1.3 Decisional Capacity

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Educational Objectives

1. To clarify the role of decisional capacity in informed consent
2. To discuss problems associated with decisional capacity and addiction

Case

Mr. N., aged 46 years, is admitted to emergency by ambulance after collapsing on the street at 4:30 in the afternoon. He arrives intoxicated (from alcohol and illegally purchased prescription opiate pain killers, in this case, Percocet). As he is wheeled into the emergency triage room, he is clutching his heart. In addition to being intoxicated, he also appears to be in considerable pain. After routine examination, questioning and laboratory testing, the patient is diagnosed with an acute myocardial infarction and severe substance dependence to opiate drugs.

Apparently, Mr. N. became addicted to prescription opiates as a result of a workplace back injury, from which he has never fully recovered, leaving him to sustain himself on social assistance. No longer able to obtain opiates by prescription, Mr. N. feeds his addiction to opiates through purchases from street dealers. He claims to have been using opiates for the last two years.

Although Mr. N. is clearly intoxicated during interview, slurring his words and rambling in speech, he is judged sufficiently decisionally capable — that is, "mentally competent" — to provide consent to treatment by the attending physician. Consent is verbally sought and obtained regarding treatment for his myocardial infarction. Intravenous treatment is initiated, and a non-opioid sedative is administered. After being informed upon questioning that proper treatment will require several days of hospitalization, the patient is transferred to a ward and quickly falls asleep.

Six hours later, Mr. N. suddenly awakes, reporting nausea, generalized malaise and muscle aching. These discomforts soon evolve and there is a marked increase in his symptoms of distress. The physician on call is called to the bedside. After reading Mr. N.’s chart, the resident on duty records "opiate withdrawal." Non-opioid sedatives are administered, but the symptoms of distress persist. Several hours have elapsed, and by this point the patient is in acute distress. The patient starts pleading with hospital staff, asking for prescription opiates — "anything you have."

One of the team physicians suggests that it would be best to provide this man with opiate drugs — to avoid his withdrawal symptoms and to avoid having his condition worsen his myocardial infarction. Methadone treatment is suggested by another staff person on the treatment team. Discussion by the team centres on the fact that the patient is already addicted to "prescription drugs." The team decides to prescribe regularly dosed oral morphine to treat his withdrawal and dependence as treatment of his cardiac condition is pursued. Methadone is not offered.

The oral morphine dosing stabilizes the patient, although he continues to want more narcotic. He is no longer in withdrawal. He agrees to the treatment plan of his heart attack. He states that he is able to stay in the hospital for cardiac care and admits that the morphine is helping him, acknowledging he wants further narcotic. He states quite openly that he is addicted to Percocet and does not wish to stop using now. He understands that he has had a heart attack and that he is medically unstable and at high risk of having further cardiac complications. Another night passes. He then leaves the ward in the early hours of his third day just at nursing shift change, having disconnected himself from the cardiac monitor and removing his intravenous catheter. He swears at the staff on the way out, and is noted to be fully clothed and purposeful in his exit. He waited until after his morning dose of morphine before leaving. On morning rounds, the cardiology team simply finds an empty bed and an angry nursing staff.

Back on the ward floor, the treatment team assembles and reviews the incident. A review of the patient’s treatment progress indicates that he may not survive very long upon leaving hospital so shortly after his...
myocardial infarction. If he does survive, he will likely have far worse cardiac function than would have been possible if he had received a full course of treatment. One member suggests that the patient should have been rehospitalized involuntarily, since he was clearly unstable mentally and in a condition to harm himself. Worries are expressed that the patient could eventually sue them on these grounds. The hospital lawyer is consulted the next day and advises that there is little chance that such a suit would be successful, since the team followed the "standard of care." The patient is deemed to have been sufficiently competent to refuse treatment.

**Questions**

1. Was consent appropriately obtained?
2. Are these good grounds for refusing to offer methadone treatment for withdrawal symptoms — while the patient is required to be hospitalized?
3. Was the patient decisionally capable to give informed consent and refuse treatment?

**Discussion**

**Q1. Was consent appropriately obtained?**

In Canada, the specific legal requirements for informed consent are a matter of provincial jurisdiction. Normally, in order to be deemed valid, consent must be voluntary, properly informed and capable. This last requirement, that consent be capable, refers to decision-making capacity. The clinical counterpart of this legal concept of decisional capacity is often referred to as "mental competence." However, in many cases the terms are used interchangeably. Generally, under the law, persons are presumed to be decisionally capable to make their own treatment decisions unless there are reasons to judge otherwise.

There are now legally sanctioned clinical methods to assess decisional capacity. Informal clinical judgment and the standard mental status examination are no longer deemed adequate standards, especially when the presumption of capacity is in question. Explicit evaluation by the physician proposing a given treatment is required of the patient's ability to understand the facts of the treatment in question and the ability to appreciate how such a decision relates to him or her specifically. An example of a clinical tool for assessing decisional capacity today is the MacCAT-T questionnaire developed by Tom Grisso, Paul Appelbaum and colleagues.1

It is important to recognize that decisional capacity in this sense is not a general notion, nor is it generalizable. It is a property of a specific putative decision by a particular person under particular circumstances at a particular time. It follows that capacity at one point in time and under one set of conditions does not imply capacity at a later point, under other conditions.

