How and When (Not) to Determine Capacity

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“ We want autonomy for ourselves and safety for those we love ”

- Atul Gawande

4 cardinal principles of medical ethics

Beneficience Whatever is done or said is for the patient's good *e.g. benefits of treatment must outweigh risks*	**Autonomy** Respect for the person and his/her rights to self-determination *e.g. it is the patient's right to decide which treatments they do or do not have.*
Non-maleficience Whatever is done or said will do the patient no harm *e.g. never lie to patients*	**Justice** Equitable allocation of healthcare resources according to need - not wealth, class, creed or colour

*Often boils down to a patient's autonomy vs. provider's paternalism

Informed consent

- 3 critical elements:

- Providing information in full disclosure
- Decisional capacity
- Voluntary capacity (no coercion)

Decisional capacity

- Is NOT the same as *competency* (determined by judge)
- IS always only about a specific decision and circumstance
- IS fluid over time and context
- Does NOT require a mental health professional
- Is NOT absent just because someone has a guardian or is committed
- Is NOT absent just because of cognitive impairment

Assessing capacity is a professional opinion, not a legal fact.

Levels of Decisional Capacity

- Ability to communicate a choice
- Ability to understand relevant information
- Appreciation of the clinical situation and its consequences
- Rational manipulation of information about treatment options

Adapted from Grisso and Appelbaum.[12]

- Capacity changes over time and depends on the question.

- If you can’t understand the question – how can the patient?

When we assess capacity we are evaluating the PROCESS of decision-making not the DECISION itself.

You should not be held to a higher standard of decision-making just because your capacity has been called into question.

Identifying your quadrant sets context

Low risk decision / consenting to recommendation	**High risk decision / consenting to recommendation**
Low risk decision/ refusing recommendation	High risk decision / refusing recommendation

Common Sense

- If low risk and and family on same page, don't force issues of POA or guardian
- Patients are not REQUIRED to have a proxy
- Seek counsel of peers, ombudsman
- Encourage second opinion on high risk recommendations
- If BIMS/MOCA = 0, the answer is usually no!
- Spend most energy on high risk, moderate impairment decisions (BIMS=8, back surgery)

Things to document

- Specific decision being addressed
- What quadrant (e.g. low risk, consenting)
- Basic orientation and cognitive measure if available
- 4 elements, elaborating on their logical understanding of risks and consequences