

Assessing Decision-Making Capacity

Alvin H. Moss, M.D.
The Center for Health Ethics and Law
Robert C. Byrd Health Sciences Center
West Virginia University
Morgantown, WV 26506-9022

Relevance of Assessing Decision-Making Capacity (DMC)

The assessment of DMC in patient care is critically important. If the patient has not completed an advance directive, specified someone to make decisions for him or her, or discussed his/her preferences for medical treatment with others, then an assessment that the patient lacks DMC means that the patient will have lost control over the decisions that are made for him or her. In almost all circumstances, health caregivers are obligated to respect the wishes, i.e., informed consent or refusal, of a patient with DMC. If a patient has completed a proxy advance directive such as a durable power of attorney for health care (called health care proxy or medical power of attorney in some states), then an assessment that the patient lacks DMC means that the person designated in the patient's proxy advance directive assumes the authority to make decisions for the patient subject to any limitations the patient has specified in the authority or any specific instructions the patient has given for care. **See V below for questions to ask to assess if the patient has decision-making capacity.**

- I. Competency vs. Decision-making capacity (DMC)
 - A. Incompetency is determined by a court.
 - B. Decision-making capacity is a clinical judgment made by those authorized under state law to make the determination. Usually physicians and licensed psychologists are authorized. In some states advanced nurse practitioners or others may be authorized.
- II. By law, patients are presumed to be competent.
- III. Mental Status Testing may be inadequate to determine DMC.
 - A. A patient may have deficits in one or more of the following and still have DMC:
 1. orientation
 2. attention span
 3. immediate recall
 4. long-term memory
 5. calculating ability
- IV. The capacity to make health care decisions requires that the patient have the following abilities:

- A. the ability to understand one's condition;
 - B. the ability to appreciate the consequences (benefits and risks) of the main treatment options including non-treatment;
 - C. the ability to judge the relationship between the treatment options and their consequences to one's values, preferences, and goals;
 - D. the ability to reason and deliberate about one's options; and
 - E. the ability to communicate one's decisions in a meaningful manner.
- V. In a practical sense, physicians, psychologists, nurses, social workers, and therapists can determine if a patient has decision-making capacity by whether the patient can give informed consent or refusal. The following questions are helpful to make this assessment:
- A. Can the patient understand what is wrong with him or her and what are the proposed procedures or treatments? Specifically, can the patient answer...
 - 1. As you understand it, what is your medical problem?
 - 2. How serious is your illness? What will happen if you are not treated?
 - 3. What do you think caused your illness, and why did it start when it did?
 - B. Can the patient understand the benefits and risks of the proposed procedure or treatment and the benefits and risks of the alternative procedures or treatments including non-treatment?
 - C. Is the patient able to reason and make a decision using the medical information which has been disclosed to him or her and to incorporate his or her personal values and wishes into the decision?
 - D. Is the patient able to explain why he or she made the health care decision that he or she did, and is the explanation consistent with his or her stated values and wishes?
- VI. Note that patients who are of advanced age, depressed, demented, or retarded, may still possess DMC.
- VII. DMC is not absolute or permanent
- A. Patients may possess sufficient understanding and reasoning ability to make some decisions (for example, agreeing to have blood drawn) but not others which require more complex levels of these skills (for example, the giving of advance directives). In this sense, DMC is said to be task-related.
 - B. Patients may have DMC at one time but not another. If possible, decisions should be delayed until reversible problems that might alter DMC such as infection, electrolyte imbalance, or medication effect resolve.

THE PATIENT AS PERSON HISTORY

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1. As you understand it, what is your medical problem?
2. How serious is your illness? What will happen if you are not treated?
3. What do you think caused your illness, and why did it start when it did?
4. Why are you being tested and treated as you are? Are there other choices for treatment beside the one you are receiving?
5. How has your illness affected you?
6. What is most important to you in receiving treatment for your illness?
7. What would you want to avoid in the treatment of your illness?
8. What is your understanding of the meaning of your illness? Is God or religion important to you as you face your illness?
9. What are your sources of strength? What role does faith play in your life?
10. How does faith influence your thinking about your illness?
11. Are there religious practices that are particularly meaningful to you?
12. Are there issues in your spiritual life that are troubling you now?
13. Would you like to talk with someone about these issues?
14. Help me understand how you see your family (and/or other significant social relationship)? What are your thoughts about their concerns or your concerns about them?

These questions are helpful in learning the patient's goals for treatment, assessing decision-making capacity, planning for care in advance, and dealing with disruptive patients to learn their perspective.