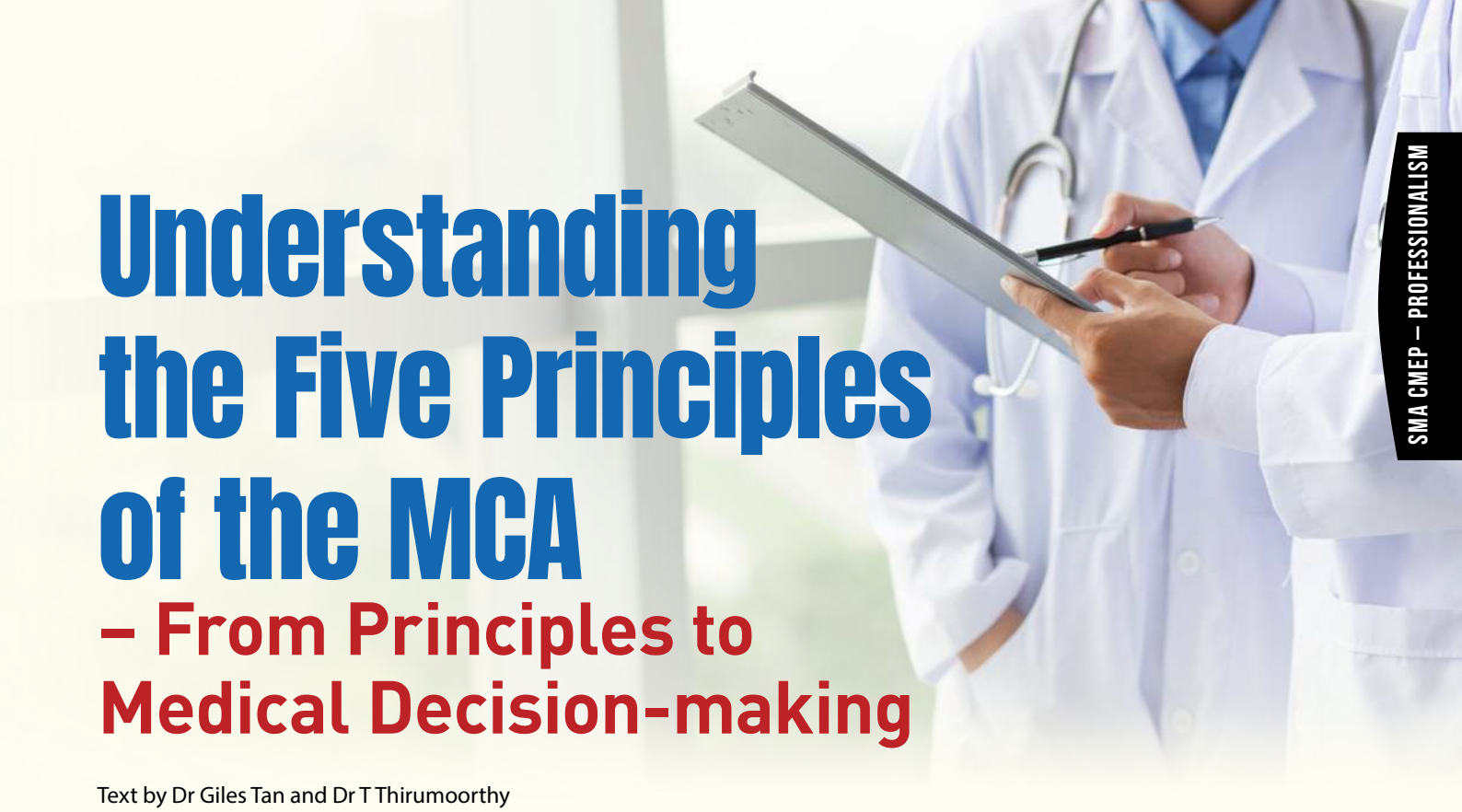

Understanding the Five Principles of the MCA

– From Principles to Medical Decision-making

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The Mental Capacity Act (MCA) was passed in Parliament on 15 September 2008 to protect people who may lack mental capacity and to allow those with capacity to appoint someone they can trust to make decisions on their behalf in the event they lose their capacity.[1] The Act came into effect with the establishment of the Office of the Public Guardian and the publishing of the Code of Practice in 2010.

Section 3 of the MCA codifies five statutory principles. Anyone making any decision or taking any action for a person who appears to lack capacity must apply these five principles to arrive at an appropriate and defensible decision. The five principles aim to balance a person's right to make his/her own decisions and the need to protect the person where he/she lacks mental capacity to make those decisions and prevent harm from those decisions. The five principles should be read in conjunction with all the other provisions in the Act to ensure that the appropriate action or decision is taken in each case.

