ARTICLE

Fluctuating capacity: the concept of micro- and macro-decisions

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SUMMARY

There is much Mental Capacity Act 2005 (MCA) case law emanating from the Court of Protection. This article reviews an important and unique case when the court specifically addressed for the first time the question of fluctuating capacity, a not uncommon clinical problem that can often be complex. It describes how the Court of Protection in *Royal Borough of Greenwich v CDM* [2019] legally approached an issue of fluctuating capacity in a 64-year-old woman with a personality disorder and chronic diabetes. In doing so it elucidates a new conceptual framework to apply when assessing fluctuating capacity in terms of considering micro- and macro-decisions which can be used in routine clinical practice.

LEARNING OBJECTIVES

After reading this article you will be able to:

- use and apply a new conceptual framework when assessing cases of fluctuating capacity in clinical practice
- understand the central importance and interrelationship of sections 2 and 3 of the MCA when assessing capacity
- understand how case law influences and shapes court decisions.

DECLARATION OF INTEREST

None.

KEYWORDS

Consent and capacity; personality disorders; psychiatry and law.

This article reviews a Court of Protection judgment involving a 64-year-old woman known in court as CDM (Royal Borough *of Greenwich* v CDM [2019]). The importance of this case is that it was regarded as a 'novel' legal case in that it was the first time the Court of Protection specifically opined on the issue of fluctuating capacity. The article concentrates on the question of fluctuating capacity in terms of CDM being able to consent to diabetic treatment under the Mental Capacity Act 2005 (MCA). It elucidates how the MCA was applied; how previous jurisprudence shaped the conclusions; the in-depth level of analysis provided by expert witnesses; and, importantly for clinicians, a new conceptual framework to apply when assessing fluctuating capacity in clinical practice.

How the case came to court

The case originally came to the Court of Protection in 2018 when CDM challenged a deprivation of liberty safeguards (DoLS) order in place at a care home (*Royal Borough of Greenwich v CDM* [2018]). Various capacity-related issues were also considered, including CDM's capacity to consent to treatment. This related to her ability to manage her diabetes and the interplay with her mental disorder, which aggravated her decision-making and control in relation to the diabetes. The judgment agreed with the expert psychiatric witness that CDM had fluctuating capacity in this regard. The case was subsequently referred to the Court of Appeal as it was considered that there may have been deficient evidence produced. Permission was given to reassess the issue of fluctuating capacity in light of further expert evidence received and the case was referred back to the Court of Protection, where it was heard in 2019 (*Royal Borough of Greenwich v CDM* [2019]). The judge posed himself three questions to answer in this regard and in doing so introduced the concept of micro- and macro-decisions (Box 1).

Background to the case

Personal and social history

Although little in-depth information was gleaned about CDM's life, it was described as a 'difficult life over many years'. CDM's husband died in 2014. Thereafter CDM was provided with a home care package and daily insulin administered by district nurses. Her care needs escalated following an amputation. She was described as living in 'squalid conditions' and was noted to be unable to access equipment in her lounge owing to furniture obstruction (she hoarded belongings). She refused to use a commode and had great difficulty in keeping the 'dog mess that […] pervaded her property out of the kitchen area'. She would only sleep on a sofa or in her wheelchair.

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BOX 1 Key questions posed by the judge in *Royal Borough of Greenwich v CDM* [2019]

'1. Whether the assessment of capacity to make decisions about diabetic management or "the matter" in relation to which CDM is being assessed is one macro-decision which encompasses all of the many micro-decisions that CDM is required to make when managing her diabetes, or, whether CDM's capacity should be assessed in respect of each micro-decision or group of micro-decisions.

2. In the light of that determination, whether the presumption that CDM has capacity to make decisions about her diabetes has been rebutted, and if so on what basis.

3. If I conclude that as a matter of fact CDM's capacity to make decisions about any aspect of her diabetes management fluctuates, what preparations the court can and should make to reflect that finding [section 15 of the MCA]. Having regard, to the factual and legal background and I have reached very clear conclusions.

