

Medical Capacity and Competency in a Geriatric Population: Self-Care and Placement

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ABSTRACT

This article discusses the complexities and ethical challenges for determining medical capacity as it pertains to ability for self-care and independence in discharge planning. Determining capacity for acute and long-term decision making is complicated for geriatric patients whose cognition may fluctuate during the course of an inpatient hospital stay. Balancing respect for a patient's autonomy and the practitioner's value of beneficence is an ethical concern. The patient presented in this article is a 72-year-old woman whose cognitive functioning was measured as very impaired for several weeks but then drastically improved over 1 month but she would not accept the safer option of discharge to a residential care facility opposed to her own home. Clinicians struggled to identify when baseline functioning had been truly identified and when maximum capacity could be accurately assessed. Decisions about long-term care need to be based on executive capacity as well as task-specific decision-making capacity. [*Psychiatr Ann.* 2016;46(2):127-131.]

This article examines the complexities and ethical challenges for determining medical capacity as it pertains to ability for self-care and independence in discharge planning.



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DECISION-MAKING CAPACITY

Adult patients are legally and clinically recognized as having the ability to make decisions about their own health care and life decisions. When an adult is unable to make well-reasoned decisions in a medical setting, it is the responsibility of the treating medical team to prove that a patient lacks decision-making capacity and that a surrogate is necessary to make treatment decisions for the patient.¹ Patients have capacity for decision-making if they demonstrate cognitive understanding of the situation by reasoning from present circumstances to future possible risks and benefits of the decision, demonstrate evaluative understanding of the consequences based on long-standing values and beliefs, and are able to express a preference.¹ The term “competency” refers to a patient’s capacity to make legal decisions, which can include consent to medical care. Both patients and families are often passionate in their opinions regarding discharge planning, with distinct preferences about where and with whom a patient should live following hospitalization. Clinicians have an ethical responsibility to respect a patient’s autonomy whenever possible; however, it can be difficult to balance respect for autonomy with an obligation to provide a safe outcome for a patient, especially when a clinician has concerns or doubts that a patient would be unable to care for him or herself without supervision.

The cognitive component of decision-making (being able to attend, absorb, retain, and reason with information provided) is often the area of capacity that is called into question in a geriatric population. Because decision-making is an interactive process, impairments in those steps can lead to impairments in appreciative and evaluative understanding. Clarifying whether an elderly person’s cognitive functioning is being impaired by an affective or medical condition that may improve with treat-

ment (ie, depression or delirium) versus a chronic and worsening condition (ie, dementia) will affect assessment of capacity for treatment. However, without baseline assessment of a patient’s functioning before hospitalization, it can be challenging to differentiate between these conditions.²

Delirium may be slow to resolve in patients whose brains are compromised by concomitant medical conditions,

Patients have capacity for decision-making if they demonstrate cognitive understanding of the situation.

sometimes taking months to return to baseline functional levels.³ In addition, screening for dementia versus delirium is often challenging using common measures.⁴ In some patients, depression can slow processing down to the degree that they present with symptoms consistent with a dementia or a pseudo-dementia, which mimics the cognitive symptoms of a true dementia. Differentiating between a true dementia and pseudo-dementia can prove challenging because cognitive slowing and impairment can be found in depression, and patients with depression sometimes have true cognitive deficits as well.⁵ Differentiating between dementia-like symptoms caused by depression and a true dementia that includes depressive aspects can lead to complexities when assessing cognitive functioning and decisional capacity. Consequently, a capacity assessment should be viewed as applicable only to the point of time of assessment, and multiple assessments are required to gauge changes over time, particularly in relation to efforts to identify and treat any reversible deficits in decision-making and to maximize autonomy.

