Assessment of Decisional Capacity

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Introduction

- Epidemiology in Geriatric Patient Population
- Informed Consent
- Competency and Capacity
- Right to Refuse Treatment
- Clinical Case
Introduction

- 12% of the population or 30 million Americans are over the age of 65
- Occupies about 30% of all acute hospital beds
- Consumes about 30% of all expenditures for health care
- Over the next 30 years demand for hospital care will likely triple

U.S. Bureau of the Census 1987; U.S. Senate Special Committee on Aging 1984
Introduction

- Studies of the hospitalized elderly found the prevalence of psychiatric problems to range from 27% to 55% (Lipowsky 1983; Rabins et al. 1983; Rapp et al. 1988)

- Retrospective study of 102 men older than age 65 years
  - admitted to the medical wards of a VA hospital
  - found 27% prevalence of mental disorders (Rapp et al. 1991)
Clinical Implications

- Elderly patients have multiple medical comorbidities that lead to psychiatric symptoms
- Depression and mania can present in an atypical fashion (Goldberg 1989)
- Hospital environment
- Psychosocial stressors lead to regression, maladaptive behaviors
  - Loss of autonomy/independent functioning
  - Loss of loved one
Informed Consent

- Informed consent
  - A process by which the patient agrees to treatment, based upon adequate information
  - Voluntarily given by the patient who is competent to do so
  - Informed refusal is as important as informed consent

- Fundamental Principle:
  - It is the patient, not the physician, who makes the ultimate choice regarding treatment.
Informed Consent

- Required before the initiation of a specific medical treatment

- Exceptions
  - Patient waives the right to receive information
  - Patient is deemed incompetent/incapacitated
  - Delay would threaten the well-being of the patient (e.g., life or limb)
    - Physician uses “best judgment” and acts in “good faith”
Informed Consent

- Therapeutic Privilege
  - Providing the information needed for informed consent may cause the patient’s physical or mental health to deteriorate
  - Physician who invokes therapeutic privilege does so at his/her own risk
  - “mainstay of medical paternalism”
    - Patients treated for carcinoma not told of diagnosis
    - It is rarely justified
Informed Consent

- Two basic standards for informed consent
  - Professional Standard
  - Patient-Oriented Standard
Informed Consent

Professional Standard

- Physician provides information that the average physician in that specialty would provide under the circumstances
- Looks to the standard of care
Informed Consent

- Patient-oriented Standard
  - Information to be provided is determined by what the patient would require to make an informed decision (e.g., “materiality standard”)
Informed Consent

- Requirements for materiality standard
  - Diagnosis and condition being treated
  - Nature of proposed treatment
  - Nature and probability of the material risks of the treatment
  - Benefits that may be expected from the treatment
  - Inability of the physician to predict results
  - Irreversibility of the procedure (in specific cases)
  - Likely results of foregoing treatment
  - Likely results, risks and benefits of alternative treatment
Informed Consent

- Second requirement: VOLUNTARY
- Coercion, even in the best interest of the patient is unethical and does not qualify as voluntary
  - Negative contingency
    - Unethical and Invalid
Competency & Capacity

- The Uniform Probate Code defines a mentally incapacitated person as:

  "One who is impaired by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication or other abuse to the extent that he/she lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person"
Competency

- The legal capacity of an individual to perform either a specific function or wide range of functions
- Judge determines competency
- Task specific and defined in relation to a specific act
Competency & Capacity

- Competency for one act does not presume competency to perform another
- Specific Acts
  - Make a will (testamentary capacity)
  - Testify in court (testimonial capacity)
  - Consent or refuse treatment (decision-making capacity)
Competency & Capacity

- Psychiatric consultant to make a clinical assessment of the patient’s capacity to function in certain areas.
- Consultant must determine the specific type of competency in question.
Competency & Capacity

- Appelbaum and Grisso’s criteria
  - Does the patient manifest a *preference*?
  - Is the patient capable of attaining a *factual understanding* of the situation?
  - Does the patient have *appreciation* of the *significance* of the facts presented?
  - Is the patient able to use the information presented in a *rational fashion*?
Competency & Capacity

- **Preference**...
  - If unable or unwilling to express a preference
  - Does not follow that a patient who expresses a choice is capacitated
Competency and Capacity

- **Factual Understanding...**
  - Nature of the illness
  - Treatment options
  - Prognosis with and without treatment
  - Risks and benefits of treatment