(*Royal Borough of Greenwich v CDM* [2019]: para. 5)

Medical history

CDM had chronic physical health disorders, including hypertension, chronic obstructive pulmonary disorder (she continued to smoke cigarettes) and unstable type 2 diabetes requiring insulin and a controlled diet. She had been admitted to hospital on numerous occasions as a result of poor adherence to her diabetes treatment; reasons for admission included diabetic comas and diabetic ketoacidosis episodes. She frequently refused advised hospital admissions and had a history of declining insulin or claiming that she had already taken it when she had not. She was also poorly adherent to her diabetic diet and oral medication. In late 2016 she suffered a hip fracture. She recovered mobility by insisting on using an upside-down broom as a walking aide while eschewing usual medical advice for such a recovery. Owing to her unstable diabetes, CDM needed a right-toe amputation. Her recovery was affected by ongoing self-neglect and non-adherence to the advice of healthcare professionals, with the result that the wound became infected, leading to gangrene and subsequent amputation of her right lower leg in May 2017.

Psychiatric history

There was no mention of CDM previously being known to mental health services. The expert witness, a jointly instructed consultant psychiatrist, concluded that CDM had a personality disorder with different components to it. Although the predominant diagnosis was of an emotionally unstable personality disorder there were also elements of paranoid, dissocial, histrionic and dependent personality disorders. A second expert witness, a consultant clinical forensic psychologist, concluded that CDM had an emotionally unstable, paranoid, histrionic and dependent personality disorder. In terms of CDM's individuality she was noted as being 'an individual with strong views' and was described as 'not just difficult but, on occasions, oppositional and downright awkward'. She was someone who did 'not readily take to professional advice, preferring to manage her disabilities and her diabetes in […] her own way'. These traits had been evident for many years and had predictably brought her into previous conflict with professionals and carers.

Salient events prior to the 2019 court case

Before being admitted to hospital in September 2017, CDM had been 'consistently assessed' by various agencies and professionals, including her general practitioner (GP), the district nursing service, the ambulance service and the local authority, and deemed to have capacity to make decisions with regard to her residence, personal care and diabetes management. In the 2 years prior to this hospital admission, CDM had been admitted from her home to hospital on 11 occasions; the majority of these admissions were related to her diabetes after she had been found collapsed on the floor by carers. However, during the hospital admission she was assessed as having fluctuating capacity and/or actually lacking capacity to make these same decisions and was making 'unsafe decisions […] which went far beyond unwise'. A best interests meeting determined that it was in CDM's interests to be discharged into residential care and not return to her home, although she it was her 'strongly expressed wish to do so'. She was initially discharged to a dementia nursing home and then to a care home that allowed her to be with her pet dogs. During this period, she was subject to an urgent and standard DoLS order, which she subsequently appealed against.

In care, CDM's diabetes remained uncontrolled and she was admitted to hospital, with her 'agreement', on around 16 occasions. During this period, she had also been seen by the London Ambulance Service on numerous occasions and advised that she needed hospital admission but she refused, having been assessed by ambulance crews as having capacity to make such decisions. Matters

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came to a head in October 2018, when CDM became physically very unwell. She had been seen by an ambulance crew but not taken to hospital following an assessment of her capacity. Overnight she deteriorated, having then been vomiting for 2 days, was unable to sit up unaided and was 'barely responsive'. She had high ketone levels and her blood sugar was 'unrecordably high' (indicative of another diabetic ketoacidosis presentation). Following this she was taken into hospital, where she remained for a protracted period; she was a 'medically fit for discharge' in-patient at the time of the court process in 2019.

Application of the Mental Capacity Act 2005

The judgment explained the 'uncontentious' application of the MCA and drew on previous jurisprudence as well as guidance from the Act's Code of Practice (Department for Constitutional Affairs 2007).

The judgment homed in on the 'test for capacity' within section 2 of the Act (People who lack capacity) and specifically section 2(1): 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'. The Code of Practice provided guidance as to when the 'material time' was within section 2(1): 'An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general' (Department for Constitutional Affairs 2007: para. 4.4).

Previous case law was applied when considering whether CDM was unable to make a decision for herself in relation to a matter, i.e. capacity in relation to her diabetes treatment was the 'single test' that was to be interpreted by applying the more detailed description given regarding sections 2 and 3 of the MCA from *PC & Anor v City of York Council* [2013]. This case opined that, although the 'core determinative provision' for capacity within the MCA was section 2(1), the remaining statutory provisions of both section 2 *and* section 3 supported the core provision of section 2(1) (especially the specific elements of the four-pronged decision-making process within section 3(1), which 'amplifies what it means to be unable to make a decision'). Hence, section 2(1) was the 'single test' for capacity, but it 'falls to be interpreted by applying the more detailed description given around it in ss2 and 3'.

Again, drawing on *PC & Anor v City of York Council* [2013], this reaffirmed capacity was 'decision specific' and within section 2(1) there needed to be 'a clear causative nexus between the mental impairment and any lack of capacity'. Furthermore, 'The court is charged in relation to "a matter", with "evaluating an individual's capacity" to make a decision for himself in relation to the matter (section 2 (1))'. It further added that no need had been identified for grouping categories of 'matter' or 'decision' into domains.

