GENERAL REVIEWS

UDC: 174:61]:350.6
https://doi.org/10.2298/VSP171026190P

Mental capacity as medicolegal prerequisite for consent or refusal of medical treatment

Sposobnost za rasuđivanje kao medikolegalni preduslov pristanka ili odbijanja medicinskog tretmana

Zoran Ponjavić*, Zoran Ćirić†

University of Kragujevac, *Faculty of Law, Kragujevac, Serbia;
University of Niš, †Faculty of Law, Niš, Serbia

Key words:
ethics, medical; informed consent; legislation; jurisprudence; mental health; physician-patient relation; therapeutics; risk assessment; serbia.

Ključne reči:
etika, medicinska; informisani pristanak; zakonodavstvo; pravna nauka; mentalno zdravlje; lekar-bolesnik odnosi; lečenje; rizik, procena; srbija.

Introduction

Occurrence and development of certain mental conditions does not necessarily place adults in such a position as to require legal protection. For a significant number of these patients their incapacity (or reduced capacity) to be rational and/or capable of making decisions has not been judicially ascertained.

However, their age, clinical symptoms, social context, sanitary or economic situation, place them in a vulnerable position. Such incapacity is not recognized by the existing system of legal protection [1], as their state is not permanent. However, this raises the question of legal validity of their cognition and willingness to conduct legal affairs pertaining to their property and assets. As they are positioned somewhere between capable and incapable [2], they must be given special protection only when their capacity to consent and/or to express willingness is diminished or nonexistent [2]. Unlike adults deprived of contractual capacity, who have been deprived of their rights in order to be protected, these people should be protected in such a way to be given more rights, although the boundaries between these two categories are very unclear [3].

These circumstances may, among other things, have certain repercussions when it comes to the patients' rights, according to the Act on Patient's Rights (APR) [4]. The problems become particularly apparent when a person admitted to a medical institution as a patient refuses the recommended medical treatment, yet shows diminished cognitive and conative capacity due to the present medical condition and its negative influence on patient's overall functioning. In such situations, the treating doctor should assess whether the patient is capable of consenting to treatment, that is, whether he/she has mental capacity. Consent to medical treatment does not qualify as a legal act [5] so it can not be equated with consent to contractual obligations and the assessment thereof. Accurate assessment of the patient's capacity in such circumstances is an important legal and ethical issue in medicine. Any inaccuracy in its assessment during medical treatment may have adverse effect or even fatal outcome. Such legally impermissible act or offence can render the doctor legally liable under misdemeanor, or civil law [5].

The issue is who may provide a required consent, if the patient is assessed as mentally incapacitated? It cannot always be the patient's legal representative, if he/she does not have one. Should the decision in this case be made by the family or the doctor? Legislation of the Republic of Serbia provides no answers to these questions. Even if such a person has, in accordance with APR (art. 16, section 5) appointed in advance an agent to provide consent, anticipating his/her future condition, the final decision (about any medical treatment) is always to be made by the doctor [6]. Doctor's definitive assessment of the patient's capacity to accept or refuse medical treatment is necessary, as it is a prerequisite for administering medical treatment. It is based on clinical assessment, and aims to protect patient's rights in each specific situation. These assessments are purely descriptive, but invariably involve normative issues.

On the grounds of the previous facts, we have determinated the main goals of this paper. It is to consider

Correspondence to: Zoran Ponjavić, University of Kragujevac, Faculty of Law, Jovana Cvijića 1, 34 000 Kragujevac, Serbia.
E-mail: zponjavic@jura.kg.ac.rs; zponjava@gmail.com

some legal and medical aspects of mental capacity assessment especially in the patients who refuse medical treatment. Also, we aim to suggest possible legislative improvements in the domain of patients' rights, with the focus on possible situations where the assessment is needed and which medical professionals should be in charge of.

Consent to medical treatment and autonomy

Before any medical treatment is administered, the patient must agree to it if he/she has legal capacity (APR Art 15 and 19). If the patient is deprived of contractual capacity, consent must be obtained from the patient's legal representative/person authorized by the law to represent patient and protect his/her rights. Furthermore, prior to making the decision about the treatment, a doctor is required to obtain the informed consent – to provide all the necessary information so that the patient can fully understand what he/she agrees to. Exceptionally, consent is not required in universally recognized cases such as emergencies when the patient's life is threatened, when such consent is assumed. According to the APR, these cases are defined as those when emergency treatment is administered to a patient who is not conscious, or who is not able to provide consent (art. 18, section 1). This suggests that mental incapacity is not expressly envisaged as an exception to consent to medical treatment, but as a condition to provide legal protection to such patients.

