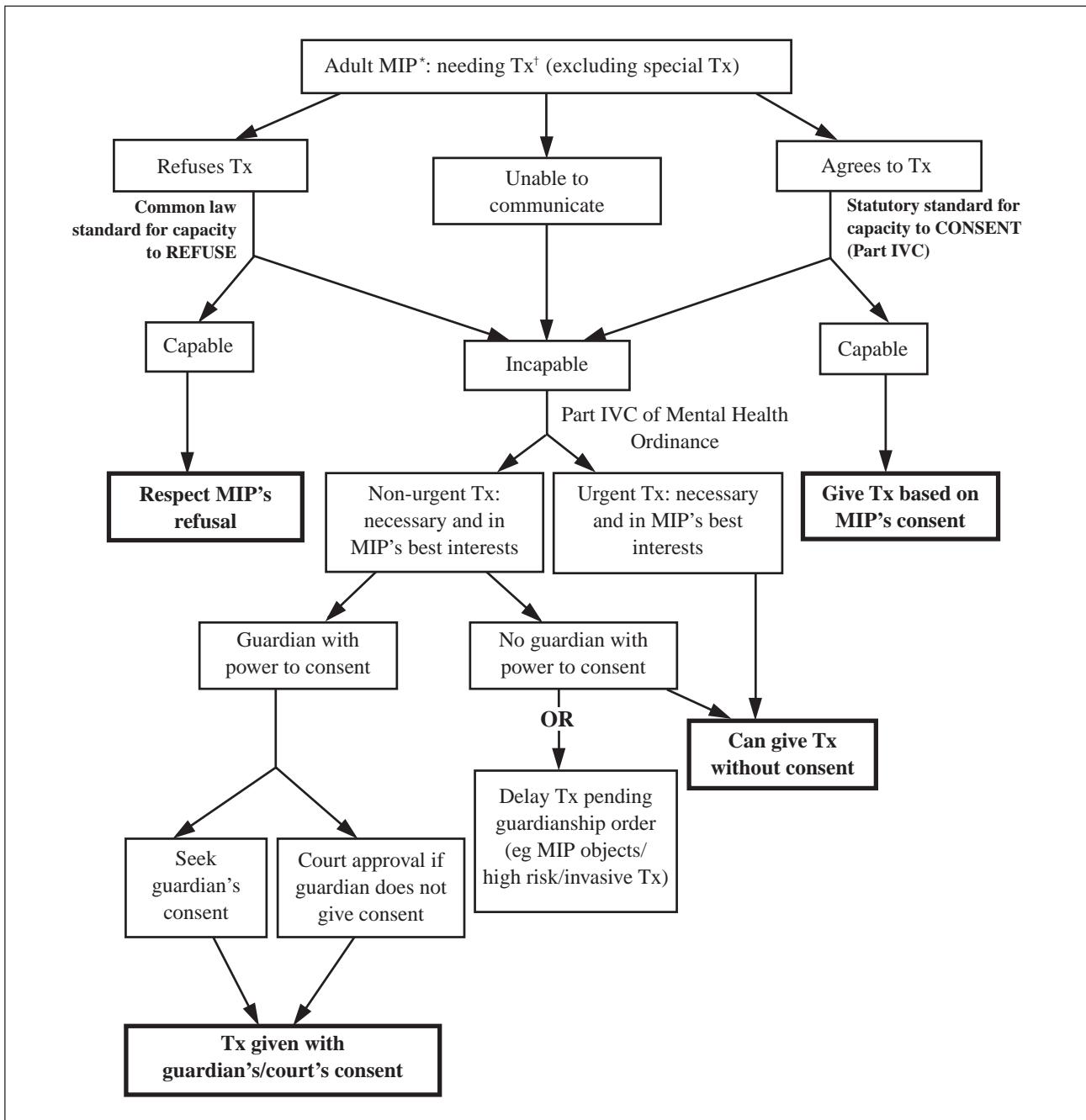
Understanding

Understanding is an ability that is important within both common and statutory law in Hong Kong. To assess the ability to understand, doctors need to examine if the patient is able to understand, in "broad terms and simple nature",¹⁰ information relevant to the treatment decision, including the nature of the problem, the recommended treatment, its pros and cons, as well as alternative treatments and their pros and cons. The ability to understand is related to general intelligence and cognitive function. It may also be affected by mental disorders (eg psychosis and mood disorders), medication, severe anxiety, or denial.

