LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital (MGH) sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. Such consultations require the integration of medical and psychiatric knowledge. During their thrice-weekly rounds, Dr. Huffman and Dr. Stern discuss the diagnosis and management of conditions confronted. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

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Capacity Decisions in the General Hospital: When Can You Refuse to Follow a Person's Wishes?

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One of the most common reasons for a psychiatric consultation in the general hospital is to help decide whether a patient has the clarity of mind to agree to or refuse a treatment or procedure. Such decisions require the consideration of many factors, and patients may have the capacity to make some decisions—but not others—regarding their medical care.

Have you ever been puzzled about whether a patient has the capacity to make treatment decisions? If the patient lacks the capacity to make a certain decision, do you know what to do next? The following case of a man with fever and confusion highlights several of the issues germane to capacity decisions. The discussion and appended references should clarify key issues in the determination of capacity.

Case Presentation

Mr. A, a 41-year-old human immunodeficiency virus–positive man with a history of cytomegalovirus, toxoplasmosis, and other opportunistic infections (currently off all antiretroviral agents) presented to the emergency room with headache, confusion, and a temperature of 104°F (40°C). Although Mr. A had blood chemistries, a complete blood count, and a head computerized tomography scan in the emergency room, he refused a lumbar puncture (LP). When asked why he did not want the LP, he was unable to give a coherent explanation of his understanding of the procedure, its risks and possible benefits, or the reasons for performing the procedure. Instead, he repeated, "I don't want that, I don't need that, and you can't do that." Notably, he was intermittently lethargic and agitated, and he was disoriented to place and date, although he could state that he had come for treatment of a headache. Attempts to contact family members were unsuccessful.

Because Mr. A was refusing the procedure and since his family members could not be contacted, the treatment team opted to defer the LP. Mr. A was started on antibiotic and acyclovir treatment for management of possible meningitis, and his temperature decreased to 99°F (37°C) over the next 12 hours. His medical team and the infectious disease consultant both thought that a LP was indicated, given that neither a clear diagnosis nor an offending infectious agent had yet been identified. Over the next few hours, although somewhat less agitated, the patient continued to refuse a LP.

A psychiatry consultation was obtained the following day to assess the patient's "competency" to refuse a LP. On interview, the patient reported that he was at the hospital because "the doctors are just experimenting on me. They don't know what I know about my viral infection. I have

special knowledge about the T-spots on the virus that they could just break if they wanted to." He made such statements even though his medical team had explained his condition to him and outlined the pertinent medical issues. When asked about his headache and what his concerns might be, he replied that the headache was unrelated to his medical condition and that he was not at all ill; instead, he was being held captive for experiments. He looked around furtively as he spoke to the consultant. When asked where he was, he reported, "I'm in a secret hospital, somewhere in Boston . . . and it's January 2001." When asked about the LP, he reported that he wasn't going to accept any more "experimental tests." Over the course of the interview, he became more agitated and confused; his temperature rose to 101°F (38°C), despite antipyretics and antibiotics.

What Is Competency? What Is Capacity? Who Can Assess Capacity?

Competency is a term used to describe the legally determined ability to perform a given function. In the process of obtaining informed consent, competency is the major issue in determining whether a person has the ability to agree to, or refuse, a procedure. Technically, only a judge can determine competency. If a person is deemed incompetent to make a decision, then a substituted decision maker is appointed by the court to make such decisions for the patient. This is often a family member who has a clear understanding of the patient's long-held beliefs and who can use this knowledge to best "substitute" judgment to make decisions that are in line with the patient's wishes.

