Assessment of mental capacity to consent to treatment in anorexia nervosa: A comparison of clinical judgment and MacCAT-T and consequences for clinical practice

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ABSTRACT

Informed consent requires adequate mental capacity to consent to treatment. Mental capacity (MC) to consent to treatment refers to the ability to make medical decisions. MC is assessed in a general psychiatric interview, but this clinical assessment is known to overestimate mental capacity in patients and the inter rater reliability is low. The MacArthur Competence Assessment Tool for Treatment (MacCAT-T) has emerged as the gold standard to assess mental capacity to consent to treatment. The MacCAT-T is a semi-structured interview designed to aid clinicians in this assessment and has shown good inter rater reliability in patients with schizophrenia and other mental disorders, but has hardly been studied in patients with anorexia nervosa. Patients with anorexia nervosa (AN) regularly avoid treatment, even when severely ill and discussion includes assessing MC to consent to treatment.

The aim of this study is to compare clinical judgment and the MacCAT-T in evaluating MC in patients with AN which in turn may influence use of the MacCAT-T in daily practice.

In a sample of 70 consecutively referred severely ill patients with AN with a mean BMI of 15.5 kg/m² and a mean duration of illness of 8.6 years, clinical assessment of MC by experienced psychiatrists and the outcome of the MacCAT-T interview were compared. Agreement (κ-value) was calculated. Agreement between clinical assessment and outcome of the MacCAT-T was questionable (κ 0.23). Unlike in other psychiatric populations, clinicians judged a high proportion of patients with AN as having diminished MC. The MacCAT-T can be useful in assessing MC in AN when used in addition to clinical judgment to aid clinicians in complex cases. Why clinicians judge a relatively high proportion of patients with AN as having diminished MC, in contrast to lower proportions in other psychiatric disorders, is an area in need of further research.

Keywords:
Mental capacity
Anorexia nervosa
MacCAT-T

1. Introduction

Informed consent is considered a central theme in health care legislation in western countries. It refers to the ability of a patient to adequately decide regarding treatment, and without informed consent a clinician cannot commence treatment. In the field of medicine adequate decision making regarding treatment is referred to as mental capacity.

Contemporary ideas on informed consent in continental Europe stem from the Nuremberg Code, where it was stated that consent to research should be voluntary, based on adequate understanding and mental capacity (Sturman, 2005). The Nuremberg Code was designed after the unethical behaviour of (German) health care professionals in the Second World War came to light and conveyed the firm resolution that such behaviour should never again occur. In the United States the informed consent principle had already been established earlier (Schloendoff v. Society of New York Hospital 105 N.E. 92, 1914).

In the more liberal view regarding patient rights that emerged after the war, informed consent in the context of medical treatment gained importance. The duty of clinicians to properly inform patients and not override patient autonomy became a central theme in health care legislation. In later years mental capacity was conceptualized further. In 1977, Roth et al. suggested this decisional capacity (i.e. mental capacity) should be assessed by tests regarding reasoning, understanding and the ability to make a choice as these were the elements on which judges...
based their verdicts in courts (Roth, Meisel, & Lidz, 1977). Based on this original work, in 1982 Appelbaum and Roth outlined four legal standards, which from that moment on have come to be used by the majority of the researchers in the field. These so-called standards, which actually are functional abilities, generally refer to the ability to understand the information provided, to engage in reasoning when deciding, to appreciate this information as relevant to one's own circumstances and to express a choice (Appelbaum & Roth, 1982). An important presumption in clinical practice is that the patient possesses adequate mental capacity to do so. Mental capacity is a task specific phenomenon and in that sense refers to one specific decision patients need to make and is not a general feature of the patient (except for extreme situations e.g. coma). A patient can thus have adequate mental capacity regarding a certain decision, but diminished or absent mental capacity regarding another medical decision (Appelbaum & Grisso, 1988; Beauchamp & Childress, 1994; Wong, Clare, Gunn, & Holland, 1999).

When severely ill patients refuse necessary treatment, the issue of mental capacity becomes especially important. In a recent review on the ethics of coercive treatment in psychiatry, Steinerst states that coercive treatment can be justified only when a patient's capacity to consent is impaired and severe danger to health or life cannot be prevented by less intrusive means (Steinert, 2017). Generally, the law will permit clinicians to provide treatment over the refusal of a patient who lacks capacity to consent, when this is necessary to prevent serious harm to the health or life of that patient, and sometimes when necessary to protect the safety of others. In this case, withholding treatment can violate the principle of justice. Lacking or diminished mental capacity is a clinical dilemma, especially in cases where withholding treatment can harm the patient or others.

