Decisional Capacity — When and How to Determine

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"A & O × 3." What exactly does that mean? Those of us in post-acute and long-term care will recognize this as shorthand for "Alert and Oriented times three," which is often the extent of many residents' "decisional capacity evaluation," relegated to a portion of the clinical examination that is frequently glossed over and buried in a note.

In truth, evaluating the decision-making capacity of a patient is core to a provider's ethical and legal obligation to gather informed consent from a patient in order to implement therapies and treatments. In order to be valid, consent must be obtained from an individual who has the "capacity" to make a decision.

Capacity Versus Competence

Capacity, meant to describe a person's decision-making ability regarding a specific choice, is often confused with *competence*, a legal term related to the right to make one's own decisions. However, there is an important interrelationship between capacity and competence. If patients have capacity and have not been found to lack legal competence, they can make their own decision about a treatment. If a patient lacks capacity, state laws govern how to determine who has the legal authority to speak for the patient. In some cases, the resident, while previously competent, gave direction to a clinician through a decision reflected in a Medical/Physician Orders for Scope of Treatment (MOLST or POLST), or an advance directive with or without appointment of an agent, or a durable heath care power of attorney.

A clinician determination (with a second opinion in some instances) can be an important part of interactions with the family when family members disagree with a patient's choice or seek a clinical action or inaction that appears to be inconsistent with the direction of the patient. In the absence of such advance planning by a patient, state law may vest others with the authority to make a decision in the form of a surrogate decision-maker. The identification and authority of the surrogate can vary from state to state. Ultimately, a guardian may need to be appointed. A guardianship petition needs to be based on a determination of incompetence — a legal standard, but relying on clinical findings.

Several common conditions in the geriatric and, in particular, the long-term care population have high risk for capacity limitations. Any cognitive impairment can be associated with impaired capacity. This includes dementia-related illnesses (such as Alzheimer's disease, Parkinson's disease, or others), psychiatric disorders (such as schizophrenia, depression [less likely], or substance abuse), and traumatic brain injury, but also an acute illness such as delirium or hospitalization in general.

It is critically important to understand that a diagnosis of dementia or other disorder, such as those previously mentioned, cannot be substituted for a true capacity evaluation. It must also be understood that a lack of capacity is neither global (individuals may not be able to decide between advanced treatment options but may be able to decide that they do not want artificial life support) nor static (capacity often fluctuates based upon the clinical picture at hand — such as delirium).

Assessing Capacity

The general rule is to assume that everyone retains decision-making capacity unless proven otherwise. In most cases, a person's capacity, or lack thereof, to make a decision is so clear that a formal tool is not required. However, in those grey areas of medicine — when clinicians have reason to believe that their findings may later be questioned in a legal or contentious family situation — a more defined process may be in order.

A face-to-face interview is generally regarded as the standard of care in terms of a capacity evaluation. In many cases, it is enough to assess the four domains of understanding, appreciation, reasoning, and choice, as articulated in many articles but most succinctly by Grisso and Appelbaum (T. Grisso and P. S. Appelbaum, *Assessing Competence to Consent to Treatment* [Oxford University Press, 1998]; and *Clin Psychol Rev* 2006;26:1054–1077).

Domain	Description
Understanding	Ability to understand the treatment/ diagnostic related information.
Appreciation	Ability to relate the treatment/diagnostic information to one's own situation, especially in terms of benefits and harms.
Reasoning	Ability to rationally evaluate treatment/ diagnostic alternatives in terms of a risk/benefit ratio, especially in relation to impact on everyday life.
Choice	Ability to communicate a decision about treatments or testing.

Clearly documenting these domains in regards to a specific choice (e.g., a treatment option) is critical to assessing and documenting decision-making capacity. Noting the ability to retain comparative reasoning (comparing two treatment options or no treatment) and consequential reasoning (inferring what it means to choose between the options) is also extremely important.

