Decisional Capacity for Hospitalists

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Disclosures

- Presenter has no conflicts to disclose

Objectives

- Define competence and capacity
- Understand components of a capacity assessment
- Identify ways to address assessment refusal
- Know how cognitive test score relates to capacity status
- Determine when to involve outside consultants

What is capacity?

- Decisional capacity refers to the patient's **ability to understand and appreciate information** required to make a treatment decision
- **Specific** to a treatment decision or situation
- Patients may have capacity for some decisions but not for others

Mr S is a 77yo…

- …Man with diagnoses that include CAD, HTN, ischemic stroke, DJD, MDD
- Admitted x 22 days following fall at home
- Lives independently, son and daughter visit daily
- "Dad needs more help than we can give him."
- Patient is insistent on discharging home, "you can't keep me here"

When is capacity assessment needed?

- All patients are presumed to have capacity unless proven otherwise
- Patients very frequently consent to treatment when they do not understand benefits or risks
- Impractical to formally assess capacity for every patient
- Depends on circumstance and context:
  - Concern for cognitive issue or psychiatric issue impairing?
  - Are risks with procedure unusually high, compared with benefits?
  - Is risk of *refusing* procedure unusually high, compared with risk of consenting?

Competence (*it's complicated*)

- Legal not clinical determination
- Question that is answered by guardianship hearing
- In actual practice, terminology overlaps
- Competence = "legal capacity"
- Capacity = "clinical competence"

Components of capacity assessment

- **Understanding**
- **Appreciation**
- **Reasoning**
- **Communication**

- Situation
- Proposed treatment/decision
- Indication
- Benefits
- Risks
- Alternatives

Pre-assessment

- Chart review
- Discussion with team members
- Review of cognitive testing, PT/OT/SLP assessments

Pre-assessment

- Is the patient at cognitive baseline and awake/alert/interactive?
- Educational/occupational achievement?
- Is there evidence for delirium or cognitive impairment?
  - Is there an MMSE/MOCA/SLUMS documented?
- Is there any evidence of or concern for a psychiatric condition?
- Has the patient received adequate PARQ counseling?
- If discharge decision – has PT/OT assessed and provided a LOC recommendation?
- Is there an advance directive, DPOA, family or a decisional surrogate?
- If non-English speaking, should you use an interpreter?

Pre-assessment

- Identification of and review of any past capacity assessments/determinations
  - With notable caveat

Understanding

- Can the patient comprehend the information provided about their medical condition, treatment options, risks, benefits, and potential consequences?

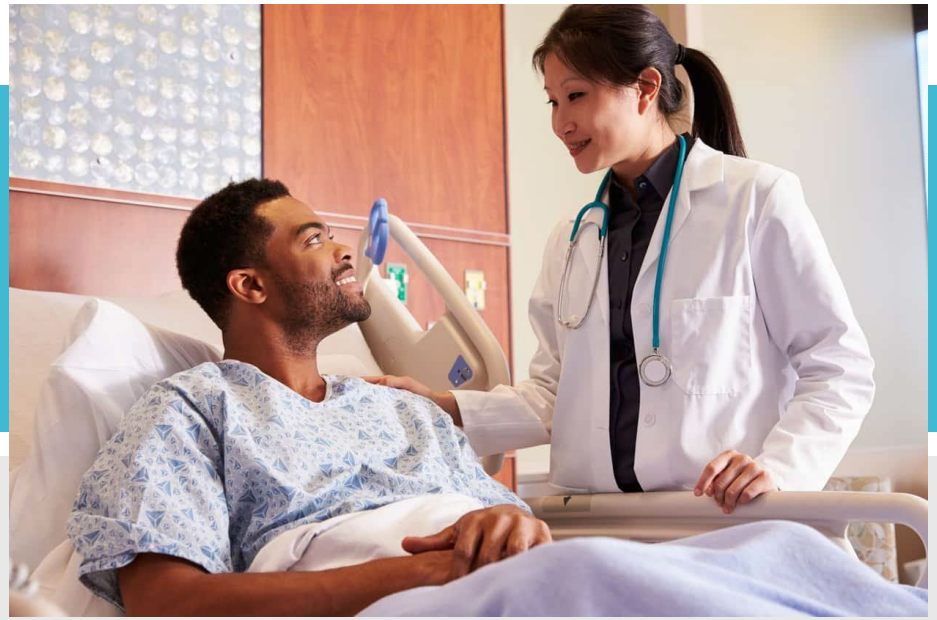
Appreciation

- Does the patient grasp the nature and severity of their illness or medical condition, as well as the potential outcomes if they accept or refuse treatment?
  - *Do they know how it applies to them?*