*Hamish v. Children’s Hospital Medical Center, 387 Mass 152, 439 NE 2d 240 1982*
Competency & Capacity

- **Appreciation of the Significance...**
  - In contrast to factual understanding
  - Broader level of understanding
  - Implication facts hold for the patient’s future
Rational, logical fashion...
- Focus is not on the rationality of the ultimate decision
- Focus on the rationality of *thought process*
Competency & Capacity

- Criteria for substitute decision-maker
  - Express the patient’s choice
  - Awareness of facts
  - Appreciation of significance
  - Thinking logically and rationally about decision
Competency & Capacity

- Not an all-or-nothing phenomenon
- Same level of competence not required for all medical decisions
- Sliding-Scale for level of competence
  - Strictness varies as the risk/benefit ratio changes
The more favorable risk/benefit ratio to patient
- Lower the standard for competence to consent
- Higher the standard for competence to refuse

The less favorable risk/benefit ratio to the patient
- Refusal not challenged as meticulously

Competency & Capacity

- Sliding-Scale approach
  - Criticized as open to manipulation by “paternalistic physician”
  - Ensures that patients make a truly informed decision based on a rational and logical process

Right to Refuse Treatment

- Based on philosophical principle of autonomy
- Right is not absolute
- May be limited when in conflict with
  - Preserving life
  - Preventing suicide

Wear AN, Brahams D: To treat or not to treat: the legal, ethical and therapeutic implications of treatment refusal, *J Medical Ethics* 17:131-135, 1991
Right to Refuse Treatment

- Decision by a competent patient presents a challenging clinical and ethical dilemma
- Competent patient’s preference is rarely denied, in a court of law
- Wishes of the patient expressed when competent take precedence
  - Honored after the onset of incompetence
  - Cultural/Religious principles
Right to Refuse Treatment

- Exceptions to right to refuse treatment
  - Medical Emergencies
  - Acute situations threatening safety of staff and other patients
  - Physician may act in “good faith” while administering treatment
    - Doubtful when the patient has indicated preferences regarding treatment before the emergency
Leaving Treatment AMA

- Right of any competent, non-consenting patient
- A *capacitated* patient who does not pose risk to self or others, cannot be held against their will

Clinical Implications

Psychiatric Disorders Leading to Incapacitation

- Progressive Dementias
- Delirium (temporary)
- Mood Disorders/Psychotic Disorders
Clinical Case

- The patient is a 66 year-old African-American male, with a medical history significant for Diabetes Mellitus, Hypertension, Right Hallux Chronic Osteomyelitis and ulceration who was admitted due to possible osteomyelitis.

- The patient has a history of SCPT, chronic.

- Please evaluate for decisional capacity
Clinical Case

Questions
- Decisional capacity to consent to what medical intervention?
  - Refusal of IV antibiotics
- What are the implications of Axis I Psychopathology?

Psychiatric consultant to make a clinical assessment of the patient’s capacity to function in certain areas
Clinical Case

Assessment of Capacity

- Does the patient manifest a preference?
- Is the patient capable of attaining a factual understanding of the situation?
- Does the patient have appreciation of the significance of the facts presented?
- Is the patient able to use the information presented in a rational fashion?
Clinical Case

- One week later, Psychiatry is re-consulted to assess for decisional capacity.
Clinical Case

- **Questions**
  - Decisional capacity to consent to what medical intervention?
    - Refusal of amputation of R 1st Metatarsal
  - Wishes when competent take precedence
  - What are the implications of Axis I Psychopathology?
  - Patient was already seen, why are we called to for a re-assessment?
    - Fluctuant course
Clinical Case

Assessment of Decisional Capacity

- Does the patient manifest a preference?
- Is the patient capable of attaining a factual understanding of the situation?
- Does the patient have appreciation of the significance of the facts presented?
- Is the patient able to use the information presented in a rational fashion?
Clinical Case

- Same level of competence not required for all medical decisions
- Sliding-Scale for level of competence
  - Strictness varies as the risk/benefit ratio changes
Clinical Case

- Patient is incapacitated to consent/refuse surgical procedure
- Proxy is assigned
- Criteria for substitute decision-maker
  - Express the patient’s choice
  - Awareness of facts
  - Appreciation of significance
  - Thinking logically and rationally about decision
Clinical Case

- Agitation and Aggression on Medical Floor
- Patient is started on neuroleptic medicines
  - IM doses given for PO doses refused