The five principles set out the values and processes that underpin the operation of the MCA. In most times, they are to be referred to in not only routine decision-making but also to be returned to when difficulties and controversies arise.

The aim of this article is to highlight the practical importance of understanding and applying the five principles in everyday clinical situations in caring for persons with diminished capacity. The five principles apply to all decisions, whether the decision relates to an everyday matter or a life-changing one, a medical matter or a non-medical one. In this article, discussion is confined to the principles' application to medical decisions involving healthcare professionals and patients in clinical practice. This discussion was presented at a talk at the Annual National Medico-Legal Seminar on 28 October 2023.

The five principles and their application

Principle 1

"A person must be assumed to have capacity unless it is established that the person lacks capacity."

It is important to remember that capacity in medical decision-making is determined with reference to the specific decision in question and is time-specific, and that the inability to make decisions in the specific situation must be due to impairment or a disturbance in the functioning of the mind or brain of the person lacking capacity.

In other words, when a clinician deems on medical grounds that the patient needs a particular treatment, the clinician should go ahead with providing the patient with relevant information on his/her medical condition and explain the nature of the treatment; explain why the treatment would be beneficial for the condition; explain the risks and discomfort involved; and the alternatives, including the option to wait and see and not have the treatment. The clinician should elicit and discuss the patient's concerns, how the risks and discomforts could be managed and mitigated, and address any other issues raised including the need for more information.

When in this process of shared discussion and dialogue, the clinician may find that the patient has difficulties and may be struggling to participate actively in the medical decision-making process. The clinician may have by this time discovered the patient's preferred language of communication or whether there are other difficulties in communications. It is in this situation that the clinician should then move to consider Principle 2.

There is no need to rush into a formal mental capacity assessment just based on the person's medical history, nor to assume a lack of capacity based simply on the person's educational level, appearance, age, condition or behaviour. This first principle supports the need for the healthcare professional to pause, ponder and act where there is objective evidence to doubt that the person has capacity, especially in complex medical decisions.

Principle 2

"A person is not to be treated as unable to make a decision unless all practicable steps to help the person do so have been taken without success."

From the application of the first principle, the clinician would be in a better position to ascertain what measures would be helpful for the patient to make a decision (eg, whether he/she should get an interpreter, seek help of a family member, improve the eyesight with glasses, use hearing aids, use sign language or make use of diagrams in decision-making to help the person in the decision-making process). Good communication skills, including active empathetic listening, appropriate choice of language and setting up a familiar environment with familiar persons, are equally important for effective sharing of information and communication. Information overload is to be avoided and information that is sufficient and relevant for decision-making should be offered. The use of jargon and complex medical terms should be avoided or if used, should then be explained in simple terms that the patient can understand.

At this point, the patient may make a decision which in the opinion of the clinician could be deemed to be a medically suboptimal decision and could put the patient at risk of harm from medical complications or lead to longer-term adverse outcomes. It is also possible that the patient may choose a different or alternative system of medical care based on his/her beliefs and culture (eg, traditional Chinese medicine or Ayurveda). In such a situation, it would be worth taking a pause and move on to Principle 3.

Principle 3

"A person is not to be treated as unable to make a decision merely because the person makes an unwise decision."

Principle 3 is a call to pause and reflect before the clinician moves on to determining whether the patient lacks capacity and if there is a need to apply the best interest principle to make medical decisions on his/her behalf. Principle 3 reminds us of the important principle of respect for the patient's autonomy, which recognises the right and freedom of the patient to make his/her own choices according to his/her experience, values, beliefs and preferences. It reminds us that when a patient makes a decision that is not congruous to generally accepted medical advice, it does not automatically imply that the patient lacks capacity.

Undue influence or coercion

Everything in healthcare and the clinician-patient relationship is consensual. Medical issues are private matters and others should refrain from placing any form of undue influence or coercion on the patient. Sometimes, unwise decisions which are not in the best interest of the patient are made when the patient is under undue influence by external parties and circumstances. In such situations, the clinician must explore the circumstances that may impede good medical decision-making.

Refusal of beneficial medical intervention

Patients have the right to choose their medical interventions according to their beliefs, culture, values and preferences. At the same time, patients have the legal right to refuse any medical treatment, even beneficial therapy, the refusal of which may lead to deterioration of health to the extent of death itself.

When there is refusal of highly beneficial established treatment, the clinician needs to review the patient's understanding of the information, the quality of the information provided and its relevance to the patient, as well as other psychosocial, cultural, financial and external dynamic factors with the patient's family or caregivers. All remediable measures that can be instituted reasonably should be offered. The doctor cannot simply accept medical decisions that put the patient at risk of harm, just based on the principle of autonomy and the legal right to refuse medical treatment.