A challenge for clinicians arises when determining whether baseline or optimal capacity has truly been reached. How do we know when a patient’s functioning is “normal” for him or her? In the hospital, basic self-care (preparing meals, taking medications, housekeeping tasks) is handled by others, so a clinician cannot easily evaluate how a patient would manage these tasks on his or her own. Does a patient’s functioning appear better than baseline because she is taking her medications appropriately in the hospital but could never do so on her own? Is the patient’s functioning worse because she is in a new place without familiar surroundings? Decision-making capacity varies along a continuum,⁶ but determining at which point a patient’s cognitive functioning should be used to make a judgment regarding placement, for example, can be challenging. If a decision is not task-specific but related to multiple tasks, determining general executive functioning abilities and instrumental activities of daily living (IADLs) may be helpful but not necessarily definitive.

Decisions regarding capacity are further complicated by the potentially disastrous results of being wrong. If a clinician misjudges a patient’s capacity and sends the person home without being able to adequately self-care, the patient will risk other adverse health consequences such as serious self-neglect. The concept of self-neglect can be defined as the failure to perform self-care acts necessary to live independently and/or the failure to prevent situations that would endanger the patient or other people.⁷ Self-neglect can occur if the patient is simply unable to manage self-care tasks (ie, preparing food) or if the patient cannot make decisions that would protect him or her from harm (ie, locking doors to prevent robbery). Self-neglect is serious and may have significant medical repercussions for the patient. In a study examining elder

self-neglect in a community setting, it was associated with increased rates of 30-day hospital readmission, with even higher rates with more severe self-neglect.⁸ In the worst case scenario, self-neglect can lead to death.⁹ Naik et al.,¹⁰ for example, found a clinically significant association between rates of geriatric self-neglect and poor performance on tasks of IADLs. In cases where performance on both IADLs and cognitive functioning are fluctuating, assessing risk for self-neglect becomes considerably more complex.

ILLUSTRATIVE CASE

The patient is 72-year-old woman who presented with symptoms of confusion and disorientation after a fall her residential care facility. The patient's friends reported that prior to hospitalization she had been performing activities of daily living (ADLs) independently, although they had noticed worsening in confusion and orientation several months prior to hospitalization. It was later determined by the medical team that her disorientation and presentation to the hospital may have been related to misusing prescription medication and polypharmacy. After acute admission, the patient was transferred to a rehabilitation hospital.

When capacity for decision-making was first questioned, the clinician screened the patient with the Montreal Cognitive Assessment (MoCA), a cognitive screening test that may detect impaired capacity.¹¹ When first screened by the psychology unit for memory problems soon after admission, the patient received a score of 17 of 30 on the MoCA. This score suggests significant memory problems just outside the range of patients with Alzheimer's disease. When reevaluated with the MoCA 10 days later, the patient again received a score of 17 of 30. These results were consistent with observations from the rest of her medi-

cal team indicating severe cognitive problems. However, when evaluated with the MoCA 23 days later, the patient's performance demonstrated a drastic improvement (score of 24 of 30), indicating only a mild cognitive impairment. Her performance on another screener of cognitive functioning, the Saint Louis University Mental Status Examination,¹² resulted in a score of 22 of 30, which places her in the "mild cognitive impairment" range and was consistent with improvement on ADLs seen on the Texas Functional Living Scales.¹³

The patient was admitted with a previous outpatient diagnosis of major depressive disorder, although she denied depressive symptoms when interviewed at the rehabilitation facility. Although she did not report any depressive symptoms to clinicians, it was unclear whether covert depressive symptoms may have affected her cognitive functioning or decision-making abilities. Poor insight, embarrassment, hopelessness, or lack of trust of providers could cause a person to underreport affective symptoms. Throughout her inpatient stay at the rehabilitation facility, the patient repeatedly stated that she did not want to return to a residential care facility after discharge but wanted to move back home to live on her own. She was distressed about alternative after-care plans and was often tearful and agitated. The team was concerned about her safety at home, especially considering her possible problems with misusing prescription medications and polypharmacy that may have contributed to hospitalization. The team also worried that depressive symptoms alone could impair her ability to make prudent decisions about her living situation and could lead to future self-neglect in an unsupervised setting. The additional factor of fluctuating cognitive functioning and capacity for decision-making fur-

ther clouded the valid assessment of prognosis and safety.

