Ten Myths about Decision Making Capacity

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Disclosures

- I do not have any conflicts of interest or financial disclosures
- Presentation material property of URHCS
- To receive contact hours for this continuing education activity, the participant must:
  - Attend the entire event
  - Complete the program evaluation at the completion of the event or within 5 days

Objectives

Upon completion of this learning activity, the learner will be able to:

- Distinguish between decision-making capacity and legal competency
- Recognize situations in which an assessment of decision-making capacity are warranted
- Identify clinicians capable of assessing decision-making capacity
- Recognize myths and common misconceptions associated with decision-making capacity

Myth 1

Decision-making capacity and legal competency are the same thing

Facts

- A legal term, to say a person is incompetent indicates that a court has ruled the person unable to make valid decisions and has appointed a guardian to make decisions for the person.
- The legal process is typically reserved for people who are very impaired, not expected to recover, and making decisions that adversely affect their well-being.

Facts

- Decision-making capacity is assessed by clinicians as an everyday part of clinical care.
- Decision-making capacity is defined as the ability “to understand and appreciate the nature and consequences of health decisions and to formulate and communicate decisions concerning health care.”

Myth 2

Lack of decision-making capacity can be presumed when patient go against medical advice (A.M.A.)

Facts

- Clinicians should *not* conclude that patients lack decision-making capacity just because they make a decision that seems ill-advised.
- Determining decision-making capacity involves assessing the process the patient uses to make a decision, not whether the final decision is correct or wise.
- It is the responsibility of the clinician to assure that the decision is not due either to a problem with decision-making capacity or to a misunderstanding that needs to be resolved.

Myth 3

There is no need to assess decision-making capacity unless patients go against medical advice

Facts

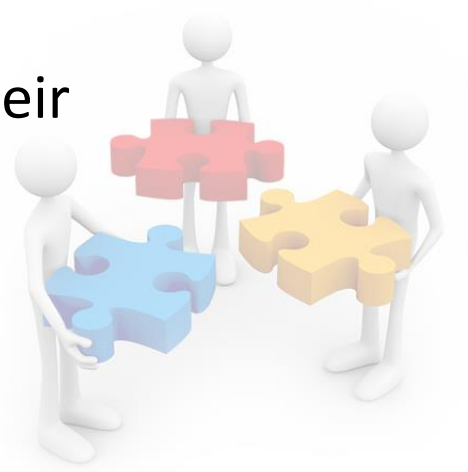
- The fact that a patient is agreeable and cooperative should *not* be interpreted as evidence that the patient is capable of making an informed decision.
- A patient may assent to an intervention without understanding the risks and benefits or alternatives sufficiently to appreciate the consequences of that decision.
- Assessment is essential whenever the risks of a proposed medical intervention are relatively high in comparison to its expected benefits.

Myth 4

Decision-making capacity is an "all or nothing" phenomenon

Facts

- Each type of decision requires different skills and therefore requires a separate, independent assessment.
- Patients should be empowered to make their own decisions, except those for which they lack specific capacity.
- Even within the realm of health care decisions, capacity is not an “all or nothing” concept.
- Rather, because health care decisions vary in their risks, benefits and complexities, patients may be able to make some decisions but not others.



Myth 5

Cognitive impairment equals lack of decision-making capacity

Facts

- Perhaps the simplest and most common cognitive test assesses “orientation to person, place, and time” by asking patients for their name, their location, and the date.
- While cognitive ability and decision-making capacity are correlated, cognitive tests should not be used as a substitute for a specific capacity assessment.

Myth 6

Lack of decision-making capacity is a permanent condition

Facts

- Lack of decision-making capacity is *not* always permanent; in fact, it is often only short-lived.

- Patients may be temporarily incapacitated, for example, as a result of general anesthesia. Another common cause of temporary incapacity is delirium.

- Delirium develops in the context of severe medical or surgical illness.

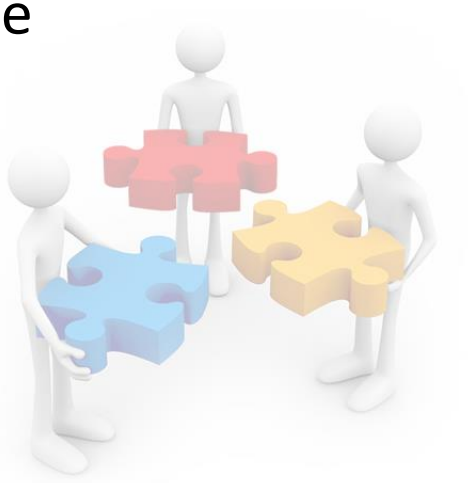
- In patients with delirium, capacity may fluctuate substantially over hours to days, or between one hospital admission and another.

