Ethics

Capacity[1]

Presented by
Egyptian Group for Surgical Science and Research
Nabil Dowidar, EGSSR Moderator
Ahmed Hazem, EGSSR Secretary General
Said Rateb
Mohamed Farid
Ahmed Hussein

Correspondence to: Ahmed Hazem, Email: ahihelmy@hotmail.com

What is capacity?

"Capacity," or "decision-making capacity," is the ability to understand information relevant to a decision and to appreciate the reasonably foreseeable consequences of a decision or lack of decision. Capacity is specific to particular decisions: a person may be capable with respect to deciding about a place of residence, for example, but incapable with respect to deciding about a treatment. Capacity can change over time. For example, a person may be temporarily incapable because of delirium but subsequently recover his or her capacity.

Why is capacity important?

The ethical principles of patient autonomy and respect for persons require that capable people be allowed to make their own informed decisions. However, the ethical principle of physician beneficence requires that incapable people be protected from making decisions that are harmful or that they would not make if they were capable.

In law, capable patients are entitled to make their own informed decisions. If a patient is incapable, the physician must obtain consent from a designated substitute decision-maker. In common law and under some legislation patients are presumed capable. If it is unreasonable to presume capacity, then a capacity assessment should be undertaken.

In some countries “the common law” there is no age below which a person is not presumed capable, i.e. a minor can give consent if he or she is able to understand the information about a treatment and to appreciate the risks and likely consequences of the treatment.(1)

Capacity is an essential component of valid consent, and obtaining valid consent is a policy of most medical institutions and other professional bodies.(2)

---

1. Summarized from: E Etchells, GSharpe, C Elliott, P A. Singer, CMAJ. 1996;155:657-61.

How should I approach capacity in practice?

A clinician develops a general impression of a patient's capacity during the clinical encounter. In most cases the clinician has little reason to question the patient's capacity and focuses on other aspects of the consent process. However, some patients, such as those who are comatose or who have severe dementia, are obviously incapable. In such cases the clinical assessment of capacity is straightforward, and substitute consent is required.

In some situations clinicians may be unsure about a patient's capacity. The patient may have a neurologic or psychiatric disease or may be behaving in a way that indicates lack of understanding. Although refusal of recommended treatment may cause a clinician to *question* a person's capacity, refusal of treatment should not be considered evidence of incapacity. Most refusals are caused by factors other than incapacity.[3-5]

When a clinician is unsure about a patient's capacity an assessment is needed. The initial objective of assessment is to screen for incapacity. Patients who appear to be incapable after the screening assessment generally require further evaluation. Clinicians may use three different measures of capacity: cognitive function testing, general impressions of capacity and specific capacity assessments.

Cognitive function tests such as the Mini Mental State Examination are reliable, easy to administer and familiar to clinicians in a wide variety of settings. However, although cognition and capacity are related, they are not identical. Most measures of cognitive status do not evaluate several cognitive functions, such as judgment and reasoning that are relevant to capacity. A person may have a perfect cognitive test score but still be incapable by virtue of delusions that directly affect the treatment decision. Another limitation of cognitive status tests is that cut-off scores for identifying incapacity have not been established.[6-11]

Gaining a general impression of a patient's capacity is a simple and quick method of assessment but can be unreliable, inaccurate and easily biased.[12-13]

In a specific capacity assessment the clinician discloses information relevant to the treatment decision and then evaluates the person's ability to understand this information and to appreciate the consequences of his or her decision.[14-18] The Aid to Capacity Evaluation is a decisional aid to assist clinicians in carrying out specific capacity assessments. It prompts clinicians to probe relevant areas, provides sample questions for the evaluation of each area and gives suggestions for scoring.[19] Other decisional aids have been developed to assist with the assessment of the patient's capacity to complete an advance directive and to consent to treatment, and to assist with the simultaneous assessment of several types of capacity.[20-22]

Specific capacity assessments have several strengths. First, they directly assess the patient's actual functioning while he or she is making a decision, which is exactly what the legal definition of capacity requires. Second, they are clinically feasible and quick: the median time for Aid to Capacity Evaluation assessments is 12 minutes.[14] Finally, specific capacity assessments are flexible and can easily be adapted to various clinical circumstances.

However, specific capacity assessments have certain drawbacks. First, they are only as good as the accompanying disclosure. If the clinician does not disclose information effectively, the capacity assessment will be inaccurate. Therefore, excellent communication skills are critical to accurate assessment. In practice, the process of disclosure should continue throughout the capacity assessment. For example, if a patient does not initially appreciate that he or she may be able to walk after a below-knee amputation, then this information should be redisclosed. Then the clinician can re-evaluate whether this consequence of below-knee amputation has been understood.

A second problem with specific capacity assessments relates to the evaluation of a patient's reasons for a decision. The goal is to ensure that the decision is not substantially based on a delusion and is not the result of depression. However, some "delusions" may represent personal, religious or cultural values that are not appreciated by the clinician. Similarly, it is difficult to determine whether a decision is substantially affected by the cognitive features of depression, such as hopelessness and feelings of worthlessness, guilt and persecution.[23,24]

A third problem is that a patient's capacity may fluctuate. If a person appears to be incapable the clinician should determine whether any reversible factors such as delirium or a drug reaction are at work. If such factors are identified the clinician

should attempt to eliminate or minimize them and then repeat the assessment. There may also be factors that prevent a person from communicating effectively with the clinician, such as a language barrier or speech disturbance. Such factors must be addressed to ensure accurate capacity assessment.

