DETERMINING CAPACITY IN THE ELDERLY

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DISCLOSURE

Dr. Bronsther has nothing to disclose.

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LEARNING OBJECTIVES

At the conclusions of this presentation, the learner will be able to:

- Recognize that competent people have a right to make poor decisions.
- Gain an understanding about why people may lose medical decision-making capacity.
- Become better equipped to make determinations about patient's capacity.

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PRE-TEST QUESTIONS

Please answer the questions as they appear on your screen.

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Table 1.

Table 1. **Principles That Guide the ACP Ethics Manual Recommendations**

Principle	Description
Beneficence	The duty to promote good and act in the best interest of the patient and the health of society
Nonmaleficence	The duty to do no harm to patients
Respect for patient autonomy	The duty to protect and foster a patient's free, uncoerced choices
Justice	The equitable distribution of the life-enhancing opportunities afforded by health care

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Components of Informed Consent

- Disclosure of information - benefits/risks and the likelihood of those outcomes, any alternatives
- Comprehension of the information
- Voluntariness (no coercion)
- Capacity to consent

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3 D's of Geriatric Psychiatry

	TIMING	ATTENTION SPAN	PSYCHOTIC FEATURES?	COURSE
DELIRIUM	Hours to days	Decreased	FREQUENT Auditory, visual and tactile hallucinations most common	Fluctuating, may be worse at night
DEPRESSION	Weeks to months	May seem decreased due to lack of effort	RARE Auditory hallucinations Paranoia Delusions	May be worse in the morning
DEMENTIA	Months to years	Normal until the very end stages of disease	ALL DEMENTIA PATIENTS MAY DEVELOP PSYCHOSIS Paranoid delusions most common	Insidious, Progressive

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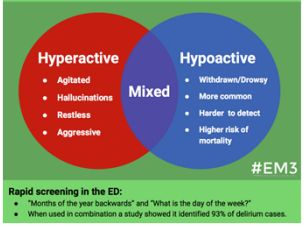
Recognising Delirium in the ED

"Acute onset and fluctuating course of disturbance in attention, level of arousal, and other aspects of mental status"



Rapid screening in the ED:
- "Months of the year backwards" and "What is the day of the week?"
- When used in combination a study showed it identified 93% of delirium cases.

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Capacity vs. Competency

- Medical decision-making capacity = ability to consent to a specific medical decision (medical setting)
  - Capacity is fluid and can change over time.
- Competency = a legal definition that applies more to global capacity (court)

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Competency = Global Capacity

- All children <18y/o unemancipated minors lack competence.

- Adults who lack competence require a legally appointed guardian.

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Prevalence of Incapacity

for at least some medical decisions

- Up to 50% of patients hospitalized schizophrenics with an acute episode of psychosis.
- 20-25% of patients admitted with severe depression.
- 2.8% (1.7%-3.9%) in healthy elderly patients.
- 20% (14%-26%) in those with mild cognitive impairment.
- 26% (18%-35%) of adult medical inpatients.
- 54% (28%-79%) in those with Alzheimer disease.

- Grisso T, Appelbaum PS. The MacArthur Treatment Competence Study. III. Abilities of patients to consent to psychiatric and medical treatments. Law Hum Behav 1995;19:149-174
- Simel, D. and Rennie, D. The Rational Clinical Examination: Evidence-Based Clinical Diagnosis. Chapter: "Make the Diagnosis: Medical Decision-Making Capacity Prior Probability" 2009.

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Who can assess capacity?

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Who can assess capacity?

- All medical providers informally assess this every time you obtain a consent.
- All providers can formally assess capacity.

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Criteria for Determining Decision-making Capacity

Table 1. Legally Relevant Criteria for Decision-Making Capacity and Approaches to Assessment of the Patient.

Criterion	Patient's Task	Physician's Assessment Approach	Questions for Clinical Assessment*	Comments
Communicate a choice	Clearly indicate preferred treatment option	Ask patient to indicate a treatment choice	Have you decided whether to follow your doctor's [or my] recommendation for treatment? Can you tell me what that decision is? [If no decision] What is making it hard for you to decide?	Frequent reversals of choice because of psychiatric or neurologic conditions may indicate lack of capacity
Understand the relevant information	Grasp the fundamental meaning of information communicated by physician	Encourage patient to paraphrase disclosed information regarding medical condition and treatment	Please tell me in your own words what your doctor [or I] told you about: The problem with your health now The recommended treatment The possible benefits and risks (or discomforts) of the treatment Any alternative treatments and their risks and benefits The risks and benefits of no treatment	Information to be understood includes nature of patient's condition, nature and purpose of proposed treatment, possible benefits and risks of that treatment, and alternative approaches (including no treatment) and their benefits and risks
Appreciate the situation and its consequences	Acknowledge medical condition and likely consequences of treatment options	Ask patient to describe views of medical condition, proposed treatment, and likely outcomes	What do you believe is wrong with your health now? Do you believe that you need some kind of treatment? What is treatment likely to do for you? What makes you believe it will have that effect? What do you believe will happen if you are not treated? Why do you think your doctor has [or I have] recommended this treatment?	Courts have recognized that patients who do not acknowledge their illnesses (often referred to as "lack of insight") cannot make informed decisions about treatment Delusions or pathologic levels of distortion or denial are the most common causes of impairment
Reason about treatment options	Engage in a rational process of manipulating the relevant information	Ask patient to compare treatment options and consequences and to offer reasons for selection of option	How did you decide to accept or reject the recommended treatment? What makes [chosen option] better than [alternative option]?	This criterion focuses on the process by which a decision is reached, not the outcome of the patient's choice, since patients have the right to make "unreasonable" choices

* Questions are adapted from Grisso and Appelbaum.[9] Patients' responses to these questions need not be verbal.

