Capacity for Medical Decision-Making: Different Models and Considerations

Laura Guidry-Grimes, Georgetown University Philosophy Ph.D. Student

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I. Models

A. Outcome model

1. Only consider content or outcome of decision
2. Patient well-being valued over self-determination
3. External/substantive rationality

B. Minimal expression model

1. Ability merely to express a preference is all that is required
2. Patient well-being not part of assessment

C. Algorithm model

1. Same questions asked, regardless of risks/benefits of proposed treatment (Jones & Holden)
    a. Can the patient communicate a choice?
    b. Can the patient understand the essentials of informed consent?
    c. Can the patient assign personal values to the risks and benefits?
    d. Can the patient think rationally and logically?
    e. Is the patient's capacity stable over time?

D. Sliding scale model

1. Risks/benefits determine the standard for competence (Buchanan & Brock, Drane)
    a. Should be judged according to *patient's* relatively and minimally consistent aims and values
    b. When the patient's values are unknown, "the risk/benefit assessment will balance the expected effects of a particular treatment option in achieving the general goals of health care in prolonging life, preventing injury and disability, and relieving suffering as against its risks of harm" (Buchanan & Brock 52)
    c. Balancing patient well-being and self-determination

2. Decision-specific, choice-specific
3. Internal/procedural rationality *and* external/substantive rationality
4. See chart on next page for example

From Buchanan & Brock, pg. 53:

Patient's treatment choice	**Other's risk/benefit assessment of that choice in comparison with other alternatives**	**Level of decision-making competence required**	**Grounds for believing patient's choice best promotes/protects own well-being**
Consents to lumbar puncture for presumed meningitis	Net balance **substantially better** than for possible alternatives	Low/minimal	Principally the benefit/risk assessment made by others
Chooses lumpectomy for breast cancer	Net balance roughly **comparable** to that of other alternatives	Moderate	Roughly same benefit/risk assessment made by others ; best fits patient's conception of own good
Refuses surgery for simple appendectomy	Net balance **substantially worse** than for another alternative(s)	High/maximal	Principally from patient's decision that the chosen alternative best fits own conception of own good

II. Normative and objective assessments
   A. Cannot reduce capacity to cognitive mechanisms
      1. Ethically undesirable, empirically inadequate
   B. "involves assessing the internal rationality of a putative decision against a background set of values and beliefs" (Charland 136)
   C. Replicable results
   D. Significant intersubjective agreement
   E. "rigorous operationalized measures for all standards and tests" (Charland 136)

III. Necessary components of capacity

A. Understanding

1. Does the patient understand relevant information about the proposed treatment and alternatives?

B. Reasoning

1. Does the patient provide strong justification for her/his choice?
    a. Important not to insist on perfect rationality or reasons that are accepted by the general public
2. Asking "Why?" (cf. Charland)

C. Appreciation

1. Does the patient grasp the situation, risks, and benefits?
2. What are the relevant consequences for the patient's life with each of the available alternatives?

D. Applying values

1. What are the various consequences in relation to the patient's own values?
2. Has the patient communicated a stable choice?

IV. Patients with mental illness

A. Involuntary *hospitalization* determination separate from involuntary *treatment* determination (Buchanan & Brock 311)

1. Legal and ethical standards for involuntary hospitalization have varied significant over the years, from loose criteria to strict and back again (ibid. 312)

B. Grounds for involuntary commitment

1. Imminent danger to self or others
2. Likely to "suffer substantial mental or physical deterioration" (1982 APA Guidelines)
    a. i.e., patient cannot provide for his/her basic needs or will, if not treated, experience mental or physical distress that is significant enough to cause impairment (qtd. in Buchanan & Brock 316)

b. "nearly anyone with the usual regard for him- or herself would [have] a concern for these other serious effect on his or her well-being, not simply the threat of serious physical harm" (ibid. 322).

C. Compromised capacity?
   1. Understanding – delusional beliefs?
   2. Reasoning – inability to form justification?
   3. Appreciation – inability to grasp consequences?
   4. Ability to apply values – distorted or unstable values?

D. "mental illness often attacks the same thought processes that are necessary for competent decisions about hospitalization [and treatment]" (Buchanan & Brock 319)
   1. Illnesses, symptoms, and individuals vary
      a. No blanket statements about competence/capacity are warranted
      b. Studies show that even patients with schizophrenia are less compromised when educational efforts are made (Misra & Ganzini 118)

References

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Full Case Details *(Quotes are from patient's medical record)*

A 59 year-old homeless woman with an uncertain medical history comes to Georgetown Hospital on December 19th for a fractured mandible and injured finger from alleged assault. Surgery is recommended, but patient "refuses surgery which she feels would be 'disfiguring.'" Patient requests that staff call one of her parishioners, who is a microbiologist, and her pastor. At the time, she declines analgesics. A psychiatric evaluation is done, and her chart notes the following:

> Patient is oriented to self, "hospital" and "December 2011," not sure of day/date → but says she lives on the street and has "no need to know that." After detailed discussion of risks/benefits of surgery vs. no surgery, pt clearly able to state understanding of risks—including risks of malunion, decreased function or range of function. […] infection which could be severe—even leading to death."

Psychiatry team concluded that "she was able to consent for herself."

Eventually the staff contact the parishioner and pastor, and they say that the patient has bipolar disorder and has not been taking her medications for months. They report her as having increased erratic behavior, which resulted in her being asked to leave the church. The parishioner claims that she is infatuated with him and has been stalking him. However, he talks to the patient and reassures her that surgery is the best option, so she consents to the procedure. On December 21st, the surgery is successfully performed, but she leaves three days later against medical advice.

On December 30th, the same patient is transferred from an outside hospital with exposed hardware and wound drainage from mandible. Following examination, the doctor concludes that the hardware is stable, so medicated mouthwash and antibiotics are prescribed. Patient responds by refusing all care and treatment, including labs, vital signs, IV, mouthwash, and antibiotics. She accuses the doctors of "trying to contaminate her." She claims that her face is disfigured from the CAT scan, and she denies that she ever had surgery. The psychiatric evaluation team concludes that she is "alert and oriented to person," but "not oriented to her situation." They concluded that she does not have capacity and is harming herself by refusing the treatment. On January 4th, the patient is involuntarily committed to inpatient psychiatric therapy.