Reasoning

- Can the patient think rationally and weigh the pros and cons of different treatment options, taking into account their personal values and beliefs?
  - *Will depend on health literacy, experience with health care system, educational achievement*

Communication

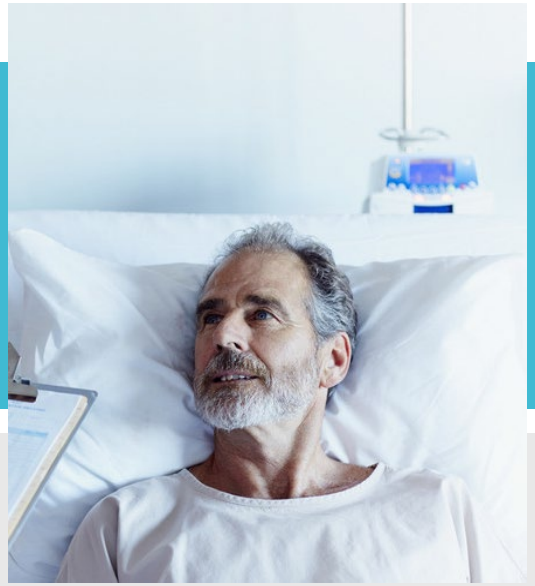


- Is the patient able to express a clear and consistent choice regarding the treatment decision?
  - *Is the decision stable over time?*

Mr S

- *Appreciation*
- "Can you tell me some more about your medical issues?"
- "Sure. I've had a hip replaced, I know if have a heart problem… hypertension, I had a stroke a couple years back…"
- "…you know, I'm not sure I like where this is headed, I don't think I want to answer any more questions."

Mr S



- *Understanding*
- "Can you tell me why you came to this facility, in your own words?"
- "I'm not sure, but I think… I must have had a fall, a pretty bad one."

Complications

- Patients commonly decline to participate in capacity assessments
- Refusal to engage in assessment should not be interpreted as showing lack of capacity

Reasons for refusal

- Distrust of care providers
- Fear of loss of autonomy
- Worry that cognitive deficits will be uncovered
- Pain/physical distress
- Poor health literacy/sophistication
- Underlying psychiatric condition especially psychotic-spectrum

Addressing refusal

- Build trust and rapport from the beginning
- Ensure physical needs are met
- Explain role and purpose of assessment
- Switch gears
- Assess for concerns
- Ask permission to return another time

Mr S

- "I apologize Mr S, I don't think I explained the purpose of this assessment. I'm a provider working with your care team, and we are trying to determine your understanding of your treatment plan and your safety to leave the hospital."
- "Well, I guess that makes sense. Who did you say you are again?"
- I'm Dr Z, I'm a psychiatrist who works in the hospital. I see patients like you who are facing some medical decisions, to try to figure out how to make sure your voice is heard."

Mr S

- Provider knows from reviewing chart that:
  - SLUMS score 26/30 two weeks prior
  - PT assessment states "up with one person assist, independent w FWW, 24 hour supervision recommended"
  - On escitalopram 10mg daily for MDD, in partial remission
  - No DPOA paperwork in chart
  - Discharge note from last year: "…while concerns were raised for the patient's quality of decision-making, he was determined by myself and other members of the care team to have capacity to make discharge decisions."

Mr S

- "I guess that's OK, I'm not sure why I need a psychiatrist though, I'm not crazy"
- "Of course, I work as sort of a cognitive specialist, to figure out if people can make safe decisions."
- "Well let's get going, what else do you need to ask me?"

