Medical Decision-Making Capacity: Assessment and Practical Application

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Disclosures

No disclosures

OBJECTIVES

1) Define medical decision-making capacity and informed consent.
2) Identify the four criteria for assessing patient's decision-making capacity.
3) Distinguish whether a patient's decision-making capacity is modifiable.
4) Develop a formal assessment, including documentation.
5) Apply assessment to clinical practice.

INTRODUCTION

60 year old male with history of DM type 2, HTN, and peripheral neuropathy admitted to the hospital for AMS. Work up remarkable for poorly controlled DM and sepsis 2/2 right lower leg ulcer. Initially treated with antibiotics with some improvement in white count and fever. Vascular surgery consulted to evaluate wound and recommends below knee amputation (BKA).

Informed Consent

- Communication between patient and provider
- Patient's authorization or agreement to intervention
- Present information to include:
  - The diagnosis (or assessment)
  - Nature and purpose of recommended intervention
  - Burdens, risks and expected benefits of all options
    - MUST INCLUDE FORGOING TREATMENT

Scenario 1: Assessment, nature/purpose of recommended intervention, risks/benefits/alternatives are discussed. Pt agrees and signs consent. Procedure and planed.

Scenario 2: Assessment, nature/purpose of recommended intervention, risks/benefits/alternatives are discussed. Pt refuses surgery, stating "you aren't taking my leg"

Must be free of coercion
The patient has decision making capacity

Case One

50yo male with base of tongue mass who presents to the ED for evaluation and treatment. Pt has been evaluated by ENT in the past and previously recommended treatment is tracheostomy (due to difficult airway) and resection of mass. Further treatment likely to include chemotherapy and/or radiation.

Focused Physical Exam:
Gen: Pt is alert, oriented to place and situation
Throat/Neck: mass right submandibular, no tracheal deviation, hoarse voice
Lungs: CTA bilaterally, no wheezes, rhonchi or rales
Heart: RRR, no murmurs
Psych: bizarre thought content, unable to abstract

- On interview, patient makes bizarre statements but seems to understand treatment plan. Upon chart review, pt was seen last week for same thing however left hospital prior to intervention because he had “business to tend to”
- Day of proposed procedure, pt now refusing because his daughter just passed away and he needs to collect the body at the morgue before close of business. He requests to be discharged

Does this patient have capacity to refuse?

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Decision Making Capacity

4 criteria for assessing decision making capacity:

1. communicate a consistent *choice*
2. *understand* the relevant information
3. *appreciate* the situation and its consequences
4. manipulate the information, *reasoning*

TASK SPECIFIC

Appelbaum PS, Grisso T. Assessing patient's capacities to consent to treatment. N Engl J Med 1998;25:1635–1638.

Assessing patient's capacity now that he is refusing the recommended and likely life saving procedure.

If there is concern patient lacks DMC then it is essential to be documented by the treating provider.

The appropriate management of a patient who wishes to refuse medical care includes determination of decision making capacity; negotiating to encourage compliance; discharge planning, including the best treatment alternative; and documentation.

____

1. Communicate a consistent choice.
    Is the patient consistently refusing medical care? Is the patient consistently in agreement?
2. Understand relevant information.
    What is the nature of the illness?
3. Appreciate the situation and the consequences.
    Risks and benefits to purposed test or treatment.
    Indication.
    Alternative options.

4. Manipulate/reason the information.

    Does the patient understand the explanation of medical care that has been provided?

Decision Making Capacity:

WHAT IT IS

- Decision making capacity is TASK SPECIFIC
- Decision making capacity is fluid, it can change*
- All providers who are responsible for the care of patients should be able to perform routine capacity assessment

WHAT IT IS NOT

- Decision making capacity is NOT competency
- Decision making capacity is NOT ALL OR NOTHING
- Lack of decision making capacity is NOT permanent in many cases
- Evaluating decision making capacity is NOT specific to mental health

Ganzini, L et al. Ten myths about decision-making capacity. J Am Med Dir Assoc. 2005 May-Jun;6(3 Suppl):S100-4.

- *Will discuss treatment that can modify decision making capacity (ie forced medication)
- Ganzini, L et al. Ten myths about decision-making capacity. J Am Med Dir Assoc. 2005 May-Jun;6(3 Suppl):S100-4.

DMC in question

- Unresponsive patient
- Altered patient
- Patient refusing
- Significant mental illness
- Significant cognitive impairment

Is this modifiable?

Modifiable: delirium, acute psychosis, uncontrolled mental illness.
Nonmodifiable: cognitive impairment, neurocognitive disorders, chronic mental illness.

Case One
Does this patient have capacity to refuse surgical intervention?

- Respecting autonomy
- Weighing risk and benefits of proposed treatment – tracheostomy, future chemotherapy and/or radiation
- Patient likely homeless, lack of social support

Ethical consideration when patient lacks capacity however ….

Case Two

45yo male with history of schizoaffective disorder presenting with chief complaint of cough and weight loss. Pt found to have disorganized thought process and grandiose delusions. Pt admitted to medicine for TB rule out. Pt refusing medical work up for likely active TB.