Capacity is a clinical assessment. It can be made by a psychiatrist or by another physician, and it is a clinical determination of a patient's ability to function in certain areas. Most frequently, psychiatrists are called upon to assess a patient's capacity to agree to (or to refuse) a certain medical intervention as part of the informed consent process. If a person is found to lack capacity to make medical decisions, a decision may then be "bumped up" to the legal system to assess the patient's competency. A judge ruling on competency will usually—but not always—agree with and use the capacity assessment by the psychiatrist to make a determination of competency. If the judge agrees with the psychiatrist's capacity assessment and finds the patient incompetent to make such a decision, then a substituted decision maker will be appointed by the court.

In emergent medical situations, in which treatment decisions must be made before legal proceedings can occur, physicians can go ahead with emergent medical care for a patient who lacks capacity to make decisions regarding that care. In practice, if the patient has already appointed a health care proxy, consent (leading to refusal or acceptance of a procedure or treatment) will usually be obtained through the decision maker if the patient is found incompetent.

Importantly, capacity assessments assess a person's ability to perform a certain function *at the time of evaluation*. Capacity assessments cannot be made for past or future dates. For example, the psychiatric consultant in Mr. A's case could not make an assessment about the patient's capacity from the previous night (though, based on the data, could postulate about Mr. A's capacity), nor could she make an assessment of the patient's future capacity. Given that the cause of incapacity may be treatable or may resolve spontaneously, a determination of incapacity on one day does not imply indefinite incapacity with regard to that decision or function.

In addition, capacity assessments should be made for a *specific* decision or function. Frequently, patients have the capacity to make certain medical decisions but do not have the capacity to make others, so an evaluation for the "capacity to make medical decisions" is too general to be useful. The consultant should clarify with the consultee the specific decisions or functions that need to be assessed. In this case, the specific decision surrounded the patient's capacity to refuse a LP.

How Does One Assess Capacity?

When assessing decision-making capacity, the psychiatric consultant must perform a focused mental status examination and must apply specific criteria to determine whether a patient has a sufficient understanding of the situation and an adequate assessment of the necessary skills to make logical decisions. Appelbaum and Grisso[1] have outlined 4 criteria to be used in the assessment of decision-making capacity. The mnemonic CRAM summarizes these criteria.

Communication of a stable choice. If the patient is unable to express any choice (by any form of communication), then a lack of capacity is assumed. In addition, if the patient is unable to communicate the choice in any consistent way (such that no consistent choice can be recognized or the fluctuation of choice leads to an inability to effectively implement care), then the patient also does not have the capacity to make the decision. In this case, incapacity may result from delirium, psychosis, severe anxiety, or ambivalence. This does not mean that the patient cannot change his or her mind; however, if the patient's choice regarding a particular decision shifts so often that treatment cannot be delivered, then the patient does not have the capacity to make the choice.

Relevant information is understood. The patient should be able to display a factual understanding of the nature of the medical illness, the treatment options, the risks and benefits of treatment (and of no treatment), and other important data related to the proposed decision. It is

important to note that the patient is not required to know such information prior to the admission. Instead, the important question is whether the patient (once the pertinent factual information has been explained) is able to "receive the factual information and retain it in some reasonable form during the decision-making process" (p. 422).[2]

Appreciation of the situation. In addition to having an understanding of the *facts* of the situation, the patient should also have a more general understanding of the *implications* of this decision. The patient should recognize the significance of the possible outcomes with regard to his or her medical condition. He or she should also understand the implication of this decision in his or her own future. It should be clear that the patient is not simply having a theoretical discussion about a set of facts, and the patient must realize that there is an ongoing decision that will impact his or her medical care and future.

Manipulation of information in a rational manner. The patient should be able to display an ability to assess the facts and to use them in a logical manner to come to a decision. The patient should be able to describe the logic that he or she has used to come to a decision, and this logic should be rational and make use of relevant information about the medical situation. Even if the decision seems potentially unwise to the consultant, the key issue is whether the patient is using rational processes to come to that decision. Likewise, irrational (or psychotic) thought processes that lead to a "reasonable" end decision would not imply that the patient has capacity.