Finally, clinicians may find it difficult to perform unbiased capacity assessments, particularly when the patient's choice goes against their recommendations. It is important to remember that agreement or disagreement with the patient's decision is not at issue; the purpose of capacity assessment is to evaluate the person's ability to understand relevant information and to appreciate the consequences of a decision.

If the result of screening indicates that a patient may be incapable, further expert assessment is generally recommended, particularly if the clinician is unsure about the assessment or if the person challenges the finding of incapacity. Expert assessments can be conducted by individual practitioners (e.g., psychiatrists and psychologists), hospital ethics committees or legal review boards. If a finding of incapacity is based primarily on the clinician's interpretation of the person's reason for his or her decision, then the clinician should seek further input from others, such as the patient's family or relevant representatives from the patient's cultural or religious group. If the clinician suspects that a decision is based substantially on delusions or depression, then psychiatric evaluation is recommended.

References

1. Sharpe G. Consent and minors. Health Law Can. 1993;13:197-207.
2. Canadian Medical Association. Informed decision-making [policy summary]. CMAJ. 1986;135:1208A.
3. Mebane AH, Rauch HB. When do physicians request competency evaluations? Psychosomatics. 1990;31:40-6.
4. Katz M, Abbey S, Rydall A, Lowy F. Psychiatric consultation for competency to refuse medical treatment. Psychosomatics. 1995;36:33-41.
5. Appelbaum PS, Roth LH. Patients who refuse treatment in medical hospitals. JAMA 1983;250:1296-301.
6. Molloy DW, Alemayehu E, Robert R. A standardized Mini Mental State Examination: its reliability compared to the traditional Mini Mental State Examination. Am J Psychiatry. 1991;48:102-5.
7. Janofsky JS, McCarthy RJ, Folstein MF. The Hopkins Competency Assessment Test: a brief method for evaluating patients' capacity to give informed consent. Hosp Community Psychiatry. 1992;43:132-6.
8. Fitten LJ, Waite MS. Impact of medical hospitalization on treatment: decision making capacity in the elderly. Arch Intern Med. 1990; 150:1717-21.
9. Fitten LJ, Lusky R, Hamann C. Assessing treatment decision-making capacity in elderly nursing home residents. J Am Geriatr Soc. 1990;38:1097-104.
10. Rutman D, Silberfeld M. A preliminary report on the discrepancy between clinical and test evaluations of competence. Can J Psychiatry. 1992;37:634-9.
11. Freedman M, Stuss DT, Gordon M. Assessment of competency: the role of neurobehavioral deficits. Ann Intern Med. 1991;115:203-9.
12. Kaufmann CL, Roth LH, Lidz CW, Meisel A. Informed consent and patient decisionmaking: the reasoning of law and psychiatry. Int J Law Psychiatry. 1982;4:345-61.
13. Markson LJ, Kern DC, Annas GJ, Glantz LH. Physician assessment of patient competence. J Am Geriatr Soc. 1994;42:1074-80.
14. Etchells EE, Darzins P, McKenny JM, Strang D, Naglie G, Silberfeld MS, et al. Reliability of a decisional aid for assessing capacity to consent to treatment [abstract]. J Gen Intern Med. 1995; 10(suppl):41.
15. Molloy DW, Silberfeld M, Darzins P, Guyatt GH, Singer PA, Rush B, et al. Measuring capacity to complete an advance directive. J Am Geriatr Soc. 1996;44:660-4.
16. Gutheil TG, Appelbaum PS. Clinical handbook of psychiatry and the law. New York: McGraw-Hill. 1982.
17. Pruchno RA, Smyer MA, Rose MS, Hartman-Stein PE, Henderson-Laribee DL. Competence of long-term care residents to participate in decisions about their medical care: a brief objective assessment. Gerontologist. 1995;35:622-9.

18. Ben-Aron MH, Hoffman BF. Patient competence to consent: a physician guide. Ont Med Rev. 1989:56:8-12.

19. Hoffman BF, Srinivasan AJ. A study of competence to consent to treatment in a psychiatric hospital. Can J Psychiatry. 1992;37:179-82.

20. Grossman L, Summers F. A study of the capacity of schizophrenic patients to give informed consent. Hosp Community Psychiatry. 1980;31:205-206.

21. Bean G, Nishisato S, Rector NA, Glancy G. The psychometric properties of the competency interview schedule. Can J Psychiatry. 1994;39: 368-76.

22. Naglie G, Silberfeld M, O'Rourke K, et al. A randomized trial of a decisional aid for mental capacity assessments. J Clin Epidemiol. 1993;46:221-30.

23. Ganzini L, Lee MA, Heintz RT, Bloom JD, Fenn DS. The effect of depression treatment on elderly patients' preferences for life-sustaining medical therapy. Am J Psychiatry. 1994;151:1631-6.

24. Sullivan MD, Youngner SJ. Depression, competence and the right to refuse lifesaving medical treatment. Am J Psychiatry. 1994;151: 971-78.