DISCUSSION

In this case, there were two main ethical dilemmas that the treatment team needed to address. The first dilemma concerned the optimal timing for a determination of capacity. It is important to screen for reversible barriers to capacity, including mood variables, such as depression, and medical factors that would induce delirium that would impair a patient's cognitive abilities in the short term and that could be addressed, leading to improved cognitive outcomes.² In this case, it was unclear whether the patient's cognitive factors and decision-making abilities were being affected by mood and medical comorbidities. It was also unclear whether the patient had adequate insight into her own strengths and weaknesses. The patient's consistent refusal to return to a supervised living situation was creating challenges for social work when determining the after-care planning for this patient. The patient was also frustrated that the team continued to bring up returning to the residential care facility. The team looked for and tried to treat the potential factors that might undermine cognitive functioning while repeatedly evaluating cognitive functioning over time instead of labeling the patient as lacking capacity based on assessment only.

Balancing autonomy while protecting her from serious predictable and irreversible adverse consequences from her decision-making relative to the living situation was also a focus of ethical concern. The patient was clear in her objections to going back to a residential care facility, yet the team was concerned about her ability to care for herself once at home. The assessment of decision-

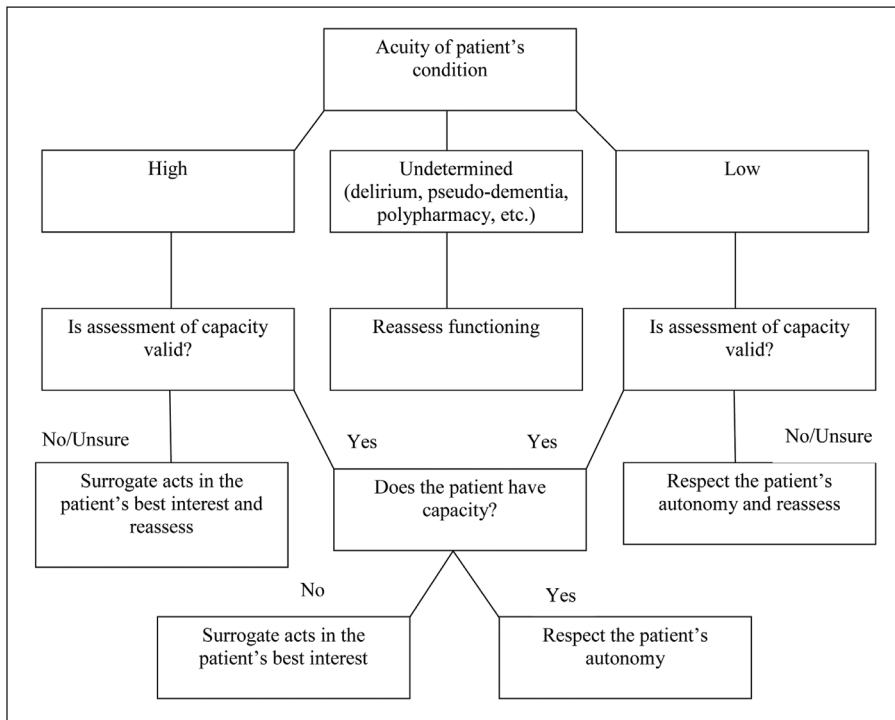


Figure 1. Balancing clinician concerns and patient autonomy with capacity and acuity.

making capacity is supposed to be task-specific. Living alone requires multiple tasks throughout the day with unpredictable occurrences that cannot all be assessed by the clinician. Naik et al.⁷ argue that conceptualizing autonomy only in terms of decision-making is inadequate in such cases and that executive autonomy, which they define as the “ability to implement and adapt plans, especially when faced with both predictable and unexpected challenges,” must also be assessed and considered.