It is well-known that the right to consent to certain medical treatment usually implies the right to refuse it as well. In the common law countries, the right to consent to medical treatment is legally based in the right to self-determination [7], which is the individual right to make decisions about one's own life freely, following one's goals, as defined back in 1914 in the ruling of the US Supreme Court, Schloendorff v/Society of New York Hospital [8].

In continental law legal systems, this is based on the principle of inviolable right to physical and mental integrity. As a capacity to make autonomous decisions, it is also the prerequisite for the right to self-determination [9]. The principle of personal autonomy pertains to medicine as well, since the person who makes decisions about his/her body and health actually exercises the right to self-determination. A lack of mental capacity risks personal autonomy [10], especially with precarious medical treatments when a refusal of life-saving treatment can have fatal consequences. The mental capacity assessment should draw the line between the right to personal autonomy and obligation to provide legal protection [11]. This affirmation of the right to self-determination and personal autonomy, which became the basis of patient's right to consent to medical treatment, could not pass without conflict. Not only did it improve the patient's right, but it also emphasized the difference between medical and legal profession. Each of these two attempts to operate in the best interest of the third party – the patient [12].

Recently introduced legislative changes in Serbia have been heavily influenced by international law so as to promote the principle of personal autonomy within the concept of right to health protection, especially of persons deprived of contractual capacity [13]. The latter can receive medical treatment if their legal representative or statutory agent agrees to it (APR, art. 19, section 1). The medical professional in charge, however, must make it possible for the patient to be involved in the decision-making process to the extent his maturity and mental capacity allow. In other words, no individual deprived of contractual capacity is automatically and in every situation incapable of making decisions regarding his/her health nor is every individual with contractual capacity always capable of giving proper consent to medical treatment. However, in the latter case, due to their legal invisibility, this affirmation has bypassed those individuals who are not under legal protection, yet whose mental capacity may be diminished, or absent at a given moment in a given situation. Consequently, a patient's mental capacity is a prerequisite for consent to, or refusal of medical treatment. If a patient has mental capacity, medical treatment can be administered only if he/she consents to it. Otherwise, if the patient is mentally incapacitated, decisions about medical treatment can be made on other grounds.

Legal assessment of mental capacity

Mental capacity is primarily a legal category. In denoting mental illnesses, law applies its own terminology, which is broad enough to avoid frequent changes, as psychiatric terminology is very diverse and subject to numerous alterations [14]. In relation to medical treatment, mental capacity can be defined as the ability to understand the importance of agreeing to medical treatment and its potential consequences. It presupposes that the patient is conscious: the patient must understand presented facts and information and be able to weigh them rationally when making the decision [15]. There is assumption that all adults have mental capacity, the assumption that serves to protect their personal autonomy [16]. This assumption can be dismissed by a court decision, or medical assessment conducted while applying medical treatment. A person deprived of contractual capacity due to mental incapacity cannot give valid consent to medical treatment. Conversely, a consent given by a person with mental capacity is valid and mandatory. The problem is with previous temporary mental incapacity conditions that cannot be limited to mental illness diagnoses. Decisions on mental incapacity carries a variety of risks including a possible violation of the right to autonomy, integrity and personal dignity.

Assessment of capacity to consent to medical treatment is essentially legal in nature, and it is performed by physicians. It is based on the definition of 'mental capacity' which is, according to the APR, expressly required only when the patient refuses the suggested medical treatment. Namely, art. 17, section 1 stipulates that 'the patient with mental capacity has the right to refuse the suggested medical treatment, even when it saves or sustains his/her life.' Legislation of the Republic of Serbia does not provide a definition of mental capacity, except for minors above 15 in the APR, where it is defined as a child's capacity to understand the nature of his/her health condition, the purpose of the proposed medical treatment, the risks and consequences involved if the treat-

ment is applied or not applied, as well as the capacity to weigh the presented information while making the decision (Art 2).

