Decision-Making Capacity

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Fundamental Starting Point:

- **Adults are presumed to have decision-making capacity**

- **It is the responsibility of medical professionals to promote the fundamental goals of medicine—to restore health and wellness and to alleviate pain and suffering**

  This means that licensed medical professionals are prepared to offer and deploy the appropriate medical treatments for the proper management of a patient's condition, disability, disease or injury.

- **Adult patients with decision-making capacity have the right to accept or refuse medical intervention consistent with *their* goals and values**

  This remains true, even if refusals can foreseeably result in a poor outcome.

Concerns about Decision-Making Capacity (DMC)

Determination of capacity is a clinical judgment. Concerns about DMC are triggered by unusual decisions; for instance, a patient's refusal of recommended medical management for their condition (ie. low risk – high benefit treatment). The trigger for concern is even stronger when the consequences of honoring the patient's refusal:

a. Are serious and far reaching, including imminent danger to self or others
b. Include irreversible illness or loss of functional status
c. Include preventable death.

However, refusal in and of itself does not mean a person lacks decisional capacity. Further, psychiatric diagnoses such as schizophrenia, depression or dementia, do not, in themselves, rule out the possibility that a patient as the capacity to make particular decisions. In fact, many persons with mental illness retain the ability to make reasonable decisions about particular medical choices that face them.

Assessing Decisional Capacity

Decision-making capacity is decision-specific. Simple decisions require less capacity than complex ones. For example, consent to a blood draw (low risk) requires less capacity than consent for surgery (higher risks and requires greater ability to execute reason). For each decision, clinicians assess patient's abilities to:

1. Pay attention
2. Absorb, retain and recall information that is presented to them
3. Understand – to reason from present events to future likely consequences
4. Appreciate – to believe that the consequences could happen to them
5. Reach a judgment about whether they want those consequences to happen to them
6. Express a choice

Decision complexity directly correlates with decisional capacity. All patients are free to make choices that their capacity supports, regardless of diagnosis. Even when choices may seem unwise, patients remain free to make choices based on their own goals and values. This changes when decisions are not merely unwise, but unsafe.

Lack of Decisional Capacity

1. Clinicians then look to see if there is a clinical intervention that could restore the person's decisional capacity. This is important when the cause may be something that is a treatable clinical condition (ie. infection). Such a condition should be treated with the goal of restoring decision-making capacity and health.
2. Clinicians also seek to determine if the patient has an advance directive that would guide decisions on their behalf. Also, determining if there a surrogate decision-maker (ie. health care agent or guardian) who can speak on behalf of the patient.

The patient has been determined to lack decisional capacity and is continuing to refuse the recommended treatment

1. **For Non-Psychiatric Illness:** Try to restore capacity and convince the patient to accept the recommended treatment. In emergent situations, can override the refusal in certain, limited situations w/o judicial involvement. According to Vermont statute—physician can treat over a patient's objection when:
   - The principal lacks capacity; and
   - The principal will suffer serious and irreversible bodily injury or death if the health care cannot be provided within 24 hours; and
   - If the principal has an agent who is reasonably available or an applicable provision in an advance directive, then the agent or advance directive authorizes providing or withholding the health care. (Vermont Statute §9707.g.1.B)

   The challenge here is when that "24 hour period" has arrived. Often there is clinical data (ie. blood pressure, level of consciousness, breathing pattern, urine output, etc.) that can help clinicians assess what is happening. Also, given the nature of untreated acute illness, it doesn't take all that long usually for things to deteriorate. When that happens, there is no time for judicial review and action is taken immediately.

   However, if capacity can't be restored and it looks like the problem will be permanent—need to go to court to seek guardianship to establish someone who can make decisions ongoing.

2. **For Psychiatric Illness:** Trying to convince the patient to accept treatment to restore their capacity. This is more challenging since it is the mental illness that is causing the incapacity. This creates a Catch-22 where we can only restore capacity by treating the illness, and we can't treat the illness because the patient lacks capacity and is refusing the treatment. The purpose of involuntary medication is not only to "improve the health" but to restore the patient's decisional capacity so that they can make autonomous choices. The burdens of treatment and the ramifications of non-treatment need to be considered and weighed. Giving patients the opportunity to spontaneously improve, regain decisional capacity or voluntarily agree to accept medication are all less invasive than involuntarily medicating. However, waiting must be counterbalanced against the harms associated with not medicating; confinement, isolation from one's home and family, and the clinical deterioration that may accompany waiting too long. Establishing a judicial process that seeks to achieve a balance and is also flexible to provide for necessary individualized care, is essential.