It may also be important to evaluate the likelihood that a patient will be able to consistently and independently perform tasks that will keep her cognitive functioning intact. For example, is this patient likely to remember to take her medications appropriately? Will she take herself to appointments necessary for maintaining mental wellness, such as psychiatry and therapy appointments? Does she have the organizational abilities as well as the motivation to care for

herself? If not, then it is likely that self-neglect could occur when medical and depressive symptoms re-emerge at home.

Using historical information, including observations of problems with medication management in the past, may also help clinicians to form realistic predictions about the future. In this case, the patient’s problems with polypharmacy in the past may be indicative of poor ability to manage medications in the future. Of course, ideally the patient could have some degree of observation during at least the initial days of her return home. Sometimes, family is able to provide this additional degree of safety and certainty. Home health and occupational therapists can also provide input concerning ongoing self-care. The availability of these additional supports will have an impact on whether or not to respect the patient’s preferences to return home even when she remains impaired in decision-making. Generally too, pre-

venting her from returning home is justifiable only when the issues at stake are predictable or a certainty, serious, and irreversible.

CONCLUSION

Balancing autonomy while ensuring a safe outcome (as well as possible as understood from a well-reasoned and evidenced clinical perspective) is the ethical goal of every treating clinician. It is simpler to make an assessment of capacity for a one-time procedure (eg, ability to consent to a specific surgery) in a controlled situation versus assessment of executive abilities to make a series of decisions in unpredictable situations that the medical team cannot control (Figure 1). Many dangers could occur at home and the patient may not be able to adequately remain safe. In the hospital, these dangers are addressed by trained professionals whereas at home alone a patient must regularly make safe decisions, often without guidance. Occupational therapy assessment of ADLs may provide more detailed information about a patient’s IADLS or the patient’s ability to complete more complex executive tasks such as paying bills, taking medications, and writing checks, which go beyond the basic self-care needs. However, a patient’s performance on these tasks will still be affected by cognitive functioning and can change over time, as seen in the illustrative case, in which the patient’s performance on assessment of ADLs was consistent with performance on the MoCA.

One of the ethical dilemmas in this case was determining when a medical team can get the most accurate assessment of a patient’s ability. The timing of the capacity assessment is extremely important. If a patient is assessed when he or she is in an unusually intact cogni-

tive state due to the structure of the hospital setting, then the team may judge the person to have capacity to return home. Once at home, the patient might well decompensate without the full-time nursing care that was received at the hospital.¹⁴ However, if a patient is evaluated when he or she is abnormally impeded by reversible barriers of capacity and a surrogate makes decisions against long-standing wishes and preferences, autonomy has been ignored and worsening depressive symptoms could result, further impairing decision-making capacity and cognitive functioning. Although concern for physical safety is often a focus of providers, fostering independence is also important and is strongly related to psychosocial well-being.¹⁴ Is it better to err on the side of caution or to allow a truly incapable patient to make a possibly dangerous decision? What if no family members are present to provide an outside perspective? What if the patient refuses to go to a residential care facility and there are no other housing options acceptable than to return home? In their study regarding self-neglect in elderly people, Dong and Simon⁸ make the following assertion:

If a self-neglecting older adult is sent home in whom self-neglecting be-

haviors are likely to continue, unless healthcare professionals address the issues of self-neglect, it is likely that the vicious cycle will continue and the person's health will deteriorate which may further warrant hospital admission.

Determining whether a patient has previously demonstrated dangerous behaviors, including self-neglect, may further clarify the issue. Involving the entire medical team, including occupational therapy and social work, and family members, and reassessing the patient's capacity and preferences over time while trying to correct reversible barriers to capacity are necessary for thoroughly addressing ethical concerns on a case-by-case basis.

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