Routine scales of cognition are not specifically geared toward capacity determination and may miss the fluctuating nature of decision-making ability. That said, a Mini-Mental State Examination (MMSE) score of less than 16 or a Montreal Cognitive Assessment (MoCA) score of less than 22 are both highly correlated with being able to detect a lack of capacity and can support the determination.

Several other scales can be of help, particularly in a contested case or in the hands of a psychiatrist/psychologist. These include over 19 different instruments, the most common of which are the MacArthur Competence Assessment Tool for Treatment (MacCAT-T), the Brief Cognitive Assessment Tool (BCAT), the Assessment of Capacity for Everyday Decision Making (ACED), the Capacity to Consent to Treatment Interview (CCTI), and the handbook developed by the American Bar Association and the American Psychological Association, *Assessment of Older Adults With Diminished Capacity* (2nd ed., 2021, http://bit.ly/3EL5R5D). The main drawback of these tools are the time constraints (the MacCAT-T takes at least 15–20 minutes to complete), the fee for use in some cases, and the training needed to accurately administer and value said tests.

Sample Case

What happens when busy, time-constrained, and intervention/treatment-limited clinicians find themselves facing a resident who, implicitly, retains decisional capacity but seems to be making an unwise and perhaps detrimental choice? A real-world clinical vignette helps to frame this conundrum:

> *A 97-year-old assisted living facility resident with known hypertension, obesity, severe multi-joint osteoarthritis, lumbar spinal stenosis, and peripheral vascular disease who self-administers her medications is evaluated for worsening lower extremity edema, weeping venous stasis ulcers, increasing shortness of breath, and orthopnea. The limited diagnostic tools available in the assisted living setting indicate a diagnosis of profound diastolic heart failure with extreme volume overload. The patient has failed multiple treatments: "intolerance" to angiotensin converting enzyme (ACE)/angiotensin receptor blocker (ARB)/diuretics other than hydrochlorothiazide (HCTZ). A recommendation for intravenous diuresis in the hospital setting to balance her heart failure and renal failure is made, but the resident refuses a hospital transfer because "I might get COVID if I go to the hospital."*

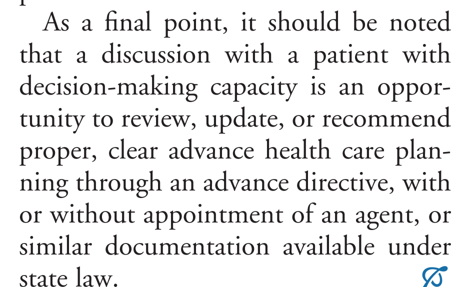
In this case, we were able to document *understanding* (she could verbalize what heart failure meant), *appreciation* (she had tried various treatment options, which she could not tolerate or failed, and she understood her worsening condition), *reasoning* (she described how her condition was deteriorating and why it may worsen by not allowing additional interventions), and *choice* (she was concerned about hospitalization because of the potential for exposure to other pathogens). It was clear that she did indeed have decision-making capacity, so the principle of informed consent was met, and the patient's choice was respected. After continued deterioration, she eventually agreed to hospital treatment, and she improved after intravenous diuresis.

Respecting Patient Rights

The overall priority of personal autonomy with the ability to direct one's own care, provided one has the ability to make an informed decision, is paramount to individual rights. We, as clinicians, must be able to determine and document that our patients have the capacity to make these decisions and then respect those decisions, even if they may not be congruent with our advice.

A health care facility may have a patient care advisory and ethics committee to which these questions can be referred, with its role and authority governed by state law. When a clinician believes that the choice being made by a patient renders the clinician unable to continue as the health care provider, state law may impose requirements for how the clinician may exit, avoiding a situation where the clinician's own views could be seen as impeding a legally valid patient choice.

As a final point, it should be noted that a discussion with a patient with decision-making capacity is an opportunity to review, update, or recommend proper, clear advance health care planning through an advance directive, with or without appointment of an agent, or similar documentation available under state law.



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