When performing an interview with a patient whose capacity is being questioned, the consultant should assess the 4 CRAM criteria[1] and embed pertinent components of the mental status examination. The consultant should keep in mind the medical and psychiatric conditions that most frequently lead to a lack of capacity to make a decision (delirium, dementia, psychosis, and severe depression) and make an assessment for these conditions as part of the capacity evaluation. This can be done by assessing orientation, recall, attention, and concentration, as well as by questioning the patient about symptoms of psychosis and abnormal mood.

The same level of capacity is not required for all medical decisions. The "stringency" of a capacity assessment should be on a sliding scale that depends on the risks and benefits of the proposed intervention. The greater the risk and the lower the benefit of a particular decision, the more meticulously it must be examined. For example, the threshold for assessing capacity of a person to accept intravenous fluids as treatment for severe dehydration (a relatively low-risk, high-benefit decision) would be much lower than the threshold for a 90-year-old person to accept a complicated thoracoabdominal surgery to repair a slightly dilated aorta (a decision associated with much greater risk).

Did Mr. A Have the Capacity to Refuse a LP When He Arrived in the Emergency Room? Did He Have Such Capacity the Next Day When Assessed by the Psychiatrist?

Again, capacity to make a given choice at a given time can be determined only through an evaluation completed at that time. However, based on the information presented here (the patient's disorientation, confusion, and inability to discuss his condition or the proposed procedure), it seems clear that Mr. A did not have the capacity in the emergency room to make the decision to refuse the LP. He was unable to communicate a stable choice, to understand relevant information, or to manipulate the information in a rational manner.

The next day, when seen by the psychiatrist, Mr. A was more able to hold a conversation and to discuss his treatment with a bit more detail. However, his assertion that he was being experimented upon, that he had no significant medical illness, and that the LP had no diagnostic value (despite the fact that pertinent factual information had just been relayed to the patient by the medical team) indicated that he was unable to register or to recall pertinent factual information about the LP. Therefore, the patient did not have the capacity to make the decision to refuse the LP. Further evidence for his incapacity was the paranoid assertion that he was being experimented upon; this likely was a manifestation of delirium (especially given his disorientation), but it also may have betrayed an underlying psychotic process. By assessing the 4 CRAM criteria and by weaving in questions about orientation and other components of the mental status, the consultant was able to make a well-reasoned assessment that Mr. A lacked the capacity to make this decision.

Should the LP Have Been Performed in the Emergency Room? The Next Morning? After the Capacity Assessment? What Should the Psychiatric Consultant's Role Be in These Decisions?

Just because a patient lacks the capacity to refuse a procedure does not mean that the physician has the right to perform that procedure. Only in situations in which a medical intervention is considered emergent would a physician have the right to perform the procedure before a substituted decision maker was in place. Otherwise, for nonemergent procedures, legal determination of competency must be completed, and, if the patient is found to be incompetent, the decision maker must be consulted to determine whether the patient would choose to have the procedure if competent to make the decision.

One important concept, then, is to define *emergent*. Most would define a situation as emergent if, without treatment, there is an imminent risk of death or serious harm. Different jurisdictions may define *emergent* in different ways, with some having only a distinction between

elective and emergent, such that all nonelective procedures qualify as emergent.

The psychiatric consultant's role involves the determination of capacity and education of the medical team about the clinical implications of this capacity or the lack thereof. The consultant should not in general be the one to determine whether a particular procedure is emergent, urgent, elective, or unnecessary. The burden of this determination falls upon those with the greatest expertise (usually the primary treatment team and/or pertinent consultants; in Mr. A's case, the primary medical team and the infectious disease consultant would determine the urgency of the LP).

The psychiatric consultant's role here is 2-fold. The first function is to communicate to the consultee the assessment of capacity. The second is to know the law and/or to contact the legal experts affiliated with the hospital to determine the legal standards in that jurisdiction and then to advise the team about what to do next (e.g., obtain an emergency legal hearing). Although psychiatrists are often called to make such decisions, any physician can determine the decision-making capacity of a patient.