- Patient states there is no way he could have a lung infection because he has not been around anyone who is sick.
- He would know if he had an infection because his cough would be “different”
- He needs to return to his lawyers office to obtain lump sum he is owed

Does the patient have capacity?

- High risk without treatment including public health problem
- Low risk of adverse event with treatment – therefore high treatment benefit
- Risk of work up is low to moderate – bronchoscopy, labs, CXR
- Active psychotic symptoms

High suspicion of active TB due to symptoms and CXR findings. Pt required bronchoscopy to confirm dx. The health dept guides treatment for active TB which includes detaining patients who are not compliant (ie "TB jail")

Pt given high dose of antipsychotics which improved cooperation. Pt continued to lack insight into infection however was more cooperative with treatment plan

When to request a formal decision making-capacity assessment

All elements of treatment plan have been discussed with patient by the treating team.

Primary team/treating team has uncertainties after screening for capacity to refuse treatment and documenting the assessment.

In major mental illness (schizophrenia, severe personality disorders) or substance abuse, distinguishing poor judgement from lack of decision-making capacity

by psychiatry, clinical ethics or other service.

Primary teams: have a clear questions and share your opinion with psychiatry. The final responsibility for determining capacity rests with the treating team; ie "psych says patient doesn't have capacity" is not valid

Is there an ethical concern?

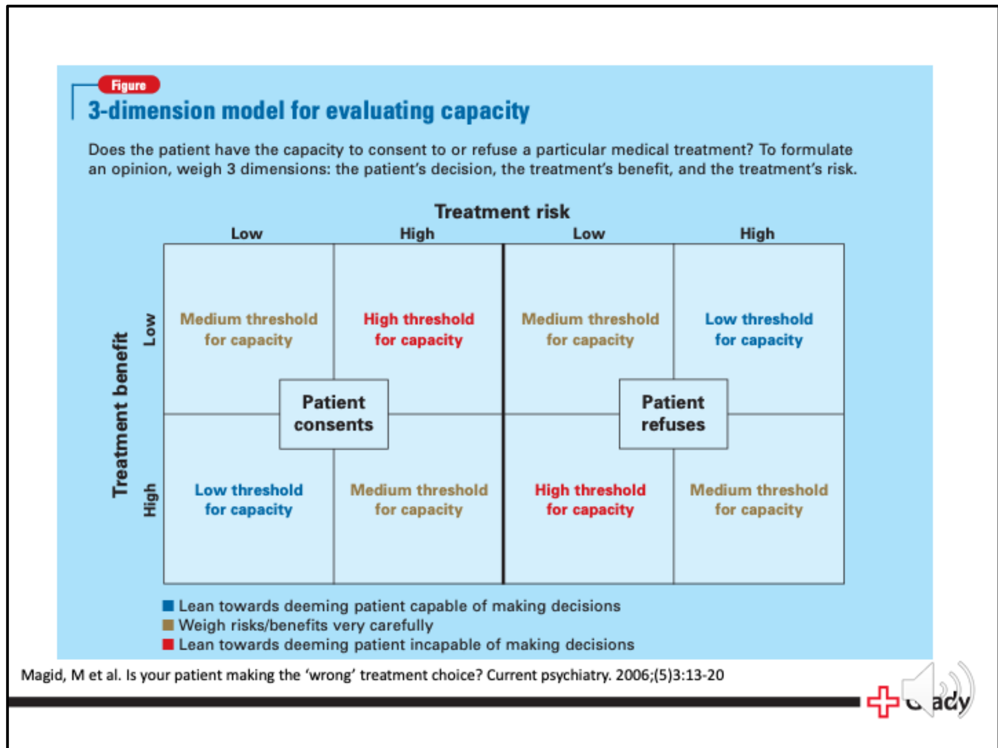
ASSESSMENT

- Identify the task to be assessed
- Use the 4 criteria. Assessment is beyond the patient being A&O x4.
- Is their capacity modifiable?
- Identify barriers to understanding
  - Language
  - Ability to communicate clearly
    - Case discussion

1. Identify the task: capacity to refuse medical work up? Refuse nec intervention? Refuse discharge plan? What about ability to consent to a complex surgery?
2. Use the 4 criteria: ask the patient their understanding of their illness, what has been recommended; any concerns the patient has re proposed tx plan; what's their understanding of morbidity, not just mortality
3. Can we restore the patient's capacity? If there are psychotic, use antipsychotics. If they are delirious, attempt to correct underlying problem. Do we have time to delay treatment plan in order to restore capacity?

Identify and address barriers to communication: does patient need an interpreter, would it be better to have an in person interpreter if available; is the patient hard of hearing; aphasic; is writing an option? Do they need communication board?

Patient's can have the ability to make a bad choice as long as they can reason the information



Resolution of a conflict between a provider, who wishes to provide the best possible medical care, and the patient, who knows his or her goals and values best, may require trust, communication, and compromise. Enhancing the patient-physician relationship and developing trust may mitigate prevention of this conflict. Mitigating the conflict may require negotiation and compromise to arrive at a treatment plan that will optimally benefit the patient.