When a doctor-patient professional relationship is established, a series of obligations naturally follows, namely, meeting the professional duty of care and standards of care by applying due diligence. Clinicians have more knowledge, experience and expertise in medical matters than patients, and sharing these is best done in a compassionate and humane manner while preserving the patient's dignity in a collaborative and therapeutic doctor-patient relationship. As such, when it appears that the patient has made a decision that may imply a practice below the professional standard, the doctor needs to review the reasons and circumstances.

In medical emergencies and urgency

Medical practice is consensual except in an emergency when there is imminent and serious danger to the patient or others. Refusal of certain investigations and/or treatment can be overridden only by law in the public interest, as in the case of certain infectious diseases or when there is serious mental disorder requiring psychiatric treatment and care.

When refusal of highly beneficial treatment is due to lack of mental capacity, the clinician is justified to move on to measures to protect the patient from harmful decisions by making medical decisions based on the best interest principle.

Principle 4

"An act done, or a decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in the person's best interests."

In the healthcare setting, it is important that patients receive timely and necessary medical treatment and care. This approach is legitimate as long as the healthcare professional first considers two aspects, namely:

1. The clinician must take reasonable steps to determine whether the patient lacks capacity about the matter in question before doing the act; and
2. The clinician reasonably believes that the patient lacks capacity and the act being done is in the patient's best interests when doing the act.

In addition, the clinician's actions should not be contrary to the patient's valid and advance decisions and not contrary to decisions taken by the donee of a Lasting Power of Attorney or court-appointed deputy.

Life-sustaining treatment

Medical decisions are made in an emergency over a range or grades of urgency. The most urgent situations are emergencies where there is immediate threat to the well-being of the patient, followed by semi-urgent, intermediate and elective situations. For situations involving life-sustaining treatment and medical emergencies where there is a risk of death or permanent or serious disability, the medical decisions should not be made by anybody other than the treating doctor in conjunction with the clinical team managing the patient. The medical decisions made must also not be motivated by a desire to end the life of the patient.

Fluctuating capacity

For elective medical procedures, the clinician should start with Principles 1 and 2. It is important to consider whether it is likely that the person will regain capacity at some time in the future to make the decision in question, and when that is likely to happen. This is particularly relevant when the lack of capacity is medically reversible (eg, with treatment of illness) or there is fluctuating capacity. It is then logical and also in the patient's best interest to get the patient to make the decision at a time when he/she has capacity to make that specific decision.

Best interest checklist

The MCA and Code of Practice provide guidance and a checklist which must always be taken into consideration in determining the patient's best interest,[2] including any past written statements, stated wishes, preferences, values, and individuals who should be consulted in arriving at the best interest decision. Some advocate a balanced sheet approach in balancing benefits and risk as an aid to arriving at the best interest decision. This checklist approach also reiterates that capacity is decision- and time-specific for each treatment decision.

Finally, the doctor is not obliged to follow the wishes of a person lacking capacity, if such wishes are judged to be against the person's overall best interests. Doctors should exercise their professional clinical judgement of what is in the best interests of the person as a patient, to determine what treatment to provide.

In developing the best interest decision, healthcare professionals must keep good contemporaneous clinical records of the processes followed, reasons for any decisions taken and the persons that they consulted. These records are important as a matter of good professional practice and are useful in the event of a dispute.

Principle 5

"Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action."

When acting or making a decision on behalf of a patient who lacks capacity, the action or decision taken should be one which is less restrictive on the patient's rights and freedoms and is also the option that is in the best interests of the patient. All practical and possible options and alternatives should be explored, and the less restrictive option that is in the best interest of the patient should be chosen.

When using measures that restrict or restrain the patient's freedom of movement or liberties, the clinician must reasonably ensure and believe that the restrictions and act of restraint are safe, effective and necessary to prevent the patient from suffering harm, and ensure the restraining act is a proportionate response to the likelihood and seriousness of the patient suffering harm. Only the minimum necessary force or intervention should be used and for the shortest possible duration.

Conclusions

The five statutory principles embody a fine balance between the right to autonomy of patients with diminished capacity in participating in medical decisions and the right to protection from harm from such decisions. The MCA and the five statutory principles also provide clear guidance for clinicians on how to maximise the autonomy of their patients with diminished capacity so that patients can participate in their medical decision-making.

Lastly, the Act provides the authority and prescribes the processes on how to arrive at a decision based on best interest when the patient lacks the capacity to make medical decisions. ◆

References

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2. Office of the Public Guardian. The Code of Practice. In: Ministry of Social and Family Development. Available at: https://bit.ly/3VUxJOE. Accessed 25 June 2024.

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