In Mr. A's case, it appears likely that the LP could (and should) have been done on the night of admission. Most would consider a patient with AIDS and a fever of 104°F (40°C), with a change in mental status and a headache, to be at imminent risk of serious harm, and a LP is indicated in this clinical scenario to provide necessary information to guide treatment.

Whether the LP should have been done the next morning—when the patient was afebrile and on antibiotic treatment—is less clear. Some would no longer consider this an emergency procedure and would recommend a legal hearing as soon as possible to obtain a surrogate decision maker; the procedure would not be performed unless the situation again became emergent.

In the case of Mr. A, the psychiatric consultant consulted with the legal department of the hospital and discussed the case with the medical team. The medical team and the infectious disease consultant agreed that, because the patient's mental status and fever were now worsening despite treatment and no etiology or infectious agent had yet been identified, the LP qualified as an emergency procedure. Consultation with the legal team confirmed that this was a reasonable definition of emergent in this jurisdiction, and the LP was performed.

Drug names: acyclovir (Zovirax and others), flumazenil (Romazicon), haloperidol (Haldol and others).

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2. Schouten R. Legal aspects of consultation. In: Cassem NH, Stern TA, Rosenbaum JF, et al, eds. Massachusetts General Hospital Handbook of General Hospital Psychiatry, 4th edition. St. Louis, Mo: Mosby; 1997:415–436

ANNOTATED BIBLIOGRAPHY

Review Articles

Appelbaum PS, Roth LH. Clinical issues in the assessment of competency. Am J Psychiatry 1981;138:1462
–A well-written discussion of several clinical factors that must be considered during capacity assessments to avoid premature or erroneous conclusions about a person's decision-making ability. These factors include psychodynamic aspects of the patient's personality, the accuracy of the information provided by both the patient and the treating physician, the effect of the treatment setting, and the stability of the patient's mental status over time.

Appelbaum PS, Grisso T. Assessing patients' capacities to consent for treatment. N Engl J Med 1988;319:1462–1467
–A clear, detailed, practical guide to the assessment of decision-making capacity that has become the seminal article on the subject. It delineates the 4 criteria used in the determination of decision-making capacity.

Mahler J, Perry S. Assessing competency in the physically ill: guidelines for psychiatric consultants. Hosp Community Psychiatry 1988;39: 856–861
–This review outlines a procedure for the assessment of capacity (referred to as "apparent competency") in the general hospital. The authors outline 4 important aspects in the capacity assessment of physically ill patients; these include the clinical evaluation of the patient, interventions with staff and patients, treatment recommendations, and appropriate documentation. Case vignettes are used to frame pertinent issues.

Christensen K, Haroun A, Schneiderman LJ, et al. Decision-making capacity for informed consent in the older population. Bull Am Acad Psychiatry Law 1995;23:353–365
–A review of 12 studies of capacity and informed consent in elderly persons. The authors report that aging appears to be associated with impairments of decision-making capacity. Elderly persons with medical illness, low vocabulary levels, and low education levels appear to be at greatest risk for impaired decision-making capacity.

Zaubler TS, Viederman M, Fins JJ. Ethical, legal, and psychiatric issues in capacity, competency, and informed consent: an annotated bibliography. Gen Hosp Psychiatry 1996;18:155–172
–A useful compendium of important articles in this subject area. The authors begin with an introduction of the topic and a discussion of the history of informed consent. The authors then provide descriptions of articles in 3 domains: the ethical and legal foundations of informed consent, clinical issues in the assessment of decision-making capacity, and empirical studies of clinical and demographic characteristics of capacity assessments. Sixteen articles in total are reviewed.

