The Effect of Psychotic Symptoms on Decision-Making Capacity and Its Assessment in a Patient With Schizoaffective Disorder

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One of the 4 pillars of medical ethics—patient autonomy—demands respect for an individual's wishes regarding their own health care. It is imperative, however, to ensure the individual is capable of executing effective decision-making. According to Grisso and Appelbaum,[1] the capacity to consent to or decline medical intervention relies on 4 distinct factors: the ability to communicate a *preference*, factual *understanding* of information relevant to the decision, *appreciation* of the facts presented and how they directly relate to the individual and their situation, and their *reasoning* with the information. All these factors must be present and free from coercion for a patient to be considered capable of making a treatment decision. Without this ability, a patient is in danger of selecting a treatment option that is not genuinely in line with their own wishes and has the potential to cause considerable harm. Assessment of decision-making capacity has now become an integral part of daily clinical practice and can be rather complex and at times even controversial. Despite being frequently consulted to help assess difficult cases regarding decision-making, half of psychiatrists believe the evidence base in the area of decision-making capacity is weak,[2] and it has been shown that physicians fail to recognize incapacity as much as 58% of the time.[3]

Studies[4,5] show that up to 75% of patients with severe mental illness, such as schizophrenia or bipolar disorder, retain their ability to make medical decisions despite the presence of their psychiatric symptoms. Therefore, it is important for a physician to avoid assuming that the presence of severe mental illness in a patient precludes them from having effective decision-making capacity. Conversely, thorough and accurate assessments must be done to avoid missing incapacity when it is indeed present.

We present a case of an individual with schizoaffective disorder who initially seemed to have decision-making capacity to refuse hemodialysis as life-sustaining treatment; however, upon further assessment, it became apparent that initially discrete psychotic symptoms were impacting the patient's capacity to refuse treatment.

Case Report

Mr A, a 62-year-old Black man with a history of hypertension, type II diabetes mellitus, chronic kidney disease, and schizoaffective disorder, presented to the emergency department from his nursing facility in March 2022 for shortness of breath and hypoxia. He was found to be in hypertensive crisis with flash pulmonary edema and acute hypoxic respiratory failure, requiring a nitroglycerin drip and bilevel positive airway pressure. Chest x-ray showed vascular congestion with prominent vascular markings, and electrocardiogram showed sinus rhythm with P-pulmonale and poor R wave progression.

Nephrology was consulted for worsening renal function, as his creatinine level was 5.40 mg/dL. It was concluded that he was approaching end-stage renal disease, and dialysis was discussed as an impending treatment option that would be necessary for sustainment of life. In the initial nephrology consult, it was noted that Mr A "has no plans for dialysis" and "understands the consequences of no dialysis." Mr A was then admitted to the intensive care unit.

Over the next few days, Mr A was adamant with his primary team, a different consulting nephrologist, and a consulting urologist that he did not want dialysis. It was well documented that Mr A was focused on alleviation of pain rather than prolonging life, and he was able to communicate that refusal of dialysis would be terminal. Though Mr A expressed a clear choice and seemed to understand the facts of his situation and choices, there was some skepticism regarding his health literacy among the treatment team, and his hospitalist decided to consult the psychiatry department for capacity to refuse treatment. The hospitalist explained that the patient seemed to refuse or was unable to answer questions at times and thought it best to have the psychiatry team weigh in before proceeding with a treatment option (or withholding one), which would certainly result in death.

During the psychiatric interview, Mr A demonstrated significant thought slowing and speech latency; however, if given the time (up to 30 seconds in some instances), Mr A could answer almost all questions asked of him. He was alert and oriented to person, place, and time. He confirmed he had consistently communicated that he did not want dialysis.

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He expressed understanding of his disease and that without dialysis he would almost certainly die a horrible death. He reported knowing he could live many more years if he chose to proceed with dialysis. At that point, Mr A was asked to explain his reasoning behind the choice he had made. After a long pause, he began to cry and seemed hesitant to explain his rationale. The decision was made to pivot the interview to evaluate psychiatric symptoms, and it was discovered that Mr A was not only experiencing significant depressive symptoms, but also hearing affect-congruent command auditory hallucinations to refuse dialysis. He said these voices were leading him "into torment" and telling him to hurt himself, despite that he personally wanted to proceed with dialysis. He also reported a remote suicide attempt that occurred due to command auditory hallucinations telling him to hurt himself. After discussion, the patient repeated several times that he did want dialysis if needed.