Facts

- Decision-making capacity discussions should be timed to correspond to periods when the patient is capable of decision-making.

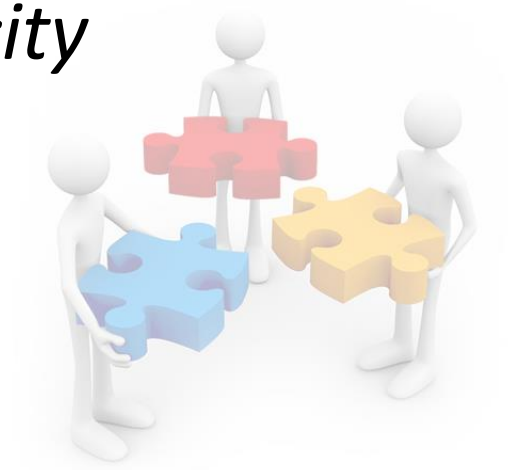
- Conversations may need to be repeated to assure that any decisions made are an authentic reflection of the patient's values and goals.

- Whenever loss of decision-making capacity is expected to be only temporary, important decisions should be delayed.



Myth 7

Patients who have not been given relevant and consistent information about their treatment lack decision-making capacity



Facts

- A patient who has not received appropriate information, or who has received inconsistent information, cannot be expected to be able to make an informed decision.

- Therefore, lack of adequate information should *not* be mistaken for lack of decision-making capacity.

Facts

- Regardless of who has previously communicated with the patient, it is the responsibility of the clinician recommending a particular treatment or procedure to assure that the patient is adequately informed.

- The clinician must inform the patient of the expected benefits and known risks of the recommended intervention, as well as the risks and benefits of all reasonable alternatives, including no intervention.

- In addition to providing adequate information, clinicians should also assure that the information they provide is understood.

Myth 8

Patients with certain psychiatric disorders lack decision-making capacity

Facts

- The fact that a patient has a particular psychiatric or neurologic diagnosis does *not* necessarily mean that the patient lacks the capacity to make health care decisions. In fact, patients with serious disorders such as Alzheimer's disease or schizophrenia often retain decision-making capacity.
- Although a particular psychiatric diagnosis does not necessarily imply incapacity, the most common causes if incapacity include delirium and dementia.
- The presence of such syndromes should alert clinicians to assess decision-making capacity with special care.

Myth 9

Patients involuntarily committed lack decision-making capacity

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Facts

- Even with involuntarily committed patients, incapacity should never be presumed, but must be assessed.

- Like all other patients, those who are involuntarily committed should be allowed to make health care decisions, except decisions for which they lack specific capacity, and should be allowed to participate in all decisions to the extent that they are able.

Myth 10

Only mental health experts can assess decision-making capacity

Facts

- Although assessments of decision-making capacity are often conducted by mental health professionals, especially psychologists and psychiatrists, mental health experts are *not* the only clinicians who can assess decision-making capacity.

- Rather, all clinicians who are responsible for the care of patients should be able to perform routine capacity assessments.

Resources

- Fast Facts
  - http://www.mypcnow.org/blank-v7dyv
- What to do when a patient refuses treatment
  - http://www.mypcnow.org/blank-c3tds

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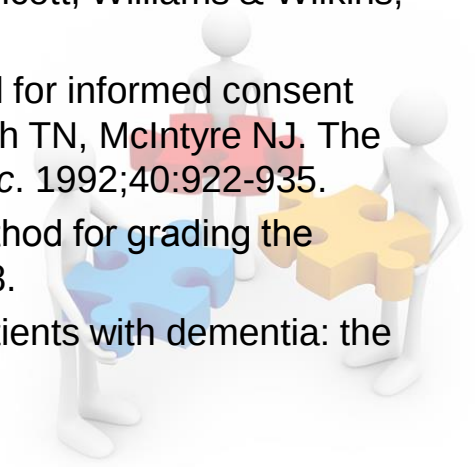

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Questions?

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