Mental capacity is a factual state, relative and subjective. Its assessment is not conducted in a general manner, as it used to be, but functionally [10]. The functional approach to capacity to consent to medical treatment starts from the 'natural contractual capacity' of the person in question, regardless of his/her legal status [17]. It is indisputable that a person can be incapable of giving consent to medical treatment, yet capable of making all other decisions. For instance, the cognitive capacity of an Alzheimer patient may vary seriously from one day to another. Such functional and individual approach promotes respect for personal autonomy, where actual capacity is preserved. This is the starting point of the Convention on the Rights of Persons with Disabilities, according to which all protective measures must be individual and adapted to a person's disability [1]. It focuses on functional parameters of a person's state when making a concrete decision – the patient's ability to make a clear and valid choice in the given situation [10].

The assessment of the capacity to decide whether a medical professional should administer medical treatment can be performed only on patients who voluntarily consented to medical treatment, as his/her mental state can vary. Medical treatment can be imposed on a patient who is hospitalized against his/her will in cases listed in the Act on Protection of Persons with Mental Disorders (art. 21) [4]. The patient who voluntarily agreed to hospitalization has the right to accept or refuse medical treatment, although this sometimes seems to be a rather theoretical possibility, especially in situations when a doctor has doubts about the patient's mental state. This primarily pertains to cases where the patient refuses medical treatment which is urgent. In practice, however, urgent medical treatment is understood in quite general terms so as to limit the obligation to assess the patient's mental capacity or ask for legal representative's consent. Therefore, in terms of assessment it seems that it makes no difference whether the patient was admitted to hospital voluntarily or not.

The wording in Art 18. sec. 1 of APR pertaining to urgent medical treatment suggests that it can serve as an excuse to medical professionals to relieve them of responsibility or ethical duty, rather than as an exception to obligatory consent and the mental capacity assessment. One can even ask whether this exception can cover all the situations where medical treatment is given without consent [18]. The answer primarily depends on how urgent medical treatment is defined. Urgent medical treatment is not defined in legislation. To interpret it, it may be useful to resort to analogy with urgent medical assistance, regulated in art. 53 of the Law on Health Insurance [19] as 'immediate medical assistance provided so as to avoid putting the insured person in danger to life, that is to avoid irreversible or serious deterioration of or damage to his health or death.' In legal theory, it is defined as surgical or psychiatric treatment where diagnosing and treatment cannot be postponed due to the symptoms, and the emphasis is placed on its restrictive interpretation [20].

According to a Swiss medical case study [21], the capacity assessment should take into consideration four basic elements. Firstly, the mental capacity assessment is a case-specific. Secondly, the mental capacity is either present or absent. In practice, this implies that it is necessary to determine the sufficient capacity level in order to establish whether it is present or not in the given case, which means that it is gradable. The evaluation of the sufficient capacity level depends on the severity of the suggested medical treatment – the potential risk to patient's life and health. Thirdly, the capacity is a condition: as such it must be assessed during the decision-making process, rather than in relation to its outcome. This means that a patient can have mental capacity when making the 'wrong choice' from the assessor's point of view, or not have it when making the 'right choice' [21]. Fourthly, in any case, the results of the assessment must be documented.

Even when it is established that the patient suffers from mental disorder or intellectual development disability, toxicomania, or psychopathological symptoms, it does not imply in itself that the person lacks mental capacity. A patient can be schizophrenic, severely depressed, demented and so on, and yet possess mental capacity to make certain decisions. The fundamental question is to which extent these conditions, affecting psychological capacity, are deemed decisive when assessing mental capacity. Although there are the confirmed statistical correlations between the foregoing conditions and psychological capacity, there are a number situations where it is possible to show that a certain number of such patients are capable of making decisions regarding administration of medical treatments. Furthermore, the same diagnostic group comprises a large number of heterogeneous psychological states [22].

Medical assessment of mental capacity in case of refusal of medical treatment

Medical aspect of mental capacity

The medical assessment in these situations focuses on evaluating mental capacity in relation to the recommended medical treatment. Although different bodies of law link mental capacity to lower or higher level of psychological capacity [23], in general it can be claimed that the mental capacity encompasses a person's ability to understand the meaning of his/her actions: to understand the real, natural and legal importance of his/her acts. This capacity predominantly comes from the preserved intellectual (cognitive) mental functions and the capacity to govern one's actions: to adequately direct and take actions, and make decisions based on the preserved motivational processes – that there are no volitional deficiencies when certain actions are taken or not taken.

