The treatment of adult patients with a mental disability. Part 2: Assessment of competence

A. M. Bridgman,[1] and M. A. Wilson,[2]

Over recent years practitioners are increasingly being asked to attend to, or to provide treatment for, adult patients with some degree of mental illness, either in their homes or in the dental surgery. Because the issue of competence and the assessment of the patient is crucial to this aspect of dental practice this second paper is devoted to an overview of that assessment process; outlining the legal tests and standards to be employed.

The provision of dental care for adult 'special needs' patients with some degree of mental disability can present the dentist with a variety of complex medical problems. The first paper in this series dealt with the lawfulness of treatment in the absence of consent and the duty to provide care in respect of such patients. Perhaps, the most difficult question concerns their ability to participate in treatment decisions. The treatment of patients with mental disability can raise serious ethical issues. Gillon identifies the possible conflict between the principles of helping those in need of help and recognising their right to make their own decisions.[1] He suggests that the polar cases are uncontroversial. The fully competent patient who decides to reject treatment even if there is a likelihood or a certainty of death ought to have that decision respected. On the other hand the patient who is clearly incompetent to make any decision ought to have that decision made for them. The polar cases cause no problem but the borderline cases of mental competence sometimes place the dentist in a difficult ethical and legal predicament. The difficulty does not arise so much where there is doubt between (a) consent and (b) no decision, that was discussed in the previous paper, but where there is doubt between (b) no decision and (c) a valid refusal. The key to unlocking this dilemma is assessment of the patient's level of competence and this is the topic of this second paper.

The dilemma

In Case Scenario 2 — the initially compliant patient (see the Box on the next page), it would seem from the patient's behaviour that she is refusing to accept treatment, treatment which, in the dentist's opinion, would be in her best interests. Is the patient's behaviour a manifestation of her true wishes or, perhaps, fear? Or is it a manifestation of her mental illness? Is she competently refusing treatment or making no decision at all? If her behaviour is misinterpreted the potential exists for depriving her of her right to make her own decisions, or depriving her of the help to which she is entitled.

In such a situation, it is not only an ethical dilemma that faces the dentist because the legal implications are a very important consideration. If the patient is capable of deciding for herself and is making a valid refusal, then any treatment provided amounts to a battery even though it may be in her best interests. If she is incompetent then the dentist has a duty to provide the necessary care that is in her best interests. This is clear from the judgement in *F v West Berkshire.*[2] A considerable dilemma. The consequence of error being liability for battery or liability for negligence.

In brief

- Adult patients with mental disability resisting treatment may or may not be making a valid 'refusal'.
- Assessment of their capacity to decide for themselves is important to respect their rights.
- Assessment of competence is based on capacity to understand basic information.
- Assessment of competence involves discussion with family and carers, where possible.

Assessment of competence

In normal circumstances when there is conflict between a dentist's recommendations of treatment proposals and the patient's expressed wishes the dentist would not consider overriding the patient's wishes. The dilemma arises when there is doubt about the patient's competence and their ability to make decisions. When dealing with patients with a mental disability, such conflict will usually give rise to some concern about the patient's decisional capacity. It is clear from the survey of 'special needs dentists' that most would not accept a patient's resistance in such circumstances at face value, and they would wish to challenge the patient's autonomy.[3] They would be aware that a patient's ability to make a decision might be affected by mental disability, but that this would not be a certainty. Such a response would be correct for although there is a presumption that adult patients are competent, rigid adherence to that presumption would prevent many patients from receiving the care that they require.

It is widely accepted that competence, defined as an ability to perform a task, is a relative concept — relative to the task in hand. In this sense competence is recognised to be a specific concept rather than a global one, even though the presumption of competence is bestowed upon all adults.

