Case study

Dealing with issues relating to capacity to consent to treatment and care in an older person

Patient notes

- James is 83 years old and has lived in a care home since his wife died in 2016.
- He has a chroidal melanoma which was diagnosed in 2013. He was aware this tumour may eventually lead to his death. And in 2014 he made an advance decision to refuse treatment (ADRT) for the eye tumour. The ADRT was signed and witnessed and is both valid and applicable.
- He was diagnosed with vascular dementia in 2015 and in particular has expressive dysphasia with word finding difficulties.
- His vascular dementia has been deteriorating although it is felt he understands what is said to him.

Dr Pires (new GP not known to James) has been contacted by the care home. They have two new concerns:

1. They have noticed James' affected eye is bulging.
2. James has been coughing up green phlegm and has spent the last 24 hours in bed not eating.

Dr Pires does a home visit and sees him with a member of staff who is able to communicate appropriately with James.

→ Dr Pires is aware of communication challenges therefore prepares

Dr Pires notes that James looks unwell – he is thin, has a fever and looks unkempt. His eye is bulging. Dr Pires examines him and confirms he has a chest infection.

→ He does not presume James lacks capacity because of appearance

Although James is unwell, Dr Pires explains he thinks James has a chest infection. He suggests that he could be treated with antibiotics. James nods and says "yes".

Dr Pires is confident James has capacity to consent to treatment.

→ Assumes James has capacity and that he can make simple medication decisions

Dr Pires asks James if his eye is giving him any problems. James nods and says “problem”. Dr Pires asks if it is giving him pain, James nods and says “yes, problem”.

Dr Pires offers regular analgesia to which James nods.

Dr Pires asks James whether he wants to be seen in an eye hospital due to the recent changes. James becomes agitated and says some words Dr Pires cannot make sense of, although he seems to repeating the word “problem”. Dr Pires asks a care worker to help him. After sometime James becomes calmer and says “no hospital”.

Dr Pires has difficulties understanding James so appropriately utilises the help of the care worker to help with the communication difficulties.

Dr Pires confirms that he is aware of the ADRT, which states that if he were to worsen and be a threat to life he does not wish to have treatment. James nods at this in agreement. Dr Pires says he will record this for him.

Dr Pires rechecks with James that he still wishes not have treatment in accordance with ADRT

What does GMC guidance say?

The key points from *Consent: patients and doctors making decisions together* (2008) are:

- Dr Pires presumes that James has the capacity to consent both to examination and to treatment for his chest infection and to regular analgesia for his pain, despite his communication difficulties. (Paragraph 64)
- Dr Pires does not assume that he lacks capacity simply because he is old, is unkempt, has a diagnosis of dementia and has expressive dysphasia. (Paragraph 65)
- Some of the decisions are fairly simple, e.g. he wishes to have antibiotics for an infection and he wishes to have pain relief, so it is easier for him to retain the ability to make a decision for himself. (Paragraph 66)
- In order to be sure that he understands what he is trying to communicate in connection with the more complex decision about going to hospital about his eye tumour, Dr Pires asks for help from the carer from the care home, which facilitates James’ ability to communicate. (Paragraph 68)
- Dr Pires keeps a written record of the consultation and of the decisions that were made. (Paragraph 70)