Further case law from the Court of Appeal provided advice where ongoing decisions need to be made on a daily basis from *Re M (an Adult) (Capacity: Consent to Sexual Relations)* [2014]:

> 'Where a decision is of a kind which falls to be made on a daily or at any rate repeated basis, it is inevitable that the inquiry required by the Act is as to the capacity to make a decision of that kind, not as to the capacity to make any particular decision of that kind which it may be forecast may confront the protected person'

i.e. where there are daily or regular decisions relating to the MCA these are to be assessed for that actual current issue and not hypothetical issues that may affect the person or may arise in the future. (Although not mentioned in this judgment, and before the MCA, it is worth noting the seminal Court of Appeal case *Re T (Adult: Refusal of Medical Treatment)* [1992], which in considering cases of 'temporarily reduced capacity' opined that a person needs to have capacity 'commensurate with the gravity of the decision' needing to be made, i.e. a sliding scale existed – the more serious the decision the greater the capacity required.)

Expert witness opinions

Joint reports from the two medical experts were submitted and 'very clear unequivocal conclusions' were reached regarding CDM's ability to manage her diabetes. The numerous conclusions and opinions are condensed into the following areas.

Application of section 3(1) of the MCA

The judgment provided a detailed insight into the reasoning of the expert witnesses in the application of section 3(1) in terms of CDM being able to understand, retain, use or weigh relevant treatment information and to communicate her decision. In doing so this demonstrated the intricate analysis they applied to each of the section 3(1) subsections; this is outlined in Box 2.

Overall, the experts opined that there 'may be some times' when CDM was able to understand, retain, use or weigh relevant information ('without the defect of a dysregulated emotional state') and to communicate decisions about her diabetes management but that these episodes were infrequent and unpredictable.

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BOX 2 Expert witness analysis of subsections of section 3(1) of the Mental Capacity Act 2005

Section 3(1)(a): Understanding the information relevant to her diabetes management

CDM did not understand:

- which foods increase and decrease her blood glucose levels
- the need to eat the same volume and types of food on a regular and predictable basis
- what a consistent or predictable diet would look like
- the level of accuracy required to make a safe decision for dosing her insulin
- the factors that determine the risk of imminent death associated with her diabetes (albeit she understood that there was a risk of death)
- the nature or degree of the risks of death at particular times, despite having a real general knowledge of the potential risks and good knowledge of her condition.

Section 3(1)(b): Retaining relevant information

CDM was able retain some of the relevant information in relation to her diabetes management all of the time but when she was emotionally dysregulated, 'which is fairly often', she may have been less able to retain relevant information.

Section 3(1)(c): Using or weighing the information as part of the process of decision-making

- CDM did not wish to die but she did not feel that she was at risk of death. She was assessed as being unable to 'realistically' weigh up relevant information about the 'likelihood of survival with raised ketones or blood glucose levels'.
- CDM lacked the ability to weigh up and understand the risks of the immediacy of the threat to her life, e.g. if her blood sugar and ketone levels were high. This also extended to her understanding and weighing the level of risk if she declined to balance her diet or monitor her insulin treatment. Hence, her ability to judge when to accept treatment and to balance this against the risk of death was not present.
- CDM was noted to be able to weigh up some of the relevant information for her diabetes decisions only on 'very few occasions' and then not 'coherently or consistently'. Hence, CDM could fluctuate 'in her ability to make micro-decisions about her diabetic management'. She was able to make capacitous decisions, albeit infrequently – it was less likely to be a capacitous decision if it was a decision to refuse treatment or advice.

Section 3(1)(d) – Ability to communicate her decision

- CDM's communication could be 'difficult when she was emotionally dysregulated'. CDM did not understand that she could become emotionally dysregulated as part of her personality disorder.

(*Royal Borough of Greenwich v CDM* [2019])

The diabetes and personality disorder interface

Although no evidence was received from a diabetes specialist as such, the court heard that diabetes management required a person to maintain consistency in their own care – single decisions needed to be coherent with one another – 'diabetes management was not a single decision, but a coherent series of decisions over time'.

The severity of CDM's personality disorder was described. She was frequently emotionally dysregulated and experienced 'this state most of the time, and in most settings' and her ability to make decisions was 'significantly compromised on a daily basis'. Her high degree of emotional dysregulation was extremely debilitating and interfered with her functioning in most contexts, for example professional interventions often triggered emotionally dysregulated states.

