Ethical dilemma

Competency, consent, and the duty of care

Doctors have a legal duty to ensure that their patients have sufficient information and understanding to make informed choices about proposed treatment. But what can and should they do if a patient whose competence to make such a decision is in doubt refuses much needed treatment? Here a general practitioner describes a tragic situation that arose with a schizophrenic patient, and a lecturer in general practice, a Church of England ordinand, and a general practitioner make their observations.

Best of motives, worst of consequences

A C Inwald

My patient was a 62 year man who was looked after by his mother. He was a "burnt out" schizophrenic of low intelligence and used to spend most of his time on long walks on his own. He was always hyperactive and communicated with staccato speech, but he was always pleasant and reasonably well presented. My patient's mother died two years ago, and he had become increasingly dirty and unkempt. He walked the streets daily and found it difficult to keep still. He continued to come to the surgery regularly for his medication, and we noticed that the chair he sat on in the waiting room was faecally soiled and he began to smell.

We alerted social services to the change. They visited the man at home, where he now lived on his own. His home was in an appalling state, with faeces everywhere, and he was overtly faecally incontinent. He consented to a physical examination and was found to have a severe rectal prolapse. He did not seem overly concerned about his incontinence and his general state.

The patient was referred to a consultant surgeon and was told he needed an operation to correct the prolapse. He refused to proceed—he would not accept that there was a problem. The situation deteriorated and his home became uninhabitable. Social services arranged for it to be cleaned and we all tried, without success, to persuade him to accept the proposed surgery. When this failed we tried to get him admitted to hospital for assessment under section 2 of the Mental Health Act , but he was not "sectionable" in the strict sense of the word. The surgeon would not operate without informed consent, and even if we could have had him admitted to hospital under section he would have required a psychiatric bed for postoperative care. We tried to coordinate these two departments, but again without success.

Negotiations were continuing between the general practice, the surgeons, the psychiatrists, and the social workers, and none of us really knew how best to proceed to help this poor man. Our problems were resolved tragically when social workers broke into his flat to find him dead after a haemorrhage from his rectal prolapse. I feel that we all failed badly in looking after this man, but I am still unclear how we could have handled the case successfully.

96 St John's Way, London N19 3RN

A C Inwald, *general practitioner*

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Let the courts decide

Julia Hippisley-Cox, Stephen Hippisley-Cox

The Hippocratic oath, which instructs doctors to do good and refrain from harm, needs to be moderated by respect for patient autonomy. The declaration of Lisbon (1981) states that "the patient has the right to accept or refuse treatment after receiving adequate information."

The doctor has a professional and legal duty to help his patient reach an understanding that enables the patient to make an informed choice. But what if the patient does not make the "sensible" decision despite an adequate explanation? Patients are at liberty to reject the doctor's advice, even for no good reason, provided they understand the consequences. The doctor's responsibility is to determine how competent the patient is to make that decision. The issue of competency is key.

If the patient is competent and refuses an operation, and the doctor operates nevertheless, then he or she is open to criminal proceedings for assault[1] and could be suspended from the medical register.[2] If the patient is not competent, then the doctor has a duty to act in the patient's "best interest," which may mean proceeding with an operation. A doctor acting in the "best interests" of an incompetent patient is unlikely to attract civil or criminal risk. Lord Brandon states that "it would not only be lawful for doctors, on the grounds of necessity to operate on, or give medical treatments to adult patients disabled from giving consent, it would also be their common law duty to do so."[3] Justification of the "patient's best interest" would rest on whether a court judges that a responsible body of medical opinion would have followed the same line.