[1*]*Clinical Teacher and Lecturer for Ethics & Law, Turner Dental School, University of Manchester Dental Hospital, Higher Cambridge Street, Manchester M15 6FH;* [2]*Consultant in Restorative Dentistry, Turner Dental School, University of Manchester Dental Hospital, Higher Cambridge Street, Manchester M15 6FH*
**Correspondence to: Andrew Bridgman*
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Case Scenario 2 — the initially compliant patient

As part of a campaign to promote the health of its patients the matron of a nursing home requests a dentist to attend the home and provide routine check ups. Examination of one of the patients, 72-years-old and suffering from senile dementia, reveals two decayed teeth showing evidence of associated infection. They are beyond repair and require extracting. Although there is no reason to suspect that the teeth are giving symptoms at present, the likelihood of morbidity in the near future is very high. Throughout the examination the patient appears alert and co-operative but is non-communicative. It is predicted that the extraction of the teeth will be straightforward and arrangements are made for the extractions to be carried out under local anaesthesia at a later visit. The patient is told of the treatment need and how it will be carried out.

At the subsequent visit all attempts to approach the patient and administer the local are met with physical resistance and the patient even becomes combative, biting the dentist's finger. It is clear that extraction of these teeth is going to be difficult, if not impossible, using local anaesthesia and not without risk of harm to the dentist. Arrangements are made for treatment under general anaesthesia. On a later occasion, using a degree of physical force to administer the anaesthetic, the teeth are extracted.

Conversely, incompetence will similarly be regarded as specific. Therefore, even though a patient has been labelled as incompetent in one aspect of their lives it does not follow that they are incompetent in other aspects, and the law supports this view.[4]

Tests for competency

Much has been written on the formulation of tests addressing the question of competence.[5] In what is regarded as a seminal paper Roth *et al* conclude that there can be no single test of competency.[6] They suggest that in reality the 'test' applied is a combination of the five tests identified and described by them:

- Evidencing a choice
- Reasonable outcome of choice
- Choice based on rational reasons
- The ability to understand
- Actual understanding.

It is fair to say that the law pays little heed to the first two tests and seems to focus on the patient's ability to understand. Simply evidencing a choice is no indication that that choice is a considered one and that a patient is competent. However, if the patient is unable to make their choices known, the law expects them to be treated as if they are incompetent. In Case 2 it seems obvious that early intervention would be beneficial for the patient because ensuing infection and pain could precipitate an emergency situation. Accessing dental care may then prove difficult and the patient may be left suffering with considerable pain and swelling, perhaps even with some detriment to her general health. To the dental team, relatives and the nursing staff of the home her refusal may seem irrational, and the temptation to deem her incompetent and provide treatment despite her protests may be irresistible. Even if the patient is showing signs that she is already suffering a degree of discomfort that temptation ought to be resisted. It should be remembered that, '*[t]housands of patients whose competence is never questioned stay away from the dentist out of 'irrational' fear to the detriment of their dental, and sometimes general, health. Yet it is only patients labelled mentally handicapped or demented who will find their "irrational" treatment decisions overridden.*'[7] And the law quite clearly states that a patient's choice '*which is contrary to what is expected of the vast majority of adult patients is only relevant if there are other reasons for doubting his capacity to decide.*'[8] The reasonable outcome test by itself is therefore not an appropriate test for competence but a seemingly irrational decision will be useful in alerting a dentist to the possibility that the patient's decision-making capabilities are compromised.

In relation to treatment for mental illness, the Mental Health Act 1983 determines that treatment involving the destruction of brain tissue, surgical implantation of hormones and electro-convulsive therapy requires not only the consent of the patient, but certification that 'the patient is capable of understanding.'[9]

The Court of Appeal, in a case concerning a Caesarean section, recently confirmed the common law position and stated that a patient will lack the capacity to make a decision when:

'(a) the patient is unable to comprehend and retain the information which is material to the decision, ...

(b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at a decision'.[10]

and that ruling is now contained within the Health Service Circular HSC 1999/031.