When applied to refusal of treatment, this means: the person has the capacity to understand the nature of the treatment and the manner of its administration, the importance of the treatment for the patient's health, the health condition he/she is in and its relation to the recommended treatment, as well as the potential negative consequences if the treatment is not given,

the risks involved if the treatment is refused and its possible side effects if accepted and that the patient is capable of making the decision to consent to or refuse the recommended treatment independently and rationally, weighing pros and cons. This means that the person making the decision expresses his/her real, free volition, and does not uncritically accept someone else's position that the treatment should be refused (or accepted) – the decision is the expression of his/her volition pertaining to the medical treatment. This also means that the person has, in the processes preceding decision-making, 'overcome' some, predominantly unpleasant emotions [24], which may accompany such conditions, and that his/her ratio and volition prevailed over emotional aspects of decision-making.

This is the minimum of prior knowledge that should guide a doctor when assessing the mental capacity of patient refusing medical treatment. In addition, the assessment should not neglect the patient's education, age, social and cultural background, the rate of progress of the disease that requires medical treatment, etc. Furthermore, the patient's family should be involved in the assessment, although research suggests that this rarely happens [22]. Their involvement in the assessment of the patient's moral values and motives for the refusal of treatment is invaluable, and they may even prove to be more competent for this assessment than doctor is.

It should be emphasized that the mental capacity can be affected by various mental disorders [25], which includes the cases when a person refuses medical treatment. In such case, it needs to be assessed how much these mental disorders influence or compromise the mental capacity. In other words, the assessment is made to determine the degree and manner in which these pathological mental states disturb the patient's capacity to independently and adequately take care of him/herself, his/her rights and interests [26]. Naturally, this is also taken into consideration when assessing the mental capacity of patients refusing treatment, and in practice it comprises a whole spectrum of psychiatric entities. The most frequent ones include the acute and temporary mental disorders, permanent psyciatric illness, mental retardation and mental disorders caused by an acute physical or neurological illness.

The methodology of mental capacity assessment when medical treatment is refused

When is assessment conducted?

This capacity is assessed only if there is a serious doubt accompanied by indications that a patient's mental capacity is limited. These indications comprise unexpected changes of mental state, such as disorientation, problems with attention, concentration and memory. Some patient's behavior can also indicate certain mental disorder – if the patient, for example, behaves as if the decision about medical treatment does not concern him/her at all. Interpretation of the above mentioned provision of APR (art. 17, section 1) requires that the doctor must conduct the assessment whenever he/she has doubts about the presupposed capacity of an adult with contractual capacity who refuses medical treatment which saves or sustains his/her life. Only if a doctor determines that the refusal of treatment is the result of a rational decision – that there is harmony between his/her autonomy and his/her best interest – it can be concluded that the patient possesses mental capacity [27]. Once established mental capacity to refuse medical treatment must be reexamined in later treatment stages [28]. It is not a permanent state, as an individual can be in an excellent mental condition one day, and show reduced capacity the next day [29].

Refusal of treatment is in itself a great ethical challenge, especially if a person's life is at stake and his/her mental capacity is limited, or absent [30]. There is a double contradiction: it challenges the patient's right to treatment and the doctor's obligation to provide treatment while respecting the patient's autonomy. In general, one could tentatively claim that a refusal of treatment is irrational. This argument is even stronger when the doctor's values differ from the patient's. When medical treatment is refused, the treating doctor must raise the question of the patient's capacity to consent to the treatment. However, the opposing views between the doctor and the patient are not in themselves a sufficient reason to deprive the patient of mental capacity [31] nor is the acceptance of treatment the proof of mental capacity [32]. There are certain criteria that need to be respected in both situations of refusal and acceptance of medical treatment. The expression of willingness must be free and clear, communicated by a person with mental capacity. To obtain a definite answer, a doctor must provide all the necessary information regarding the diagnosis, alternative treatments and the treatments' potential side effects. Sometimes it is difficult to determine whether refusal of treatment is a result of patient's values, or of his diminished mental capacity. In any case, the fact that the doctor finds the patient's refusal of treatment unreasonable does not necessarily imply that the patient lacks mental capacity [10].

Who conducts the assessment?

A doctor (medical institution) - patient relationship is a type of contractual relationship [34] where each party has certain rights and responsibilities. These include the patient's decision-making, which is his/her right and responsibility – responsibility to him/herself. As decision-making pertains to a single suggested action, under a single agreement, it is logical that the doctor should conduct the assessment if there is doubt about the patient's mental capacity.