1.1. Assessment of mental capacity to consent to treatment

Assessment of mental capacity to consent to treatment is usually done by the treating clinician, but generally only in situations where the clinician doubts whether or not mental capacity is adequate. This clinical assessment is known to overestimate mental capacity in patients (Lepping, Sambhi, & Williams-Jones, 2010) and has low inter rater reliability (Kitamura & Kitamura, 2000; Marson, McInturff, Hawkins, Bartolucci, & Harrell, 1997; Shah & Mukherjee, 2003), i.e. two clinicians have low agreement in their assessment of mental capacity in the same patient. Therefore, efforts have been made by various researchers to provide clinicians with a tool to assess mental capacity in clinical practice. Sturmans discusses in his review eight (semi)structured interviews, one self report instrument and one questionnaire (Sturman, 2005). Virtually all of these instruments demonstrated good interrater reliability, the most serious limitation of these instruments lies in their validity testing. Of these instruments, the MacArthur Competence Assessment Tool for Treatment and for Clinical Research (MacCAT-T and MacCAT-CR to assess mental capacity to consent or treatment or to consent to participating in clinical research respectively) have emerged as the gold standard today. This is due to the more substantial research into reliability, the demonstrated concurrent validity with other measures and the extensive testing in a range of patient populations, medical as well as psychiatric (Candia & Barba, 2011; Dornan, Kennedy, Garland, Rutledge, & Kennedy, 2015; Mandarelli et al., 2016; Mandarelli et al., 2017; Okai et al., 2007; Raymont et al., 2004; Sturman, 2005; Wang et al., 2016). The MacCAT-T (Grisso, Appelbaum, & Hill-Fotouhi, 1997) is a shorter version adapted from the original mental capacity assessment tool developed by Appelbaum and Grisso in the nineties of the previous century (Appelbaum & Grisso, 1995; Grisso & Appelbaum, 1995; Grisso, Appelbaum, Mulvey, & Fletcher, 1995). As mentioned in the introduction, four abilities (understanding, appreciation, reasoning and making a choice) were condensed from legal ruling in the United States in the 1980s; these were the abilities that were considered central to mental capacity by court rulings. As these abilities seemed clinically meaningful, they became the four central issues in the research and development of their assessment tools for clinical practice. Using the MacCAT-T the clinician provides patients with adequate information and assesses their degree of understanding, reasoning and appreciation and ability to make a choice. The MacCAT-T provides ratings for four subscales; Understanding (0–6), Appreciation (0–4), Reasoning (0–8) and Choice (0–2). It has shown good inter-rater reliability in the assessment of mental capacity (Grisso et al., 1997).

The MacCAT-T has since been used in a range of populations, psychiatric and medical, and the high inter rater reliability has been replicated a number of times. Two reviews (Candia & Barba, 2011; Okai et al., 2007) and one meta-analysis (Wang et al., 2016) have been published on mental capacity in psychiatric patients. In most studies in these reviews the MacCAT-T was the instrument of choice to assess mental capacity. The inter rater reliability again proved to be high, indicating that it was possible to reliably assess mental capacity with the MacCAT-T. Schizophrenia, bipolar disorder and major depressive disorder were the most common diagnoses in the two reviews. The meta-analysis studied only patients with schizophrenia. Psychosis, symptom severity, involuntary admission and treatment refusal were indicators for incapacity. A review found 28% patients incapacitous (Okai et al., 2007), Wang et al. (2016) found that patients with schizophrenia performed worse on all subscales of the MacCAT-T compared to healthy controls.

In studies using the MacCAT-T a persistent finding is that the proportion of patients that is judged as having diminished mental capacity is generally much higher when adding the MacCAT-T to the clinical assessment, than when clinicians judge without this tool (Cairns et al., 2005; Vollmann, Bauer, Danner-Hoppe, & Helmchen, 2003). For instance, in the study by Vollmann et al. it was found that when the clinician assessed patients with a major depressive disorder the proportion of patients found to lack capacity was substantially lower than when the MacCAT-T was used in this assessment (3% vs 20%); the same pattern was seen in patients with schizophrenia (18% vs 53%). An interesting study by Owen et al. (2013) showed that when physically ill patients have diminished mental capacity it is mainly their reasoning that is deficient, whereas in psychiatrically ill patients appreciation is lower when mental capacity is compromised. This suggests a different pathway to mental capacity problems in medically ill and psychiatrically ill patients.

1.2. Legal and ethical considerations in mental capacity to consent to treatment

The MacCAT-T and the focus on the four key abilities have been influential in clinical practice. Clinicians regarded these four abilities as essential, teaching them to new generations. But this translation of legal logic to clinical reality might be inherently problematic. The legal paradigm is much more rational than clinical reality, it is more dichotomous and pays less attention to interpersonal differences. Laws do not leave much room for personalization, whereas in medicine diagnoses, treatments and prognoses are constantly influenced by personal circumstances of the patient.

Another legal matter complicates the assessment of mental capacity in daily practice. Different health care legislation exists for mentally ill and physically ill people with a different weight put on the importance of mental capacity to consent to treatment. There have been some that have argued for the merging of these two different health care legislations as medical law would benefit from one system, with mental capacity as a core feature regardless whether a patient would have a psychiatric disorder or another medical disorder. These authors see no justification for two different legislations and argue that it promotes stigma and enables discrimination against people with a psychiatric disorder (Dawson & Szmukler, 2006; Richardson, 2007; Szmukler & Kelly, 2016). Appealing as this might seem, this has not been the turn society
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