Case Three

56yo female admitted to the surgical ICU after being hit by a car. Pt complained of left elbow pain and abdominal pain. Physical exam remarkable for left elbow deformity, left sided abdominal tenderness, mild abrasions to extremities. Pt consented for left elbow ORIF for fracture/dislocation. Two days later patient is tachycardic and hypotensive. Routine labs remarkable for Hgb of 6.8.

Blood transfusion and further work up for acute blood loss anemia.

- Patient refuses blood transfusion. Denies religious reasons.
- States “my blood is low”
- “If I don’t have a transfusion, I could die but I won’t actually die.”
- Patient states she will turn into another person if she is given someone else's blood

DOCUMENTATION

Clear

Concise

Easy to read

DOT PHRASE

Standardized approach including the 4 criteria offer a reliable, reproducible tool

Documenting Case Three

1. Choice: Patient refuses blood transfusion. Denies religious reasons.
2. Understand: States "my blood is low"
3. Appreciate: If I don't have a transfusion, I could die but I won't actually die
4. Reason: Patient states she will turn into another person if she is given someone else's blood

Ms. A lacks capacity to refuse blood transfusion based on above assessment.

Task –
Essentially there are two tasks:
1) Capacity to refuse blood transfusion → pt refusing this intervention
2) Capacity to either consent to or refuse further work up for acute blood loss anemia. In this case patient needed abdominal CT scan, found to have a spleen laceration → pt agreeable to CT scan

APPLICATION

The patient lacks decision making capacity….
So now what?

- Identify a surrogate decision maker
- What is the urgency?
- Is this modifiable? Is there time to restore?
- Treatment over objection
- Discharge capacity

Identify a surrogate. Every state is different, know your statutes

When a patient lacks capacity, a surrogate decisionmaker or applicable advance directive should be identified. State law varies in regard to surrogates. Some states require a legally appointed surrogate, and others designate a hierarchy of surrogates, often including spouse, adult children, or parents. For example, the 2010 Family Health Care Decisions Act in New York describes the following hierarchy: (1) an MHL Article 81 court-appointed guardian (if there is one); (2) the spouse or domestic partner (as defined in the act); (3) an adult child; (4) a parent; (5) a brother or sister; or (6) a close friend (as defined in the act).

If no surrogate is readily available, medical interventions should be undertaken, using the standard of what a reasonable patient would desire under those circumstances.

Marco, C et al. Refusal of emergency medical treatment: case studies and ethical foundations. Annals of Emergency Med. 2017;(70)5:696-703.

Treatment Over Objection

Just because a patient is lacking capacity does not mean they lose their right to autonomy

Things to consider:

- What is the anticipated benefit?
- What is the level of cooperation required?
- What is the time required for treatment and recovery?

Structured approach delineating 7 core questions to address in these situations as described by Rubin and Prager.

Rubin J and Prager KM. Guide to considering nonpsychiatric medical intervention over objection for the patient without decisional capacity. Mayo Clin Proc. 2018;93(7):826-829

Ethical underpinnings:
Autonomy: decisions based on patient’s values
Beneficence: provider advocates for patient’s best interest
Nonmaleficence: Burden should not outweigh the benefit.

7 core questions:

1. What is the likely severity of harm without intervention
2. How imminent is harm without intervention
3. What is the efficacy of the proposed intervention
4. What are the risks of the intervention
5. ***What is the likely emotional effect of a coerced intervention on a patient***
6. What is the patient’s reason for refusal
7. What are the logistics of treating over objection

Case Comparison

54yo male with history of CAD s/p bypass, poorly controlled HTN and CKD presenting with hypertensive urgency, AKI on CKD and encephalopathy. Patient has progressed to ESRD and now requiring dialysis. Pt refusing HD.

80yo male with no significant past medical history admitted for management of infected wound on right foot. Pt with osteomyelitis and recommended amputation below knee. Pt refusing amputation.

Scenerio 1: pt with uremic encephalopathy. No clear surrogate identified. Patient's capacity likely restored when delirium resolves → requires dialysis.

Scenerio 2: pt aware of risks and benefits. Currently feeling well after receiving Abx therapy. Is aware he could become more sick and septic.

Discharge Decision Making

- Complex and multidimensional process
- Prediction of how a patient will behave in the future
- Prediction of how a patient will manage independently in the community after leaving the hospital

Will the patient be able to adhere to recommended treatment plan, including procedures, medications and appointments

Discharge home, nursing facility, AMA

What can we do to decrease risk?

Photo:
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Case Four

72yo male with history of hypothyroidism who presented with neck pain after ground level fall. Pt sustained cervical spine fracture s/p multi level fusion. No paralysis. PT and OT recommend SAR due to decreased strength, impaired balance and poor safety awareness. Pt states he just wants to go home. Unable to state social work and therapy concerns. Later is agreeable as long as the rehab is short and in the hospital.

Conclusion

Any physician, PA or NP can formally assess decision making criteria

Having a standardized and structured approach will allow for consistency

Keep in mind ethical issues that arise

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