the remarkable similarity of the two schools of traditional medicine, I believe that the Aryans knew about the four fundamental elements. Their descendants who settled in India later tried to improve this school of medicine by adding the fifth element—the 'sky'. However, Iranians and Indians were not the only descendants of the Aryans; there was a third group of Aryans who neither stayed in Iran nor went to India; they went to Europe. In fact, most Indians, Iranians and Europeans are cousins and, no surprise, their languages belong to the Indo-European language family.5

Empedocles (c. 490–430 BCE), a citizen of Agrigentum (a Greek colony), is best known for his theory of the four fundamental elements—'earth', 'water', 'fire' and 'air'. Later, Aristotle (384–322 BCE) added a fifth element to Empedocles' proposed elements, namely 'aether', a word which in Homeric Greek means 'pure, fresh air' or 'clear sky'—very similar to the Ayurvedic fifth element, the 'sky'. The very similar concepts on basic elements proposed by these philosophers and the chronology of events would cast a shadow on our belief that whether the philosophy of four elements really originates from Greece. Could it be possible that the third group of Aryans who presumably knew the four elements, spread the word in Europe? For several centuries BCE, Greece was one of the most important trade centres. Is it not reasonable to think that many people from different parts of other countries, say India, travelled and probably brought manuscripts on Ayurveda to Greece, since it is very unlikely that Aristotle added exactly the same fifth element to the system of four elements using the exact Greek equivalent word of 'aether' for the 'sky' in Ayurveda—a word that had been used by Indians at least 700 years before? This proposed scenario is against all that we have so far been taught, but who knows? Considering the chronology of events, this might be the true version!

Conflict of Interest: None declared

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Letter from Bristol

WHEN PATIENTS CANNOT CONSENT TO TREATMENT

Making treatment decisions with patients is a core component of clinical practice. Clinicians have a duty to ensure that informed consent has been obtained, but confusion arises when the patient does not have the capacity to consent to these decisions. Such situations can pose challenging ethical and medico-legal dilemmas. Here, we highlight selected principles of the Mental Capacity Act of England and Wales, 2005, specifically those that may offer a transferable, common-sense good practice framework for clinicians making such decisions in other jurisdictions. These suggestions do not constitute legal advice, and a useful summary of Indian law (or lack thereof) in relation to these issues is available elsewhere.2

A brief background of capacity

The right of capable adults to determine what shall be done to their bodies is a fundamental civil right, which is recognized and protected by law in the UK and elsewhere. In UK law, a capable adult ‘has an absolute right to choose whether to consent to treatment, to refuse it or to choose one rather than another treatment being offered’.1 This right exists whether the reasons for making the choice is ‘rational, irrational, unknown or even non-existent’.1 In the Indian Constitution, this concept is embodied within the right to life and personal liberty.2

Types of consent

Consent can be express or implied, oral or written. Express written consent usually involves the patient signing a consent form. Implied consent is one which is inferred from a patient’s action; for example, a patient who holds his/her arm out for an injection. The term ‘valid consent’ is frequently used in this context. In England and Wales, in order to be able to give valid context, the patient must be competent, that is, over 16 years of age (as opposed to Indian law where this age is 18 years),2 have the mental capacity to consent to the particular treatment, must have been explained the nature and purpose of the treatment and understood the information given and, most importantly, have given the consent voluntarily.

The right to refuse consent

The right to autonomy prevails even where the decision may clearly compromise health or even lead to the death of the patient, something which medical practitioners may find hard to come to terms with. Nevertheless, any intervention carried without the person’s consent can amount to a criminal offence and may violate certain human rights enshrined in the European Convention on Human Rights, 1950.4
When capacity is lacking

Where a person lacks capacity to give valid consent, the dilemma faced is that no other person has the legal right to decide on the individual’s behalf. However, treatment and care may still need to be carried out. Until recently, patients who lacked capacity to make healthcare decisions and required medical treatment were treated under common law in the UK. This has now been superseded by the Mental Capacity Act, 2005 which provides a framework for making decisions not only about the incapacitated person’s medical care but also about their welfare, property and affairs in their best interests.