The treating doctor needs to give relevant treatment information to the patient using simple terms. In general, understanding is assessed by asking the patient to recall the information and to paraphrase it using his or her own words. If the patient cannot speak, other modes of communication must be considered, perhaps with the assistance of other professionals such as speech and language therapists. Reviewing the empirical literature, there are certain simple measures that can improve understanding. These include disclosure of information using simple, jargon-free language; giving information in small units; and using assessment methods that are less dependent on verbal expression, such as non-verbal demonstration.^{11,12}

Believing the information

Belief refers to the patient's beliefs about the mental or physical disorder and the potential treatments; it especially refers to the ability to apply the information realistically to his or her own situation. It is distinct from factual understanding, and is more akin to the concept of insight, as widely used in psychiatry. Therefore, its assessment involves an



* MIP mentally incapacitated person

† Tx treatment

Fig. Providing medical or dental treatment to mentally incapacitated adults

examination of the patient's beliefs about whether or not they are ill, and their beliefs about the efficacy of treatment. Alternative views to health and illness, because of cultural influences, may be acceptable, bearing in mind the culturally diverse society we live in.

An example of a person who is able to factually understand treatment information but is unable to believe the information is a patient with schizophrenia who has been shown to understand all the information about his illness and the recommended medication treatment. The patient says, "If I had schizophrenia, I would take the medicine, but I don't have schizophrenia. The voices I hear come

from the extraterrestrials who are trying to harm me." The patient's ability to believe the relevant information has clearly been distorted by the psychotic disorder.

Weighing the information to arrive at a choice

Weighing information connotes the patient's ability to process the treatment information, given his or her preferences, in a logical manner. The doctor should ask the patient how the choice was reached. The assessment process should concentrate on the reasoning process, not the outcome of the decision. What is required is an assessment of the way in which information is used and whether the decision was made on the basis of plausible grounds.

An example of impaired weighing of information to arrive at a choice is the case of needle phobia in *Re MB (An adult: medical treatment)*.¹³ MB understood and appreciated the information about the need for a caesarean section to save the life of her unborn baby, but she was unable to reason with the information, owing to her overwhelming unreasonable fear.

Expressing a choice

Expressing a choice is an essential requirement for decision-making capacity, even though it was not explicitly listed in the *Re C* case. A competently made decision has to be communicated for it to be respected. This ability can be simply assessed by asking the patient to state his or her choice. This ability is impaired when the patient is unable to indicate a choice because of communication problems, or is unable to choose because of ambivalence. As mentioned earlier, doctors should be aware of alternative modes of communication and should enlist the help of carers and other professionals such as speech and language therapists. Language barriers may also be important—for example, if the patient speaks a different language or dialect. The assistance of interpreters may be necessary.

When a capacity assessment should be made

Notwithstanding the common law presumption of capacity, informal assessments of capacity are performed routinely in clinical practice when seeking consent from patients. However, situations in which more formal assessment of capacity should be made and documented are as follows:

- (1) When treatment is proposed for a mentally incapacitated person, as defined in the Mental Health Ordinance (Fig); and
- (2) When a patient displays risk factors for impaired decision-making, such as
 - (a) Diagnosis: organic mental disorders (eg delirium, dementia), intellectual disabilities, mental disorders, and acquired brain injury (ie cerebro-vascular accident with cognitive deficits);
 - (b) Very young or old age;
 - (c) Abrupt change in a patient's mental state or behaviour; and
 - (d) When a patient makes a decision that is not only contradictory to what most people would choose, but also appears to contradict that individual's previously expressed attitude.

As capacity can fluctuate from day to day in some patients, it may be necessary to assess or reassess capacity among those patients just prior to the relevant treatment.

Guardianship

The Guardianship Board is a quasi-judicial tribunal that makes orders appointing guardians for mentally incapacitated persons who are unable, or limited, in their capacity to make their own decisions about matters such as medical

treatment, welfare issues, and financial management. It is a multidisciplinary tribunal consisting of three panels: lawyers (panel A); doctors, psychologists, and social workers (panel B); and persons who have personal experience of mentally incapacitated persons (panel C). At a hearing, the lawyer presides and there must also be at least one member from each panel.