When medical treatment is refused, the law (APR) stipulates that 'the treating doctor is obliged to inform the patient about the consequences of his/her refusal of medical treatment.' The APR does not identify who should conduct the assessment of mental capacity, but practitioners are of the opinion that it should be done by the treating doctor. There is the issue of competence of practicing doctor given that there is no systematic training of doctors for the assessment of mental capacity. In addition, the broad legal definition makes the assessment even more difficult, as the criteria are mainly subjective [34]. On the other hand, one may raise the question

whether it is necessary to consult a psychiatrist to assess mental capacity in every case of refusal of treatment.

The position that the treating doctor should assess the mental capacity when treatment is refused, does not imply that the assessment cannot be done by consulting a larger number of medical professionals, most often working for the institution in which the patient is treated. In special cases, it is necessary to seek opinions of other medical specialists, outside the institution where the patient is treated (or from other wards in the same institution), especially neuropsychiatrists and medical psychologists. This type of assessment is the termed consultative assessment.

As legislation does not prescribe the form of the assessment; it can be conducted *ad hoc*, which is unfortunately the most frequent type of assessment in Serbia. Consequently, it is necessary to standardize the procedures, incorporate them into medical standards and health-care legislation either as general regulation or as regulation of an individual medical institution. Solutions should primarily be proposed by medical experts' associations, especially since no official procedures have been established. This would reduce improvisations in methodology, variations in assessment, as well as potential mistakes and damage.

Principles of clinical examination when assessing mental capacity in case of refusal of treatment

It is of an utmost importance that the doctors conducting the additional examination to assess mental capacity be guided by the fundamental rules of good practice. Most significant of these is the interview about the recommended treatment conducted with the patient. It implies asking questions to clarify whether the patient understands what he/she is refusing and whether he/she can provide an explanation for the refusal. The doctor would next ask questions to assess the mental state (and disorders) and functions such as thinking and rational reasoning to make sure that the patient understands recommendations and to identify reasons (motives) for the consent to, or refusal of treatment. Naturally, all this should be put into the context of the patient's overall health status, as sudden physiological or neurological disorders can alter the patient's psychological functioning, which may have been intact prior to illness, treatment or even during a part of the treatment. As medical practice abounds in such situations, it should be taken into consideration in case of refusal of treatment. What we lack, however, in this part of the world are relevant studies which might indicate the frequency of these situations and the problems related to them, so that the solutions to potential clinical problems could be found.

The foregoing suggests that the basic assessment of mental capacity in the patient's refusal of medical treatment should comprise: valid medical assessment of the patient's overall health status, in accordance with the rules of medical profession and in relation to adequate mental functioning; focused interview with the patient about the suggested medical treatment to establish whether the patient understands the nature of treatment, its purpose and risks in case of refusal, its potential complications and side effects, as well as to make sure that he/she is capable of making an adequate decision, as an act of volition.

If these are conducted in a conscientious, medically adequate manner, majority of assessments will be done *lege artis*, efficiently and competently.

In situations when the treating doctor does not clearly understand the circumstances of assessment, certain structured methods can be applied, including the following: the Guidelines (directives) of the Association Suisse des Sciences Médicales (ASSM) which recommend the assessment of following capacities: the capacity to understand information about the suggested treatment; capacity to correctly evaluate the situation and the consequences of alternative solutions by comparing their risks and benefits; capacity to rationally evaluate obtained information applying coherent set of values; capacity to communicate his/her choice. It should be emphasized that these criteria are useful and systematic and they are also applied in procedures described above. Therefore, they are part of the subjective assessment of the examiner and not a structured questionnaire. Using the verified and standardized tests and questionnaires which enable rough assessment of mental state (being more objective than those resulting from the interview). It is our opinion that these tests can be applied by any doctor. The question is whether he/she would do it every time, which depends on the patient's mental state as observed during clinical examination.

In Serbia, most frequently used is the Mini-Mental State Examination (MMSE) [35], which can be applied by medical professionals other than psychiatrists, to determine whether there is a mental change in the patient who refuses medical treatment. If the score on this scale is such to indicate a significant cognitive damage, it is our opinion that this is an indicator requiring a consultation with a psychiatrist, except in cases where the urgency of the intervention and its life-saving nature make it technically impossible.

