Dear Dr. Jeff:

I recently received a form from the Social Security Administration asking whether one of our residents had the capacity to manage his own Social Security check. We have a facility policy that capacity determinations are made by a consulting psychiatrist and signed off by the attending physician. I felt uncomfortable asking a psychiatrist a question like this and the psychiatrist refused to come in to see the resident. She has said that the resident’s “money is always paid.” Meanwhile, the family is anxious to get the form completed. What do you think?

Dr. Jeff responds:

Former AMDA President Dr. Steven Levenson, CMD, in 1990 wrote, “Competence is the central ethical issue in geriatrics.” He then went on to argue that rather than focusing on the evaluation of “competence,” which is essentially a global determination of cognitive ability, geriatricians should look at specific capacities, which are task-specific abilities.

Those who care for and about frail seniors are constantly on the horns of a dilemma. Failing to grant our vulnerable patients the right to make decisions for themselves infantilizes them and robs them of their dignity. It is a quintessential act of disrespect. But failing to protect the cognitively impaired leaves them open to financial exploitation and the egregious overtreatment that often characterizes the dying process in this country.

As your question illustrates, the evaluation of decision-making capacity extends beyond medicine to include major financial and personal decisions: the preparation of wills, the sale of stocks and property, the routine management of day-to-day income and bills, consent to sexual activity, and even occasionally leaving the facility unaccompanied.

Our society tends to idolize youth and disrespect the accumulated knowledge, experience, and wisdom of age. Rejection of treatments, even those with little evidence of efficacy, frequently triggers an evaluation of decision-making capacity. Obviously, anyone who refuses to comply with medical orders must have impaired judgment! Mere placement in a nursing home is often seen as a demonstration of a lack of capacity for self-care and a presumed global lack of decision-making capacity.

Assuming the Worst

Thus, many facilities require a physician’s order for the ability to be “allowed” a pass out of the building— or even to get out of bed. My grandfather was a resident of an otherwise excellent nursing home a few blocks from my house for many years. Despite profound hearing loss, he remained cognitively intact throughout his 90s. And despite having less than an eighth-grade education, he routinely read The New York Times (grumbling as he read it) and the Morning Freiheit in Yiddish. Yet every year, the home would call me as his designated representative to obtain consent for his flu shot. As I routinely referred them back to him for the decision (of course, he took it) I marveled that a facility that knew him so well felt uncomfortable recognizing his decision-making capacity.

No fixed standard exists for the determination of most aspects of capacity, and there is no generally accepted test required to make determinations. The knowledge that a patient has been diagnosed with dementia, or even has a particular score on a Mini-Mental State Exam, does not determine decision-making capacity. This leaves many clinicians uncomfortable with determinations of capacity, producing an eagerness to refer these decisions to someone else.

In this case, as in many, the intention was to defer to a “mental health professional,” who correctly concluded that there was no mental health issue to be evaluated— although this might have been expressed more elegantly. Some facilities and many practitioners believe that they may escape legal liability through outsourcing these decisions (as though, in our litigious society, anything protects us from being sued).

Measurements of decision-making capacity are essentially functional determinations. Since geriatric care and post-acute and long-term care are all about function, these measurements should seem routine. Every experienced certified nursing assistant easily recognizes a resident who can feed himself, another who can feed herself but needs reminders to eat or swallow, one who can feed himself but needs his meat cut up and a tray prepared, and a fourth who requires an aide to feed her by hand. All these residents can eat, but they are functionally different in their capacity to perform different tasks associated with eating. Functional determinations are task-specific.

What abilities are required to manage a Social Security check? Certainly, this would require a basic understanding of money and what a check represents. One would need to remember the name of the bank into which it is normally deposited and know how money is removed from the bank.

With this knowledge one could, in theory, direct someone else to use the funds. However, the task at hand is not simply to use the Social Security check but to “manage” it. This would also require both a knowledge of the bills to which the check’s funds must be applied and ability to understand simple numerical reasoning and perform calculations to evaluate the possible choices.

On the other hand, managing one’s finances does not necessarily require an ability to maintain a running balance in the checkbook or balance a bank statement. After all, it is unreasonable to hold frail seniors to a standard higher than that attained by most young people.

Not Rocket Science

I was once asked to testify in a guardianship hearing for a retired professional with considerable assets. He had been living for several years with a substantially younger companion. His pension and Social Security checks had been going into a joint account that the companion was using to pay living expenses. There was no doubt on anyone’s part that he had sustained significant cognitive decline with short- and long-term memory loss, but he still spoke in complete sentences, recognized family and friends, and was oriented to person, place, and time.

He sometimes accompanied his partner to the bank when transactions were made. The issue was not his month-to-month money but his multimillion dollar real estate assets and a stock portfolio that his family feared might be exploited. In my evaluation, I determined that he was unable to add or subtract two-digit numbers, did not remember whether $1,000 is more or less than $1,000,000, and could not explain what a bond is. Thus, functionally, he lacked the capacity to handle his financial affairs, and a guardian was appointed.

The Social Security Administration is asking for the same kind of evaluation. At issue is not a diagnosis of, say, a prior stroke or Parkinson’s disease, but what the functional implication is for the task at hand. In almost every case, this is quick and easy to determine. Occasionally, formal psychological testing might be of benefit and, when a major mental health disorder might be clouding the picture (as when a profoundly depressed patient allows his or her functional status to decline through hopelessness), the consultation of a psychiatrist regarding reversibility and prognosis may be extremely helpful.

Another common situation occurs when a lawyer comes in to execute a will. He or she would need to know who he or she is authorizing and that the proxy is getting the power to make health care decisions if the patient is unable to do so.

Similarly, a survey of cognitively intact seniors completing health care directives showed that they were frequently confused as to exactly which decisions a proxy could make on their behalf (with many thinking that the proxy also could handle finances, and a few believing that the designated person could vote their absentee ballots). Furthermore, patients with mild-to-moderate dementia identified the same type of proxies that their higher functioning peers did: family and close friends.

Clearly, the need to evaluate decision-making capacity is central to the provision of care to frail people— not only invasive procedures but every act (from the administration of a pill to the provision of a therapeutic diet to getting a person dressed in the morning) is an implied act of informed consent between a member of the health care team and a patient and thus implies an evaluation of the recipient’s capacity to grant consent or withhold it. The health care team should not see the evaluation of decision-making capacity as a daunting challenge, but rather as an ongoing opportunity to serve.

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By Jeffrey Nichols, MD

Who Has the Competence to Assess Capacity?