The Guardianship Board makes orders appointing guardians to decide on treatment of physical disorders when mentally incapacitated persons who lack capacity to refuse treatment have refused treatment. A guardian is empowered to give consent to the patient's treatment only if the patient is incapable of understanding the general nature and effect of such treatment. The Board will treat applications as urgent when doctors have not given treatment by relying on Part IVC, because the patient has objected to treatment. The time for the hearing and the obtaining of the social enquiry report can be abridged. The Board has recently granted emergency guardianship orders in very urgent cases in which the grounds for the emergency guardianship order were justified.

Illustrative case examples involving guardianship applications

Case 1

An application for guardianship was made for a mentally handicapped 35-year-old woman, an orphan, who was unable to speak. She resided in a hostel. A guardianship order was made, because the woman resisted an internal gynaecological examination that had been suggested by the treating doctor because of her symptoms. Because the hostel staff were unwilling to be appointed as guardian, the Director of Social Welfare was appointed guardian, with the power to consent to the gynaecological examination, treatment, and attendance for treatment.

Case 2

A 50-year-old woman with schizophrenia had had cervical carcinoma for 3 years but had declined surgery because of delusions and denial that she had cancer, as well as the fact that she experienced no pain. No surgery could take place because she had been assessed 3 years ago as having the mental capacity to refuse treatment. Legal issues arose as to whether she met the legal test of capacity to refuse cancer treatment, and whether she had made a legally binding Advance Directive to refuse treatment. If she had made a legally binding Advance Directive, the Board could not authorise a guardian to consent to her medical treatment, as that would be in breach of the Advance Directive. Having heard evidence as to how the woman's capacity was assessed 3 years previously, the Guardianship Board decided that she had not been legally competent to refuse surgery then or now. The Board also held that no legally valid Advance Directive refusing cancer treatment had been made. In this case, the Director of Social Welfare was appointed guardian; it would have been too much pressure on her husband because she had opposed it so strongly and his

overturning of her decision may have damaged their relationship. The Director was granted the powers of conveyance, to attend for treatment, to consent to treatment, and to provide access to the mentally incapacitated person.

Case 3

A 35-year-old man with schizophrenia had refused surgery for a benign brain tumour. The Guardianship Board decided that he did not have capacity to refuse consent to treatment, because there was a link between his delusions and his treatment; he sometimes denied having a tumour and he could not grasp the significance of the risks and consequences of delaying surgery. He was unable to weigh information about the surgery or to balance the risks and need for treatment. His mother was appointed as guardian with all powers except financial power.

Case 4

A 73-year-old woman with systemic lupus erythematosus and intracranial meningioma (left cerebellar-pontine angle brain tumour) had cognitive deficits amounting to a 'disability of mind' (a mental disorder). She was mentally unfit to consent to treatment for her brain tumour. She lacked insight into her medical condition and had refused surgery. The Director of Social Welfare was appointed guardian with the power to require her to attend for treatment, to consent to her medical treatment, and to provide access to the mentally incapacitated person.

Comments on Guardianship Board cases

The Guardianship Board applies the Mental Health Ordinance, the common law, and international and local standards of medical ethics to make decisions in appointing guardians with the power to override refusal of treatment by patients. In particular, it accepts that the decision to proceed with treatment is still a matter of clinical judgement, and the doctor must consider his or her patient's best interests and his or her own legal duty of care.

Conclusion

All doctors, not just psychiatrists, need to recognise the

increasing importance of properly assessing the mental capacity of mentally incapacitated persons for treatment and other areas of decision-making. When a patient is deemed capable of consenting to or refusing a treatment, his or her wishes should be respected. If a patient is incapable of making a treatment decision, a proxy decision needs to be made for the patient according to his or her best interests. This decision can be made based on common law or provisions of the Mental Health Ordinance. The Guardianship Board will consider appointing a guardian when there are conflicts over capacity or other treatment issues with the patient or the family. It also offers a confidential case consultation on potential applications. Because doctors have a legal duty of care to their patients, they would be failing in that duty if they do not give treatment in that patient's best interests, just because of the lack of capacity to make a decision about the treatment.

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