Assessing Decision Making Capacity

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Objectives

• Define Decision Making Capacity
• Identify the Four Components of Capacity
• Understand Ethical Challenges of Decision Making Capacity

Capacities, not Capacity

• Health Care (medical decision making; activation of DPOA-HC)
• Financial
• Independent Living
• Driving

Decision Making Capacity Defined

• The necessary *cognitive* and *functional* abilities a person must possess to complete a specific task or make a specific decision.

Some things about capacity

• Task specific not global
• Can fluctuate
• Can recover
• Is situational and contextual

Capacity vs Competency

• Capacity = clinical (historically)
• Competency = legal
• But now, capacity used legally because of the law’s interest in capacities rather than all or none
• Legal capacity vs clinical capacity
  • Assessments of decision making capacity conducted by clinicians
  • Determination of competence is legal judgment left to courts (judge determines legal capacity)
Capacity assessment different from psychological assessment

- More up-front inquiry
- Modify informed consent process (slower, more discussion of potential risks)
- Add functional assessment
- Outcome is a clinical judgment—not a test interpretation, weighing of ethical factors

Elements of Capacity

- Understand
- Appreciate
- Reason
- Express a Choice


Capacity questions

- Is there a reason to suspect that capacity is compromised?
- Complexity – How complex is the capacity question?
- Urgency – How quickly is an answer needed?
- Risk – How much risk is the person confronting?
- Environment – What resources are (potentially) available?

Decisional Capacity

- Interview (orientation, expressive and receptive language, ability to learn new information, executive functioning)
- Collateral information (review of records; discussions with caregivers, family, medical team, staff)
- Brief cognitive assessment (MMSE, Trails, Clock Draw, Reasoning and Judgment Section of the COGNISTAT, Animal Fluency, etc.)

Consent Capacity Instruments

- Vignette approach
  - e.g. Capacity to Consent to Treatment Instrument (CCTI), Hopemont Capacity Assessment Interview (HCAI)
- Semi-structured interview approach
  - e.g. MacArthur Competence Assessment Tool for Treatment (MacCAT-T)

Assessing patient’s understanding of medical condition and treatment

- Most pressing medical problem
- History of how patient arrived from curative to palliative treatment
- Where are you?
- Additional medical problems
- Expected outcome of medical problems
- Current treatments (risks/benefits)
- The effects of discontinuing treatments
- Consideration of other options
Assessing patient’s understanding...

- Reasons for choosing a particular treatment option
- How patient obtains help when needed (e.g. request for pain meds)
- Family/individual values and beliefs about health care decisions
- Assess depression/anxiety and other psychiatric symptoms (GDS-15, GAD-7)

Introduction

- Purpose of interview, framing it as a consultation and discussion.
- Describe what I believe is the patient’s medical problem and possible course of treatment and we will discuss the patient’s understanding of the information.

Understanding

- **Grasp the fundamental meaning of information communicated by clinician.**
  - “Tell me about your health problem.”
  - “What is the recommended treatment or course of action?”
  - “Tell me what will happen if we don’t treat the problem, if we just let it go.”

Appreciating

- **Acknowledge medical condition and likely consequences of treatment options.**
  - “What do you think is wrong with your health now?”
  - “What are the risks/benefits of no treatment?”
  - “Why do you think your PCP (or other health care provider) has recommended this treatment?”
  - “Now that is what your doctors think is the problem in your case. If you have any reason to doubt that, I’d like to you to tell me so. What do you think?”

Appreciating......continued...

- If patient disagrees with diagnosis or features of the disorder, must determine through discussion the basis of the disbelief. It is easily modified or rigidly held?
  - Both acknowledgement and non-acknowledgement may occur on basis of illogical, bizarre, or delusional ideas
  - May be based on experiences that logically lead to the conclusion (e.g. patients have received different diagnoses for the same symptoms during past medical consultations).
  - Commonly held belief in certain religious or cultural groups with which patient is associated with and in that social context, the belief may not be illogical, bizarre, or delusional.