Although the law centres itself on the patient's ability to understand, it does pay heed to the other tests, in particular whether the choice being made is based on rational reasons. Appelbaum and Grisso suggest that rational thinking would give rise to a conclusion that is consistent with the starting point. This requires that the patient is able to weigh the consequences of having or not having treatment in a way that reflects the value they would have previously given to the benefit (or detriment) of treatment.[11] The clearest examples derive from the cases of refusal of blood transfusion by patients of the Jehovah's Witness faith. The criminal court accepted that the decision of a Jehovah's Witness to refuse a blood transfusion, even in the face of death, would not be unreasonable because of the consistency of the values held by the patient.[12] In the Court of Appeal due consideration was given to the commitment of the patient to the Jehovah's Witness faith and on the strength of evidence that she did not have stable and enduring beliefs was disregarded.[13]

The patient's previously held values in relation to dental care may be important in the process of assessing their competence. Discussion with family or friends might reveal that the patient in Case 2 had a clear history of avoiding any dental treatment until the appearance of significant problems or symptoms. If that were so then her behaviour would seem consistent with her previous attitude to dental care. On the other hand her behaviour would be inconsistent with her values if the discussion revealed that she had always been meticulous about dental care.[14]

This information, however, may not be available. First, the patient may have no surviving relatives or the relatives and friends are unable to tell the dentist what value the patient previously placed on dental care. Second, the patient may not have any pre-existing values, or if she did they are impossible to ascertain. For example, the patient is a 28-year-old who has a severe mental disability because of arrested mental development, caused congenitally or through childhood illness, such as meningitis. It is unlikely that these patients would have previously held opinions of the importance or value of dental care.

In such a situation the advantage of a test that relies, for the most part, on capability of understanding is that it allows the dentist to widen the assessment process, beyond dental interventions. Many of the respondents to the survey stated that they would seek to establish the patient's reaction to previous interventions for dental and medical purposes. How does the patient respond to the district nurse, chiropodist or even the hairdresser? Others were keen to include discussions of more general matters and assessing the patient's ability to understand other aspects of everyday living. It is important to remember that the legal test is the patient's capability to understand information.

What should the patient understand?

The law clearly focuses on the patient's ability to process information. The question that remains is, what or how much information is a patient required to be capable of understanding in order for his or her refusal to be valid? The legal value of consent is that it provides a defence to a claim in battery. The answer to this question, therefore, is tied to that information which the patient must be given in order for any treatment not to be a battery.

The relevant treatment information required by the law to ensure a valid consent as a defence against a battery has been described as no more than in 'broad terms the nature of the procedure',[14] and approved by the House of Lords in Sidaway:

'Mrs Sidaway consented to the operation. She signed the usual consent form, in which she declared that the nature and purpose (my emphasis) of the operation had been explained to her ... '[15]

In the first case to give effect to the right of a competent adult to refuse treatment for life threatening illness it was considered that,

'Although [the patient's] *general capacity is impaired by schizophrenia, it has not been established that he does not sufficiently understand the nature, purpose and effect of the treatment he refuses.*'[16]

The provision of further information, such as risks and alternatives and risks of same, is embraced by the dentist's duty of care to give adequate advice to enable a decision. It is governed by the law of negligence and not the law of trespass (battery). If it is necessary for a mentally impaired patient to be capable of understanding information that goes beyond the 'nature and purpose' there is the danger that they will be too easily disenfranchised. It may be too easy to infer that a patient would not be able to weigh in the balance the benefits and risks of the treatments against each other or against alternative measures. The law has not made the hurdle of competence too high and this is important lest many patients with a mental disability would all too easily lose their right of self-determination.