Discussion of her diabetes management itself was noted to often cause CDM to become emotionally dysregulated. There were times when CDM accepted blood glucose monitoring and insulin administration but this acceptance was viewed as probably being due to the dependent aspects of her personality rather than being based on true understanding of imminent health risks. The fact that CDM accepted treatment was not necessarily a sign that she was making capacitous decisions, as such decisions were 'likely borne out of emotional dysregulated dependence'.

Micro- and macro-decisions

Consideration was given as to whether diabetes management decision-making should be viewed as a macro-decision, a micro-decision or groups of micro-decisions. There was a 'clear unequivocal' conclusion that the decision was a 'global or macro-decision', i.e. 'each decision was inescapably related to each other decision'. In someone managing their diabetes, it was suggested that if they ate something, it was in the context of what had been eaten before and what they were likely to eat in future. It was concluded that CDM did not understand 'at any level' that some foods may lower her blood glucose levels, as well as not understanding the information, or weighing it in relation to those foods and factors that might increase it. The judgment noted that, as regards 'the notion of specific

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BOX 3 Key learning from *Royal Borough of Greenwich v CDM* [2019]

- Section 2(1) of the Mental Capacity Act 2015 is the 'single test' of capacity.
- Ensure that a causative nexus exists within section 2(1), i.e. the mental impairment is clearly the cause of any lack of capacity found.
- The 'matter' contained within section 2(1) needs to be elucidated clearly at the outset so that capacity regarding it can be duly assessed.
- Sections 2 and 3 must be read together and are intrinsically linked.
- Seek specialist medical and psychiatric advice where needed, especially where there are complex clinical issues.
- Where there is fluctuating capacity, ensure that views are sought from relevant others involved in the care and treatment of the person.
- Where there is fluctuating capacity and clinical complexity, it is useful to consider whether the treatment decision (the 'matter' contained within section 2(1)) can be considered as one single macro-decision, a series of micro-decisions that needed on-going and regular assessments, or as a group of decisions (each subgroup being separately assessed).
- The degree of any interrelation or interdependence of micro-decisions will dictate whether they could overall be considered a macro-decision. This will ultimately depend on the individual factors and context of any given case and clinical assessment of these.
- If fluctuating capacity is found by the court, the court can make declarations as to how this is managed or assessed in the future.

decision-making, there were so many elements, all of which fluctuated over time and were or might be related, and where each was multi-factorial. There were simply too many factors to be brought to bear'. Overall it was concluded that CDM was 'probably not capacitous at all'.

In CDM's case the 'big factor' was her emotional dysregulation, which was so chronic, severe and frequent that it had 'eroded her understanding of being able to live or make any decision which is not emotionally dysregulated'.

This was further compounded by the view that, even when she did not actually objectively appear emotionally dysregulated, this did not mean she was not subjectively emotionally dysregulated: it was 'quite impossible' to tell or know at what stage and to what extent she was emotionally dysregulated and in what way this could be taken into account in any decision-making.

Conclusion of the court

The court was obliged to determine whether CDM had capacity to manage her diabetes – was this to be considered as one macro-decision, a series of micro-decisions that needed on-going and regular assessments, or a group of decisions?

The judge reached 'very clear conclusions both on the evidence and the law, on powerful experts' analysis', which was 'unanimous' and 'unshakeably clear':

- on the assessment of capacity to make diabetes management decisions, with all their health consequences, the matter was a single global macro-decision; this arose from the interdependence of diet, blood glucose testing, testing ketone levels, insulin administration and hospital admission where necessary because of her glucose levels
- CDM lacked capacity to make these decisions owing to the enduring nature of her lifelong personality disorder, which was unlikely to change. When section 2 and section 3 of the MCA were applied she did not meet the requisite capacity to make a macro-decision about her diabetes treatment (Box 2).

The judge acknowledged that there may well have been occasions when CDM did have capacity to make micro-decisions, and times when she did not, and hence her capacity did fluctuate. However, the judge approached the matter on the basis of the accepted expert evidence and conclusions and opined that diabetes management was therefore 'logically, legally and practically' a macro-decision. Because CDM lacked capacity to make the macro-decision then the issue of fluctuating capacity 'simply' did not arise.