Key principles of the Mental Capacity Act, 2005

The Mental Capacity Act highlights five statutory principles aimed at maximizing the patient’s authority and autonomy in the decision-making process.

1. A presumption of capacity. The starting point in any assessment process is an assumption of capacity until otherwise proven;
2. Unwise decisions do not necessarily lead to a finding of incapacity;
3. All decisions must be made in the best interests of the incapacitated person;
4. Every step should be taken to enhance the person’s capacity to allow them to make their own decisions;
5. Where intervention is required in the patient’s best interest, the least restrictive action should be resorted to.

Assessment of capacity

The starting point in the assessment of capacity under the Mental Capacity Act involves a determination of whether, at the material time, the patient is suffering from ‘an impairment or disturbance in the functioning of the mind or brain’.

The next stage of a capacity assessment concerns a determination of whether the patient with ‘an impairment or disturbance in the functioning of the mind or brain’ is able to:

1. Understand the information relevant to the decision;
2. Retain that information;
3. Use or weigh up that information as part of the process of making the decision;
4. Communicate the decision.

Failure to carry out any of the actions described above can render the patient as lacking capacity to make that decision.

In the event of lack of capacity

A crucial point to note is that any assessment of capacity is ‘decision-specific’; that is, an individual lacking capacity to make one decision cannot be assumed to lack capacity in respect of other decisions to be made. Further, it is important to note that capacity is ‘time-specific’ and may fluctuate, and the lack of capacity may be temporary or permanent. For example, states of temporary lack of capacity to make informed decisions in situations such as a patient being under anaesthesia; in an acute confusional or unconscious state secondary to injury or acute medical condition; under the influence of alcohol or drug use and other similar circumstances. Mental illnesses such as dementia, long-term effects of brain damage or intellectual disabilities may lead to more persistent difficulties in making decisions. In all cases, efforts should be made to enhance the patient’s capacity so that they may be able to take a fully informed decision. Using the above examples, a decision to carry out an additional surgical procedure may be delayed (unless such consent had been granted in advance); non-urgent treatment plans may be made when the patient has recovered from the effects of drugs or alcohol; or has a lucid phase in a mental illness such as dementia.

Best interests and least restrictive options

The concept of acting in the patient’s best interests is an overarching principle of the Mental Capacity Act, 2005. When capacity is lacking, there is an obligation imposed on practitioners to treat the patient in their best interests if such treatment is necessary.

The Mental Capacity Act enshrines a participative model whereby the patient’s past and present wishes, beliefs and values are important factors to consider in the determination of what is in their best interest. The scope of the ‘best interests’ is not limited to purely medical best interest but encompasses ‘the broader welfare issues of the patients, their abilities, their future with or without treatment, the views of their families and the impact of the refusal’.

In practice, such discussions are conducted within the framework of ‘best interest’ meetings where relevant (usually multidisciplinary) professionals, family members, carers and/or advocates of the patient discuss the issues at hand, and come to a consensus whether the treatment/intervention being offered may be in the best interest of the patient.

Finally, the Mental Capacity Act stresses that in the event of a best interest decision being taken, the least restrictive option should be followed. For example, if there is equal likelihood of drug treatment and surgical intervention leading to a successful outcome—treatment with drugs may be the lesser restrictive option and should be followed.

Each case where lack of capacity is suspected has unique circumstances, and brings with it unique challenges for practitioners. Adapting the above principles from UK legislation, particularly those related to enhancing the patient’s capacity, involving other practitioners and family members towards gaining an understanding of the patient’s wishes and, most importantly, always aiming to make decisions in the best interests of patients may provide a helpful framework for clinicians. Where necessary, appropriate legal advice and guidance should be sought, and the process thoroughly documented to avoid adverse medico-legal consequences.

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