A varying standard of competence

The ability of a patient with a degree of mental disability to participate in treatment decisions is a specific, rather than a global, concept. This necessitates the application of a varying standard to the assessment of competence. While there is general agreement about that, there is a dichotomy of ethical opinion about the parameters to be employed. Roth *et al.* suggest that the standards for determining competence will vary according to the benefits and risks that a proposed treatment offers.[17] A low level of competency is required if the treatment proposed carries little or no risk of harm, or will be of great benefit. Where there is high risk to health or the treatment has a low risk/benefit ratio patients will need to demonstrate a higher level of competence if they are refusing treatment.[18] However, Wicclair suggests that it is not the attendant risks or the consequences of the decision that give weight to required level of competence.[19] The risks or consequences may only be relevant because they increase the complexity of the decision making process thereby introducing the need for increased capability to appreciate their significance.

The legal cases that have explored the issue of competence would appear to support both assertions.

'The graver the consequences of the decision, the commensurately greater the level of competence is required to take the decision';[20] and

'[a patient] lacked the mental competence to make a decision ... because she was incapable of weighing up the considerations involved'.[21]

It is clear then that competence varies with the decision to be made, either because of the consequences that may arise or because of the complexity of the decision. Insofar as dental treatment is concerned it would usually be the case that both reasons would apply. If a patient simply refuses a routine examination it might be considered that this carries little threat to their immediate welfare and is also a decision that is not particularly difficult to make in view of the simplicity of information. Thus the patient need not have a high level of understanding. If disease is present with the likelihood that significant problems will develop, a higher level of understanding will be required. Refusal carries the risk of graver consequences than before, and explanations of what needs to be done are more difficult. The dentist might need evidence that the patient's decision, although appearing irrational, is based on rational reasons, perhaps that the decision is compatible with the values that particular patient is known to have placed on dentistry, or preventive intervention in the past. Finally, if it is known that the patient is suffering significant symptoms with some detriment to her general health (for example, not eating) then evidence of an even higher level of understanding might be required. The consequences of not receiving treatment are now real and not a possibility, and perhaps the explanations for treatment need and its means of delivery are more complex, more difficult to understand and weigh in the balance.

Table 1 Legal references explained

Name of case	Year reported	Reported in: Vol.	Title	Page	Judge	At page
T v T and another	[1988]	1	All ER	613	Wood	617

Glossary of titles:
All ER — All England Reports
Med LR — Medical Law Reports
FLRFamily — Law Reports

What of fear of treatment? Dental practitioners might consider that refusal of treatment through fear is irrational, especially if a patient is suffering pain. When competent persons make decisions that are inconsistent with their own well-being, the irrationality of the decision does not justify it being disregarded. Interestingly, eight of the dentists in the survey who said that they would not accept a patient's non co-operation as an indication that she did not want treatment considered that fear and/or pain played an important role.

'The patient may be afraid or unaware of what is going on'

'She may be frightened of the treatment ie the unknown'

It is tempting to override decisions that seem irrational but unless the fear affects the patient's competence it would be unlawful to do so. In *Re MB*,[22] it was considered that fear, or panic induced by fear, could temporarily destroy a patient's capacity to make a decision. It was decided that 'Miss MB's' fear of needles (a very common phobia among dental patients) destroyed her capacity in the immediate period prior to the anaesthetic induction when she resisted the injection. At that point she became incapable, as she had previously consented to the Caesarean section. There are a large number of dental phobics who only attend the dentist when absolutely necessary. Even then some of them when directly faced with an injection of local anaesthesia, or an injection for sedation or general anaesthesia, or faced with the 'drill', are unable to 'go through with it' and change their mind. Is the judgement in *Re MB* suggesting that those patients have become incompetent. Probably not. Decisions which carry risks of serious adverse consequences or are inherently more complex require a greater level of understanding. In such cases the fear must be balanced against the consequences of no treatment to estimate its effect on the level of competence. Fear of the prick of a needle might only reduce a person's capacity by a small degree, but when balanced against possible death that reduction is sufficient to suggest incompetence. When balanced against the likelihood of continuing dental pain the reduction in capacity is insufficient to render the patient incompetent. Treatment would only be lawful if it could be shown that the patient lacked sufficient understanding to make a decision that ought to be respected, and that fear would play no part in making that assessment.