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'Communicate a choice.'

- "Clearly indicate preferred treatment option"
- (with reasonable stability of choice)

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'Understand the relevant information.'

- "Grasp the fundamental meaning of information communicated by the physician."

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'Appreciate the situation and its consequences.'

- "Acknowledge medical condition and likely consequences of treatment options"

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'Reason about treatment options'

- "Engage in a rational process of manipulating the relevant information"

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Case examples

- Do these patients have capacity?
  - Yes?
  - No?
  - Need more info

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Case #1: 86 y/o F with mild cognitive impairment who lives alone and is insisting on signing out of the hospital against medical advice.

- The nurse tells you she was agitated last night.
- She is being treated for pneumonia with a parapneumonic effusion and has a chest tube, and is receiving IV antibiotics.
- Risks and benefits of leaving the hospital are discussed and her response is "I need to get home to feed my cat and that nurse is trying to poison me. I know I have pneumonia; I will drink some tea and be fine."

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Question…

Zoom poll

- Does this patient have capacity?
  - Yes?
  - No?
  - Need more info

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She LACKS capacity.

- She is likely experiencing an acute delirium which is causing her to lack understanding of the situation.

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Case #2: 71 y/o F with PVD admitted with gangrene of the three middle toes of her L foot.

- Risks and benefits of amputation of the toes are explained to the patient.
- Patient recounts everything she is told and refuses the surgery.
- When asked why, she says that the doctors are mistaken about the nature of her condition.
- She states that her toes are dirty because she cannot reach to wash them.
- Even after washing her toes, she still refuses the surgery as she maintains "they are simply dirty".

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Question…

Zoom poll

- Does this patient have capacity?
  - Yes?
  - No?
  - Need more info

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She LACKS capacity

- She lacks APPRECIATION of how the decision applies to her.

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Case #3: 89 y/o M with CAD, HTN, depression and dementia presents with chest pain. He is diagnosed with a STEMI.

- Cardiology explains risks/benefits and wants to do a cardiac catheterization with possible revascularization for an acute STEMI, which he declines.
- He tells you he is having a heart attack which can kill someone. You ask him to tell you in his own words about it. He says, "You want to clean out the old pipes or something."

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Case #3: *continued*

- When asked why he is refusing he raises his voice and swats you away and says, "Listen Missy, I don't need anything fancy! I know my heart is sick, I don't need some resident slipping up and I bleed everywhere and you're not putting me on no kidney machine! I will take my chances with some aspirin!"

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Question…

Zoom poll

- Does this patient have capacity?
  - Yes?
  - No?
  - Need more info

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He HAS capacity.

- He understands a heart attack can kill him and appreciates that he is having one.
- He understands a cardiac cath means "cleaning out the old pipes".
- When asked why he is refusing, he gets frustrated, and slightly aggressive, which may be related to underlying dementia or depression, but he is able to state that his heart is sick, but, in his own words expresses that he does not want to take the risk of hemorrhaging or going into contrast-induced kidney failure.

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What happens when a patient lacks capacity?

- Best case — If possible, treat what may be causing impaired decision making.
- OR, someone must decide on their behalf
  - HCPOA, spouse (unless petitioned for divorce), adult children, parents, adult grandchild, adult niece or nephew, adult aunt or uncle, close friend.

https://www.americanbar.org/content/dam/aba/administrative/law_aging/2014_default_surrogate_consent_statutes.authcheckdam.pdf

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'Principle of Proportionality'

- The consequences of the decision affect the threshold for capacity.
- Many object to this "sliding scale" approach, but it has been endorsed by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research

Appelbaum, P., "Assessment of Patients' Competence to Consent to Treatment" *N Engl J Med* 2007; 357:1834-1840
Image courtesy of psychiatrictimes.com

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Standardized tools

Tool	Validated populations	Length to administer	Strengths	Limitations
MacCAT-T	Dementia, depression, schizophrenia	15-20 minutes	Broadly validated, well-established	Requires formal training, does not specify a passing score
CCTI	Dementia	20-25 minutes	Standardized format	Vignettes are hypothetical, might not be applicable to a specific clinical decision
MMSE	Dementia, delirium, psychosis	10-15 minutes	For most, requires no additional training, can give rapid information at the extremes of scores	Psychosis under-represented in the validation study, does not address informed consent
HCAI	Dementia, nursing home residents	30-60 minutes	Might be good for screening	Length, poor performance of reasoning and appreciation assessments

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Summary

- The "3 D's" (delirium, depression, and dementia) may affect one's ability to make decisions on their own behalf.
- The four elements of capacity are: communicate, understand, appreciate and reason.
- Autonomy is one of the four guiding ethical principles by which we practice medicine.

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POST-TEST QUESTIONS

Please answer the questions as they appear on your screen.

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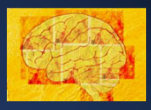

THANK YOU

QUESTIONS & DISCUSSION

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