Reasoning

- "It sounds like your doctors are concerned about you going home. Why is that important to you?"
- "I've always lived on my own, I don't want someone else in my business. Being independent is the most important thing to me."

Risk

- Does the patient understand and appreciate:
  - Potential adverse outcomes
  - Likelihood of outcome
  - Options for mitigating risk
  - How they would proceed if negative outcome occurs

Risk

- "Why are your doctors concerned about you going home?
- "[Laughs] They don't want me to fall again and bust my head open!"

Risk

- "What are the odds of that happening, you falling again?"
- "Oh, pretty high. Old people fall, and I'm definitely old. I can manage though. I have my kids, I have a lifealert, I use my walker. Stuff happens, that's life."

Risk

- "Mr S, it sounds like you know falling is a real concern. How do you square that with living alone?"
- "Like I said, stuff happens. I can walk to the store and get hit by a truck. Is it risky for me to go home? Sure, but that's my call. Anything else?"

Collateral input

- Patient provides consent for provider to call daughter
- "Well, we're worried about Dad. I work but Jim can come by in the morning, and the case manager said he qualifies for more caregiver support. We need to figure something else out long-term though"

Communication

HAS CAPACITY

- Mr S has demonstrated
  - Orientation
  - Intact short and long term recall
  - Understanding of medical issues and concerns surrounding decision
  - Understanding of likely risks of decision
  - Ability to reason using information and personal preferences
  - Able to communciate his decision
  - Family confirms patient's understanding of relative safety of discharge plan

Cognitive impairment?

- Studies suggest cognitive tests should not be used as sole factor
- Study of 80 medical inpatients and 40 psychiatric inpatients
  - 14.3% of medical patients lacking capacity scored "normal" on MMSE
  - 63.6% of psychiatric patients lacking capacity scored "normal"
- Positive association between MMSE score and decisional capacity
- However, authors cautioned that an unacceptable percentage of patients with normal scores were found to be incapable

Marrodán, I. & Baón Pérez, Beatriz & Mercedes, Navio Acosta & Vizcaino, E.J. & Álvarez, M.B. & Faci, Tirso. (2018). Limits on the use of the MMSE for assessment of capacity to consent for treatment. The European Journal of Psychiatry. 10.1016/j.ejpsy.2018.02.003.

Cognitive impairment?

- Additional studies have found high specificity but very low sensitivity for MMSE
- Study of 152 patients with dementia, TBI, or psychiatric diagnoses found zero patients were assessed as having capacity when MMSE score was 19 or lower
- However, extremely poor sensitivity was found across all groups

Pachet A, Astner K, Brown L. Clinical utility of the mini-mental status examination when assessing decision-making capacity. J Geriatr Psychiatry Neurol. 2010 Mar;23(1):3-8. doi: 10.1177/0891988709342727. Epub 2009 Aug 6. PMID: 19661490.

NOT GOOD at identifying patients who POSSESS capacity at a given MMSE score

Table 2. Sensitivity, Specificity, PPV, [illegible]

Cutoff	Sensitivity	Specificity		
17	0.17	1.00	1.00	0.26
18	0.21	1.00	1.00	0.27
19	0.23	1.00	1.00	[illegible]
20	0.30	0.94	[illegible]	[illegible]
21	0.34	0.91	[illegible]	[illegible]
22	0.38	0.91	0.94	[illegible]
23	0.48	0.88	0.93	0.33
24	0.54	0.79	0.90	0.33
25	0.65	0.73	0.90	0.38
26	0.69	0.53	0.82	0.33

NOTES: PPV = positive predictive values; NPV = negative predictive values.

Good at identifying patients who LACK capacity at a given MMSE score

MMSE score

Pachet A, Astner K, Brown L. Clinical utility of the mini-mental status examination when assessing decision-making capacity. J Geriatr Psychiatry Neurol. 2010 Mar;23(1):3-8. doi: 10.1177/0891988709342727. Epub 2009 Aug 6. PMID: 19661490.

Cognitive impairment?

