A review Paper on Ethical Problems and Mental Ability Laws

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ABSTRACT

The claim that the conferment of incapacity may not be based on the wisdom of a decision alone is central to the Mental Capacity Act 2005(MCA). That is what this paper problematizes. Value-based medicine examines the capacity assessment process and highlights the presence of preconceptions throughout the evaluation. In two cases before the Court of Protection, the complexity of the assessment without reference to wisdom is examined in order to focus. The paper proposes that every stage of the capacity assessment is carried out with reference to preconceptions and that recognition of these, along with transparency in the use of them, would enable greater clarity about what MCA requirements practitioners are.

KEYWORDS: Review, Mental Ability, Ethics

INTROCUTION

When the Mental Capacity Act 2005 (MCA) came into force in October 2007, it formalised an approach to the categorization of personal actions. There is a difference between people who are able to take decisions and people who are not able to make decisions. A definition of mental capacity is established, a set of principles governing the categorization process is proposed and a best interest method is set for decision-making, where an individual is made to decide on the action(s) as capable or incapable.

It was found incapacitated [1]. A distinction between the perceived knowledge of a decision and a determination of the lack of ability to make a decision is central to understanding supported by the MCA ([2], para. 3). The fourth principle is that "a person should not be treated just because he makes an unwise decision as unable to make a decision" ([1], Part 1, Section 1). Any determination of a lack of capacity must therefore rely on a supplementary requirement or issue other than the judgement on the relative wisdom of the decision. However, this requirement does not imply that a decision's wisdom is irrelevant in determining whether or not a person has the capacity, just that direct equivalence is not available.

The ongoing support of the MCA, and the distinction between knowledge and skill, is identified in this paper as ethically questionable in two respects. First of all, what does this quality of "other than wisdom" differ from a judgement about the perceived weisdom of the decision in any capacity determination? Since the MCA allows interference to be made with the actions of individuals, the basis on which such interference is allowed is ethically significant. If the additional requirement is not established then the rationale for such classification is obscured but also the basis on which people can challenge capacity determinations is limited. Secondly, the distinction proposed between the wisdom of an action and the capacity for an action demands that healthcare professionals adhere to such a distinction. If the determination of capacity is to be based on a judgement different from the wisdom of the decision, then it

must be possible to assess this "other than wisdom" quality. Otherwise, the requirement for evaluators to conform to the MCA appears at best unclear and perhaps unworkable [3-6].

This paper begins with a proposal to understand how legal capacity differs from mental capacity. Sensitivity to this distinction allows various approaches to understand the relationship between legal and mental capacity, if any. In the historical context, the approach adopted in the MCA is characterised by prohibitive and prescriptive aspirations. A break between these two aspirations is proposed, which clearly shows the MCA what practise it aims to relegate to the past but is unclear as to how future practise should be conducted. The distinction between wisdom and capacity and the requirement of Section 2(3) explanatory notes for the evaluation of capacity to be free from preconceptions and harmful assumptions ([7], paragraph 23) is evaluated from a value-based medicine point of view. The MCA is construed to support a distinction between sanctioned and non-approved preconceptions. The Court examines two cases concerning the capacity of two women diagnosed with severe Anorexia Nervosa. The aim here is not to discuss how the actions of persons diagnosed with Anorexia Nervosa should be addressed. Instead, it examines whether the distinction between capacity and knowledge is maintained in practise [8-11].

In response to difficulties in complying with the MCA's regulatory ambitions, it calls for greater transparency and a change in capacity language. The argument that action can and should be divided into categories of ability and disability is itself a value judgement. How differentiating regimes such as the MCA have chosen to identify actions as disabled is a further value assessment. The values that first underpin the concept of capacities and the values that permeate capacity determinations can be highlighted through a change in the way capacity is discussed, to give a better understanding of how we differentiate action and how evaluators act according to the MCA [12-13].

The capacity understanding adopted in the MCA proposes a combination of functional and status approaches and rejects status or outcome approaches alone. Section 1 sets out principles underlying the use of the Act that reflect the principles already laid down in the common law. Principle 2 provides that all persons over the age of 16 have the ability until the ability is established. Principle 4 reads that a person "is not to be treated merely because he makes an unwise decision." This principle suggests that the conferment of incapacity should be based in a degree on an aspect that does not have to do with a judgement on the perceived knowledge of the decision.

Section 2 sets out a diagnostic requirement to determine any absence of capacity. If a person lacks the ability to address a problem, he or she must not be in a position to make a decision "because of impaired or disordered functioning of his or her mind or mind" ([14-16], Part 1, Section 2). In limiting the potential attribution of an inability to individuals who meet the diagnostic threshold, the MCA helps us to understand that a person's ability or ability is a property or feature rather than a judgement of the actions by others. If a person does not meet this diagnostic criterion, he may not be considered to be incapacitated.

CONCLUSION

The approach to distinguishing Fulford's values can be used in distinguishing the preconceptions in the MCA. The MCA is both expressive and dependent on a number of important preconceptions. Initially, the definition of mental capacity endorsed by MCA is a product of a series of consultations led by the Law Commission, which was supposed to distinguish action by means of capable and incompetent measures. In practise, applying the MCA depends on medicine's preconceptions or values at various stages of the evaluation process. These two preconcepts may be read as "narrow descriptive criteria" for the MCA, representing what is considered to be generally accepted or factual. In addition to these sanctioned preconceptions, the MCA seeks to reduce and delete the assessment process. The preconceptions of an evaluator and prejudicial assumptions match the "wide descriptive criteria." The aim of the assessment process to remove contested values, such as religious views, is a laudable effort to prevent health care professionals from imposing their will on a patient.

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