Needless to say, the MMSE is not the only diagnostic instrument to recognize psychologically altered states, especially when it comes to cognitive and volitional aspect of the patient's personality. The Montreal Cognitive Assessment (MoCA) [36], the Sheffield questionnaire [37] and other tests are also widely used. Although these tests are useful, it is often emphasized that nothing can replace the individual assessment conducted by a doctor [10].

Who should conduct an assessment and in which cases?

There are variety of factors influencing how to conduct the assessment. Primarily, the question is whether the patient's awareness of potential consequences of a decision to consent to or refuse the treatment must play part in capacity assessment. In other words, does the mental capacity level required in the given case vary depending on the potential consequences of a decision, as suggested in a ruling of an English court: "What matters is that the doctors should consider whether at that time he had a capacity which was commensurate with the gravity of the decision. The more serious the decision, the greater the capacity required" (Re T [1992] 4 All E.R. 649) [28].

More precisely, a person can be capable of making decision about taking analgesics, yet incapable of deciding about a complicated and risky surgery [16]. Consequently, different capacity will be required when a high-risk medical treatment is to be administered, or when life-saving or life-sustaining treatment is refused. In the former case, the patient must possess the highest level of mental capacity and be able to explain his/her choice applying his/her own set of values [38]. In the latter case, it is sufficient for the patient to be able to understand the presented information in order to be considered mentally capable. To accept proportionality between the gravity of the recommended medical treatment and the degree of mental capacity seems easily defensible, but there are certain apprehensions. Some authors suggest that there is a point where proportionality stops while in some extreme situations a patient's wishes can be met regardless of his/her mental capacity [38].

Considering the foregoing discussion, in order to help those performing assessment decide whether they are entitled to do it, we tentatively propose a procedure which, in our opinion, should be incorporated into the existing regulations [40]. It is as follows: If a medical treatment implies administering procedures that do not threaten physical integrity (e.g., medication-taking, noninvasive diagnostics, noninvasive physical therapy, etc.) and/or can have mild side-effects, it is sufficient that the treating doctor assess the patient's mental capacity and make a record of it. Even when there are the observable psychiatric symptoms, whose quality and/or prominence is such that they do not violate this capacity, it is not necessary to consult a psychiatrist, although other medical professionals from the same health-care institution may be consulted (but do not have to) and involved into the assessment. Sometimes the medical treatment violates the patient's physical integrity, but does not present a serious risk to patient's health. In that case, if the patient's life is not at risk, or if he/she is not classified as a 'serious' patient, the assessment needs to be necessarily performed by an in-house consulting expert body if the suggested treatment is refused. If the expert body identifies psychiatric symptoms, or expresses doubt about the patient's psychological state, the consultative assessment of a psychiatrist is required. When recommended diagnostics and medical treatment seriously violate a patient's physical integrity, or when medical treatment is to be given to a patient whose life is at risk and who is classified as a 'very serious' patient, and the patient refuses treatment, we propose that the psychiatric assessment evaluate the patient's mental capacity regarding the treatment. This is to eliminate potential situations where the treating doctor has doubts about the patient's mental status and capacity, and thus loses precious time, since such a standardized procedure would present practical assistance to the treating doctor.

Undoubtedly, there would be situations where some necessary, especially technical requirements could not be met, but this is expected to happen less frequently. If our recommendations are inapplicable, there is always the clinical method of assessment: an adequate, conscientious, comprehensive examination. Only *lege artis* medical procedure [41] can create the preconditions for the objective assessment of mental capacity.

Conclusion

If the patient understands presented information about the recommended medical treatment, correctly evaluates consequences of his/her choice weighing risks and benefits, he/she can be deemed to have the mental capacity to decide whether to consent to treatment. The weight of potential consequences of the suggested treatment determines the necessary capacity level in each individual case of assessment. In some cases, assessment can be conducted by the treating doctor, while in case where medical treatment with serious potential consequences is to be administered, especially if the patient refuses life-saving treatment, the assessment should be conducted by medical teams, sometimes consisting exclusively of psychiatrists. The assessment implies structured clinical approach, based on a doctor's personal assessment as well as on the standardized procedure. To avoid potential consequences both for the patients and the doctors in case of inaccurate assessment of this capacity, certain standardization of assessment procedure should be adopted.

Acknowledgements

This work was supported by the Ministry of Education, Science and Technological Development of the Republic of Serbia, through Contract No. 179046.

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Received on October 26, 2017.
Revised on November 24, 2017.
Accepted on December 13, 2017.
Online First December, 2017.