- Takeaway: Cognitive tests can *sometimes* help identify patients who lack capacity but cannot reliably identify if a patient possesses capacity
- Should be used only as supporting information within the context of a broader clinical capacity assessment

Refusal redux

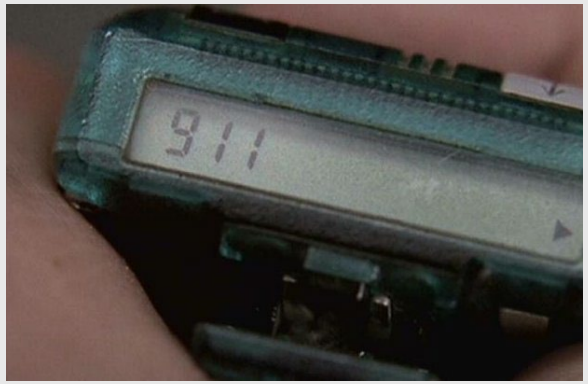
- Sometimes patients will not participate
- Or
- Patient is on way out the door at time of assessment
- *"I'm not talking, I'm leaving right now."*

Provisional capacity determination

- Sometimes, provisional determination of capacity is necessary
- Information from chart
  - How did patient arrive to hospital?
  - How serious is the medical issue and risk?
  - Does the patient have a history of self-presenting or self-rescuing?
  - Prior capacity assessment?
  - Cognitive testing including SLUMS/MOCA
  - PT/OT assessments for independence
  - What have the collaterals said?

The "one-question capacity eval"

- "Is this psych? Yeah we have a 56 year old lady who needs another 10 days of IV vanc, she's insisting on leaving and is getting dressed, we need you to say if she has capacity"

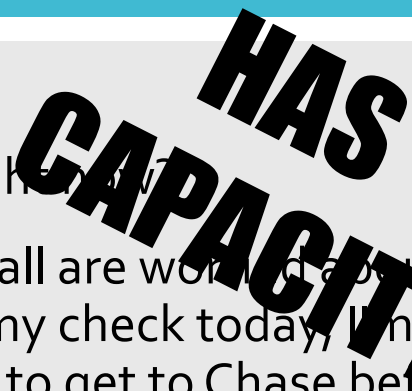


The "one-question capacity eval"

- **Risk**
- "Janet, I have one quick question for you."
- "Look, I'm leaving right now"

"One question capacity eval"

- "Can you tell me the risks of you leaving the hospital right now?
- "[Sighs] Another f-ing doctor. I know I can die, OK? You all are worried about the infection, but I've been here 3 weeks and I need to get my check today, I'm going to lose my apartment. I know you don't care but I need to get to Chase before 5. I'm not going to die by 5, OK? I'll come back to the ER tonight and you guys can do whatever you want."



Documenting & Follow up

- Always chart your determination of capacity
- Cite specific hospital policy (Epic smartphrase)
- OK to specify if determination is provisional
- Complex or higher-risk decisions may require multiple capacity assessments or additional input
- Redetermination of capacity may be necessary if:
  - Need for new decision emerges
  - Cognitive state changes/improves/worsens
  - Emergence or resolution of psychiatric condition/intoxication/withdrawal

When to involve…

- Psychiatry
  - Patient has a diagnosed or suspected mental health issue interfering
  - "Tiebreaker" is needed due to uncertainty or complexity of decision

When to involve…

- Ethics
  - Circumstances where one or more ethical principles may require deprioritizing a capacity determination (esp in context of autonomy or justice principles)
  - Determination leads to moral distress among family/caregivers
  - Members of care team are in conflict as to capacity status

When to involve…

- Risk Management/Legal
  - Clarification of policy
  - Review of situational legal concerns or factors
  - Unusually high-risk or high-profile situations

Takeaways

- Capacity assessment require consideration of patient's understanding, appreciation, reasoning and communication
- Understanding and appreciation of risk is uniquely important
- Structured cognitive tests can be used as supporting information but not as a sole means of determining capacity
- Strategies can and should be implemented to understand refusal of capacity assessment as well as means to address refusal