Discussion

The judgement acknowledged that this case would resonate with many healthcare professionals in different care settings and specialties where the assessment and management of fluctuating capacity can be a complex and vexing issue. It noted the 'mixed messages and confusions' arising in this case for care home staff, who had been advised at times not to call the ambulance service if CDM was refusing to go into hospital whatever her capacity status. Where fluctuating capacity cases present, especially with the juxtaposition of complex mental and physical health problems, the importance of using information from a variety of sources is vital to enable a

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detailed understanding of the patient's capacity (the judge placed great emphasis on obtaining opinions from different healthcare professionals to help him have a wide understanding of CDM's presentation). Although no diabetes specialist was used in CDM's case, the court being comfortable with the level of medical understanding presented from various healthcare professionals, a specialist opinion might be something that should be considered, especially where clinical issues are complex or unusual.

Whatever the complexity of any case, this judgment has elucidated a new conceptual approach for assessing fluctuating capacity – considering whether a treatment decision is a single global macro-decision, a series of micro-decisions that individually need on-going and regular assessments, or a group of decisions (e.g. different treatment elements combined into subgroups, and then each subgroup requiring separate capacity assessment). In terms of applying section 2(1) of the MCA, defining the treatment 'matter' at hand in this way will enable the capacity assessment and application of the Act. This new concept of micro- and macro-decisions was not evident in the other judgments cited within this case (or previous MCA jurisprudence as a whole). Box 3 describes key learning points from this case.

The wider importance and public health interest associated with the outcome of this judgment was noted within it: Diabetes UK estimates that there are over 4.5 million people in the UK with diabetes and 60% of these people had experienced emotional and mental health problems. However, the judgment cautioned that it was not 'necessary or helpful' to compare diabetes with many other disorders or clinical parallels, because each treatment had to be 'looked at in its own individual context as opposed to a global context'. Whatever the medical and mental health disorders present, the 'interrelationship between the micro and macro-decisions still needs to be decided, having regard to a particular individual in particular circumstances, and having regard to their particular condition'. This is a 'first-of-a-kind' and novel MCA legal case introducing a new concept for assessing fluctuating capacity under the Act. As such it may well be a catalyst for future similar legal cases to be considered and for the concept of micro- and macro-decisions to be further developed and elucidated. Future jurisprudence in this area may then be sufficient for 'guidelines' to be developed for clinical practice.

MCQ answers
1 c 2 d 3 e 4 d 5 b

Acknowledgement

This article is dedicated to the memory of Dr Chris Vassilas, FRCPsych, a former old age psychiatry consultant colleague and valued friend.

Reference

Department for Constitutional Affairs (2007) *The Mental Capacity Act 2005 Code of Practice*. TSO (The Stationery Office).

Cases

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Royal Borough of Greenwich v CDM [2019] EWCOP 32.

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MCQs

Select the single best option for each question stem

1 As regards the Mental Capacity Act 2005 (MCA) and assessing capacity:
a section 3(1) is the 'single test' of capacity
b sections 2 and 3 do not need to be read together
c a causative nexus needs to exist between a mental impairment and any lack of capacity found
d the MCA Code of Practice does not provide guidance on the concept of the 'material time' contained within the assessment of capacity
e section 3 does not support the application of section 2.

2 As regards fluctuating capacity:
a the Court of Protection can only make declarations as to how this can be managed in the future
b the Court of Protection can only make declarations as to how this can be assessed in the future
c in complex cases it is not essential to obtain specialist advice relating to the disorders involved
d where there is fluctuating capacity, views should be sought from relevant others involved in the care and treatment of the person
e where there is fluctuating capacity, views should be sought only from immediate family involved in the care and treatment of the person.

3 In the case of *Royal Borough of Greenwich v CDM* [2019], the court opined that:
a no causative nexus was established
b the application of the MCA was contentious
c previous case law was not relevant in this case
d when section 2 alone was applied, CDM did not meet the requisite capacity to make decisions about her diabetes treatment
e CDM lacked capacity to make these decisions owing to the enduring nature of her lifelong personality disorder, which was unlikely to change.

4 When assessing fluctuating capacity, decision making should be viewed:
a as a macro-decision
b as a micro-decision
c as groups of micro-decisions
d any of the above
e none of the above.

5 As regards the judgement in the case of CDM:
a all cases of fluctuating capacity need to be referred to the Court of Protection
b the 'matter' contained within section 2(1) needs to be elucidated clearly at the outset so that capacity in relation to it can be duly assessed
c the concept of macro- and micro-decisions only applies to cases of diabetes
d the concept of macro- and micro-decisions only applies to cases of personality disorder
e it was concluded that the capacity to consent to diabetes treatment consisted of groups of micro-decisions.

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