Appreciating --- Treatment

- **Risks/Benefits of treatment**
  - Determine whether (a) patient acknowledges that the proposed treatment might be to some benefit and if not, (b) patient’s explanations and reasons for disbelieving that treatment might have some benefit for his/her own situation.
  - Not the purpose to determine whether patient is accepting of the treatment or that they speak favorably of it.
  - Purpose is to determine whether patient is unwilling even to consider (acknowledge the possibility of) the treatment because of confused, delusional, or affective states related to mental disorder
Reasoning

- Engage in a rational process of manipulating the relevant information.
- “How did you decide to accept or reject the recommendation?”
- “What makes your choice better than another option?”

Expressing a Choice

- Clearly indicate preferred treatment option.
  - Is person able to translate medical circumstances of the disorder and treatment (e.g., symptoms, benefits, and risks of treatment) into their practical, everyday consequences (e.g., effect on work, recreation, interpersonal relations).
  - “We talked about some of the possible benefits and risks or discomforts of (preferred treatment). What are some ways that these might influence your everyday activities at home or work? Now let’s consider other treatment option or no option. What are some ways that the outcome of that option might influence your everyday activities at home or work?”

Expressing a Choice....

- “When we started this discussion you favored (treatment). What do you think now that we have discussed everything?”
- “What did you decide to do?”
- Consider whether choice follows logically from the patient’s previous reasoning and generated consequences. Probe more if inconsistencies.

Making the Judgment

- Does this person have sufficient ability to make a meaningful decision given the circumstances with which he/she is faced?
  - Balance competing ethical principles
    - Justice, Autonomy, Beneficence, Non-maleficence
    - Guard against paternalism (historical relationship between doctor/patient)

Ethical Considerations

- Weigh autonomy against patient protection (former gets more weight)
- Persons are presumed to have capacity; burden of proving otherwise rests on those who would overturn a patient’s decision.
- People have the right to make bad decisions.
- Someone may have some disabilities, but may also be able to compensate.
- Sensitivity to diversity in race, ethnicity, religion, age generational cohort, or other factors essential.
- Don’t rush to make a determination; consider re-assessing later

Ten Myths About Decision Making Capacity

- Myth 1: Decision making capacity and legal competency are the same.
- Myth 2: Lack of decision making capacity can be presumed when patients go against medical advice.
- Myth 3: There is no need to assess decision making capacity unless patients go against medical advice.
- Myth 4: Decision making capacity is “all or nothing” phenomenon.
- Myth 5: Cognitive impairment equals lack of decision making capacity.
Ten Myths......continued

• Myth 6: Lack of decision making capacity is a permanent condition.
• Myth 7: Patients who have not been given relevant and consistent information about their treatment lack decision making capacity.
• Myth 8: Patients with certain psychiatric disorders lack decision making capacity.
• Myth 9: Patients who are involuntarily committed lack decision making capacity.
• Myth 10: Only mental health experts can assess decision making capacity.


Case Presentation—Mrs. Jones

• 72 year old African American female. She is a retired teacher with a daughter who lives in town and a daughter who lives out of state. Mrs. Jones has adult grandchildren who visit her as well. She is a widow who has lived independently for over 10 years. Her medical history is significant for HTN and A-fib. She is medically frail and also diagnosed with mild dementia. In discussions with her children, they said historically she is very capable and knows when to ask for help. In addition, she has no interest in moving from her home.

• Question: live at home safely? manage meds?

Case Presentation – Mr. Smith

• 70 year old Caucasian male who lives alone. He has 3 children and 5 grandchildren. He is dependent in transportation, requires assistance with shopping, meal prep, med management, and housekeeping, but he is independent in all ADLs. Medical history significant for CHF, COPD, Diabetes, bladder cancer, CKD stage 4, and MCI. His Chronic Kidney Disease has progressed and he will need dialysis.

• Question: Understanding of dialysis vs hospice

References