Summary

The assessment of competence is a key issue in the treatment of adult patients who suffer some degree of mental disability when the patient is refusing, or appears to be refusing, treatment. The responsibility of making the assessment lies with the attending dentist but it is a process that, of necessity, relies on discussion with others who are closely involved with the general care of the patient. The more the dentist can learn about the patient's capacity for decision-making and levels of understanding the better the interests of both patient and dentist are protected. A thorough assessment, involving family and/or carers, will lessen the possibility of the patient's true wishes being overridden or lessen the possibility of proper care being denied. A thorough and well-documented discussion will also considerably lessen the likelihood of liability on the part of a dentist who will have been seen to have acted properly and clearly acted in good faith.

The provision of treatment for an incompetent adult who is resisting all attempts to provide that treatment creates further problems for the dentist. The law has determined that a dentist has a common law duty to provide care despite the patient's inability to consent to, or by inference, refuse treatment. What is the extent of that duty of care? Clearly it will be necessary to control the patient's behaviour in some way to enable safe delivery of care; safe for the patient and the dental team. Does the dentist's duty of care extend to include restraint? The final paper in this series will look at the question of the use of restraint and its lawful application to control a mentally incompetent adult patient.

The following legal references are described in full in Table 1.

1 Gillon R, Editorial. *J Med Ethics* 1983; **9**: 131.
2 [1989] 2 All ER 545 per Lord Brandon at 561
3 Bridgman A M. *The use of restraint for the provision of dental care.* Dissertation submitted in fulfilment of the requirements for the degree of MA (Health Care Ethics and Law), University of Manchester. 1998 (Unpublished).
4 *The Estate of Park* [1954] 2 All ER 643. The Court of Appeal considered that Mr Park lacked the necessary capacity to understand the consequences of making a will but had the necessary capacity to understand the nature of marriage.
5 Appelbaum P S, Grisso T. Assessing patient's capacities to consent to treatment. *New Eng J Med* 1988; **319**:1635-38
Beauchamp T L, Childress J F. *Principles of biomedical ethics.* New York: Oxford University Press,1994; 132-141.
Buchanan A E, Brock D W. *Deciding for others. The ethics of surrogate decision making.* Cambridge: Cambridge University Press, 1989; 23-25.
Roth L H, Meisel A, Lidz C W. Tests of competency to consent to treatment. *Amer J Psych* 1977; **134**: 279-284.
6 *supra.*
7 Brazier M. Competence, consent and proxy consents. *In* Brazier M, Lobjoit M, (eds) *Protecting the vulnerable.* London: Routledge, 1991, p.40.
8 [1992] 4 All ER 649 per Lord Donaldson at 662
9 s 57(2)(a) and s 58 (3)(a)
10 *Re MB (Caesarean Section)* (1997) 8 Med LR 217 per Bultler-Sloss LJ at 224
11 *supra.*
12 *R v Blaue* [1975] 3 All ER 446
13 *Re T (adult:refusal of medical treatment)* 4 All ER 649
14 Chatterton v Gerson [1981] 1 A11 ER 257
15 *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] 2 WLR 480 per Scarman LJ at 486
16 *Re C (adult:refusal of medical treatment)* [1994] 1 All ER 819 per Thorpe J at 824
17 *supra.*
18 Buchanan A E, Brock D W. *Deciding for others.* p52-55. Cambridge: Cambridge University Press.
Beauchamp T L, Childress J F . *Principles of biomedical ethics.* New York: Oxford University Press, p141.
19 Wicclair M R. Patient decision-making capacity and risk. *Bioethics* 1991; **5**: 118-122.
20 *Re MB (Caesarean Section)* (1997) 8 Med LR 217 per Bultler-Sloss LJ at 224
21 *Tameside and Glossop Acute Services Trust v CH* [1996] 1 FLR 762 per Wall J at 769
22 [1997] 8 Med LR 217