In the case described by Dr Inwald it is neither easy to decide on the patient's best interests nor to assess his competency to decide to refuse treatment. The general practitioner and social services see a man whose best

The Medical School, Queen's Medical Centre, Nottingham NG7 2UH

Julia Hippisley Cox, *lecturer*

Westcott House, Jesus Lane, Cambridge CB5 8BP

Stephen Hippisley-Cox, *ordinand*

Correspondence to: Dr Julia Hippisley-Cox julia.h-cox@nottingham.ac.uk

BILL REID

interests may be served by an operation; they suspect the patient's competency, particularly as his condition deteriorates. The surgeon, who has less opportunity to assess the patient's social context and his competency, will not operate unless the patient is sectioned. For him, intervention would need to arise out of necessity. Suppose for a moment that it were known for certain that the patient would suffer a fatal haemorrhage without treatment. The patient's competency may be easier to determine—and easier still, if the haemorrhage had started and the protesting patient would die within hours unless treated. Neither of these applied here, and the surgeon was right to seek a legal sanction to override the patient's will, as he was the one who would be operating and risked a charge of assault. Sectioning the patient is a red herring. The Mental Health Acts allow compulsory treatment only of the mental condition, not a physical disability.[4]

Could these doctors have done anything more? Yes. They could have referred the case to the courts to make a judgment on the patient's competency and best interests. If he were competent, then no more could have been done. If not, then the courts might have decided that an operation was in his best interests, in which case the surgeon would have been obliged to operate.

1 Johnson AG. *Pathways in medical ethics*. 1st ed. London: Edward Arnold, 1990:59.
2 Dyer C. Consultant suspended for not getting consent for cardiac procedure. *BMJ* 1998;316:955.
3 Mason JK, McCall Smith RA. *Law and medical ethics*. 3rd ed. London: Butterworths, 1991:402.
4 British Medical Association. *Philosophy and practice of medical ethics*. London: BMA, 1988:32.

The only failure was the outcome

Ian Hill-Smith

Wigmore Lane Health Centre, Luton LU2 8BG
Ian Hill-Smith, *general practitioner*
cellis@wlhc.demon.co.uk

Is it possible to fail even if every step you take is the right decision? Indeed it is, but it needs shouting from the roof tops that those who manage to negotiate such a difficult course are not failures—it is only the outcome that can in any sense be called a failure. I read this account with great admiration for the care this man received and for the openness that prompted those who cared for him to ask if there was a better way. Two questions arise: could any of the steps taken have been done differently? And if they had, would the outcome have been any better?

Dr Inwald's patient must have managed somehow when his mother was alive; only after her death did he become increasingly unkempt. This is not uncommon after a bereavement. Perhaps he just lost all interest in living, in caring for himself. Perhaps he was depressed, but not enough to allow care under the Mental Health Act. Or perhaps his mother was strong enough to be firm with him when others with a less obvious authority would fear to bully him. She may simply have cleaned him and his clothes, with or without his consent. This might constitute a breach of his personal freedom, but who could possibly throw the first stone at such a labour of love? It would be quite another matter for a professional carer to assume such authority. It would imply that anyone who was disabled, temporarily or otherwise, physically or mentally, could be seen as deserving help from us, whether they wanted it or not—what Stevie Smith called "galloping about doing good."

The patient did consent. He consented to an examination, he attended the surgical clinic … another examination. He was not totally obstructive or withdrawn. When it came to the final decision, about whether or not to have an operation, he refused. A different question, a different answer; one that had to be respected. Perhaps he simply did not understand what the question meant. Refusing treatment that is needed can be just as disastrous as accepting treatment that turns out for the worse. Mostly we will hear about the latter because it may end up in a court of law or be highlighted in the proceedings of a medical defence organisation. No such spotlight of litigation will happen on the problem of badly informed refusal. So this problem, which may be the commoner of the two, fades into the background of the bad decisions that we all make from time to time. At least with refusal, a change of mind is possible. This patient might eventually have consented. Pushing too hard … arguing the case for operating … persuading … these are just steps along the same road. What constitutes acceptable practice and what constitutes professional bullying has to be considered to some extent in nearly every consultation. It is a matter of negotiation, but in this case all those trying to help were severely hampered by acting without the key player—the patient. Without confidence that his mind was there, switched on, aware of the facts, no wonder there was concern that he was making the wrong decision.

Stop a moment here. No one we talk to today will have the same mind as ours. Some will be less able, others more able, and some distracted. Some people will have misleading associations with words that are said, some will be too anxious to hear, while others will not care to listen. But no one will be the same as us. Dr Inwald's patient was different too, but obviously so. That should not worry us. All that we can hope to do is to inform with the best communication skills we can muster. He made his decision, and the fact that it was respected may be such a great success for those involved that his death can be seen as less of a tragedy.