A review of Mr A's chart revealed that clozapine was not ordered at admission, and he had been without it for at least 4 days. The recommendation was made to retitrate the clozapine back to the previously effective dose and proceed with dialysis when indicated. It was also recommended that the patient receive a formal psychiatric evaluation for capacity for all future major medical decisions, including if the patient decided to decline dialysis again. Within a few days, Mr A's mood, affect, psychotic symptoms, and reported pain improved significantly, and he consistently maintained his decision to proceed with dialysis if needed. He was discharged back to his nursing home on hospital day 9 once medically and psychiatrically stable.

Discussion

The primary goal of capacity assessment is to strike an appropriate balance between patient autonomy and protecting those patients who do not have proper capacity from making harmful decisions. At baseline, clinicians are less likely to assess a patient as lacking capacity.[6] However, when presented with a case in which the consequences of the decision are life versus death, it is imperative to fully explore all the facets of decision-making as identified by Grisso and Appelbaum.[1] Although Mr A was initially consistent in communicating a preference as well as expressing understanding of his illness and the risks and benefits of treatment options, the breakdown in his decision-making capacity came in both his appreciation for how the facts applied to his own situation and his rational manipulation of the information or reasoning.

A systematic review by Hindmarch et al[7] found that appreciation is the ability most notably impaired by depressive illness. The authors[7] further explained that depression may cause a "lack of decisional authenticity," meaning an individual with depression may make decisions that are not reflective of "their 'true' autonomous self." Guilt and worthlessness may make an individual believe their suffering and death are deserved, or their helplessness may make them believe there is no way for their pain and pleasure to ever reach a better balance than its current state. As a result, they lack true appreciation for how their life could be impacted by the medical decision they are making. Mr A demonstrated significant depressive symptoms and was focused on alleviation of pain rather than curative treatment. Notably, after his psychiatric symptoms were addressed, Mr A found his pain to be much more tolerable, showing that his decision-making capacity was indeed being affected by perceived helplessness. On initial psychiatric assessment, his perceived worthlessness was demonstrated by the affect-congruent voices he was hearing leading him into torment and telling him he deserved to die.

Once he admitted these symptoms aloud, he gained enough insight into the impact they were having on his decision-making that he was able to consider his own individual values better, which ultimately led to a different decision. One may also argue the voices inserted a significant amount of coercion into the decision-making process, further calling the initial decision into question.

While some studies have shown that psychotic symptoms may affect appreciation, they are more strongly associated with a decline in the understanding and reasoning aspects of decision-making capacity.[2,8] In a systematic review, Larkin and Hutton[2] found that "psychotic symptoms had small, moderate, and strong associations with appreciation, understanding, and reasoning, respectively."(p205) Other studies[9,10] have found that impaired decision-making capacity in patients with psychosis was more strongly related to cognitive dysfunction rather than severity of psychopathology. In the case of Mr A, his reasoning was being directly affected by positive psychotic symptoms, namely, his command auditory hallucinations. If his rationale had not been fully explored, he likely would have been assessed to have full decision-making capacity. A similar case was reported by Linn et al[11] in which a patient with treatment-resistant schizophrenia initially appeared to have decision-making capacity, but after further exploration of his reasoning was found to have paranoid delusions affecting his decision to refuse diagnostic colonoscopy for suspected caecal cancer. These cases support the fact that the presence or absence of capacity is not always immediately obvious, and special care should be taken to explore each facet of preference, understanding, appreciation, and reasoning. This can be especially difficult when the interview is affected by symptoms of psychosis. In the case of Mr A, the initial assessments of his capacity to refuse dialysis were affected by significant speech latency and thought slowing, making it difficult for clinicians with tight schedules and busy clinical services to allow adequate time for thorough answers.

Conclusion

Incapacity is common and important to recognize. While the majority of severely mentally ill patients retain their ability to make medical decisions, there is still a large percentage whose decision-making capacity is affected by their symptoms. It is imperative for clinicians to maintain a high degree of suspicion when evaluating these patients'

capacity and to have a low threshold for consulting psychiatry services, if available, should there be any doubts or elements of preference, understanding, appreciation, or reasoning that remain unanswered or unclear. Use of a formalized assessment tool such as the Aid to Capacity Evaluation[3,12] can be helpful in effectively evaluating decision-making capacity in a structured, consistent manner. Staying mindful of recent changes in care and ensuring that medications have been reconciled is also important. Finally, being aware of how a patient's mental health may affect their decision-making capacity or their ability to communicate their thoughts will lead to an overall improved capacity assessment.

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