Schouten R. Legal aspects of consultation. In: Cassem NH, Stern TA, Rosenbaum JF, et al, eds. Massachusetts General Hospital Handbook of General Hospital Psychiatry, 4th edition. St. Louis, Mo: Mosby; 1997:415–436
–A well-written discussion of competency, capacity, informed consent, civil commitment, and other consultation issues related to the law. Several useful clinical vignettes help to frame the discussion.

Wong JG, Clare IC, Gunn MJ, et al. Capacity to make health care decisions: its importance in clinical practice. Psychol Med 1999;29:437–446
–This article examines different criteria that have been used to determine capacity, the domains that are assessed in capacity evaluations, and different methods of substituted decision making. The article ends with an algorithm for decision making that is useful, although the recommendations are largely based on legal standards in England and Wales.

Original Articles

McKinnon K, Cournos F, Stanley B. Rivers in practice: clinicians' assessments of patients' decision-making capacity. Hosp Community Psychiatry 1989;40:1159–1162
–A retrospective review of 42 capacity evaluations of state hospital patients submitted to a New York court over a 1-year period. The authors assessed such evaluations by determining if they contained the 3 standards of decision-making capacity outlined by the New York Office of Mental Health: factual understanding of the proposed treatment, rational use of information to make decisions, and appreciation of the consequences of the decision. The authors found that only 12% of such evaluations contained all 3 standards, and that the majority made general

comments about mental function rather than more appropriate specific discussions of treatment-making ability.

Fitten LJ, Waite MS. Impact of medical hospitalization on decision-making capacity in the elderly. Arch Intern Med 1990;150:1717–1721
–This study compared the decision-making capacity of 25 medically hospitalized elderly persons (who were calm, cooperative, and presumably competent) with 25 age- and education-matched controls. Subjects were given 3 clinical scenarios to assess their decision-making capacity. The authors found that medical illness may be associated with impaired decision-making capacity in the elderly. Furthermore, this study suggested that impaired decision-making capacity among elderly medical inpatients may be more widespread than previously understood.

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–The authors described 4 cases of seriously ill patients for whom delirium resulted in a lack of capacity to make life-and-death decisions about their medical care. In all 4 cases, aggressive treatment of their delirium (with flumazenil or haloperidol) resulted in improvement of delirium and return of decision-making capacity. The patients were then able to express their wishes regarding heroic life-saving measures. The authors commented on the importance of aggressively treating symptoms of delirium to allow patients to regain the capacity to make important decisions about medical and surgical interventions.

Appelbaum PS, Grisso T, Frank E, et al. Competence of depressed patients for consent to research. Am J Psychiatry 1999;156:1380–1384
–This study examined the ability of subjects (26 women outpatients with depression) to provide informed consent for a research study. The authors found that nearly all patients had capacity to provide informed consent, confirming clinical experience that mild depression does not frequently impair decision-making capacity.

Moser DJ, Schultz SK, Arndt S, et al. Capacity to provide informed consent for participation in schizophrenia and HIV research. Am J Psychiatry 2002;159:1201–1207
–The authors assessed the ability of the subjects (25 persons with schizophrenia and 25 persons with HIV infection) to provide informed consent to a hypothetical drug trial. Eighty percent of the patients with schizophrenia and 96% of patients with HIV infection had the capacity to consent to the trial. This suggests that diagnoses of schizophrenia or HIV infection alone do not necessarily result in impaired decision-making capacity.

Ganzini L, Volicer L, Nelson W, et al. Pitfalls in assessment of decision-making capacity. Psychosomatics 2003;44:237–243
–The authors surveyed 395 consultation-liaison psychiatrists, geriatricians, and geriatric psychologists about 23 potential pitfalls and misunderstandings in the assessment of decision-making capacity. A misunderstanding about the fact that capacity is decision-specific rather than global was rated the most common pitfall among practitioners (and the most important pitfall to be addressed through education); confusion between the legal term *competence* and the clinical assessment of capacity was also felt to be very common. The authors concluded that additional education around decision-making capacity and its assessment is necessary.