Because the patient in our example was intoxicated at the time consent was sought, the validity of that consent is questionable. This is because it is recognized that intoxication due to substance abuse of the sort involved in our example can impair capacity.2 In the case of substance dependence to opiates, it is also recognized that capacity will fluctuate as the dependent individual cycles from craving to use to withdrawal, and back.3 Therefore, substance dependence to opiates can impair capacity depending on when and under what conditions consent is sought.

In this case study, the time at which consent was sought makes it highly likely that Mr. N.'s capacity was impaired. Consequently, the validity of the consent that was obtained is questionable. Moreover, in severe substance dependence, capacity can be expected to fluctuate, meaning that the consent obtained from an individual at one point in the addiction cycle might be overturned by that same individual at a later point.

It is crucial to hold in mind the different, but related, treatment decision pathways for this patient. First, the patient has sustained a myocardial infarction, which is a life-threatening condition with a natural history and for which the underlying cause (thrombus, a narrowing of the arteries supplying the heart) has treatment options available (thrombolitics, anti-coagulants, angiography/stenting or bypass). Second, the patient has a narcotic dependence, the withdrawal from which can worsen his cardiac condition. Addiction is an illness and will require concurrent effective treatment, both to treat the addiction and to prevent worsening of the patient's cardiac condition.

Consent to treatment does not occur in isolation. Finding that a patient is "incapable" of understanding and/or appreciating a given proposed treatment does not mean that the process to obtain care stops. In an immediately life-threatening situation, the treating physician is, in ethics and in law, obligated to provide emergency care. In Canadian jurisdictions, if a patient is not capable (as determined by the treating physician), then the physician has an obligation to make a reasonable attempt to find a substitute decision-maker. In provincial law, there is what is
commonly called a "hierarchy of decision-makers," such that individuals with a defined relationship to the patient such as spouse, sibling, parent, child or appointed legal representative are able to make decisions on the patient's behalf if he or she has been found incapable.

In addition, the patient in this case would qualify for detention under the appropriate mental health act in all jurisdictions in Canada on the grounds that he has a mental illness and is behaving in ways that are an imminent risk to himself. Of note, this is independent of an assessment of capacity.

In some jurisdictions, such as Ontario, there is a readily accessible formal appeals process, by which a patient deemed incapable by his or her treating physician is visited that same day by a "rights advisor," and the patient may decide to appeal the physician's finding. This appeal is held before a "Consent and Capacity Board" within seven days.\(^4\)

**Q2. Are these good grounds for refusing to offer methadone treatment for withdrawal symptoms — while the patient is required to be hospitalized?**

The patient requires treatment for his addiction while in hospital. This is a concurrent illness, and in the same way that his pneumonia would require care, so too does his addiction. There are different clinical approaches to this problem — one could consider methadone or another opioid, such as oral morphine.

It is important to recognize, however, that the treatment of addiction is a lifelong process and that the patient did not come to hospital seeking assistance for this problem. He may not wish to stop using narcotics. Methadone may be proposed, but its use is generally considered to be best within a supervised treatment program in a patient desiring assistance.

The ethical point here is that the patient should not feel (and in fact be) coerced into accepting treatment for his addiction in order to obtain treatment for his heart attack.

In addition, people also have the right to make decisions that, from the point of view of the treating team, may not be in their best interests.

**Q3. Was the patient decisionally capable to give informed consent and refuse treatment?**

At his initial presentation, the patient was not capable. Mr. N. was unable to understand or appreciate his heart attack or his addiction. This was demonstrated by his presentation while actively intoxicated from narcotics and alcohol. In fact, he may also have been in delirium tremens, which has a mortality rate of 20 per cent if untreated and would have put this man, given that he had a heart attack, at a higher risk of death.\(^5\) Importantly, his incapacity does not mean he cannot benefit from medical care. In each province, there will be a legal structure in place to provide emergency care and access a substitute decision-maker.

Mr. N. became capable once admitted to the hospital and after being treated with oral morphine. During this period he was able to talk fully about his medical problems, recognizing his heart attack and the seriousness of this event. He also was able to talk about his addiction and state that he did not wish to change his use of Percocet at this time.

Again, there are two separate, though related, treatment pathways here: treatment of his heart attack and treatment of his addiction. His heart attack is immediately life-threatening, and lack of management of his addiction will worsen his cardiac status.

Addiction treatment is only successful with the participation of the patient. It cannot be treated in an acute care short-stay medical admission. One can, however, treat the patient while being respectful of his or her autonomy to make "bad" choices. Respectful treatment will move people along in a stages-of-change model (precontemplation, contemplation, preparation and action) type of response to addiction.\(^6\)

If the patient was capable and he then refused treatment, his refusal would stand. Assessment of capacity does not depend upon the decision itself. This means that if he was capable, due to appropriate management of his heart attack and his opioid dependence, and decided not to stop using narcotics upon discharge, his medical team would be under no obligation to provide outpatient narcotics but would be obligated to remain supportive and to refer the patient to outpatient addiction services that he might or might not access. In this case, the patient simply left without discussing his plans with his treatment team. He did, however, appear to do so in an organized and purposeful manner, planning a departure around the nursing routines of the ward when he would be the least observed. He can be assumed to have been capable because he demonstrated understanding and appreciation of
the details of his case just the day before and because of his thoughtful, if ill-advised, hospital departure. He did not display any signs or symptoms of delirium. Capacity is presumed, unless strong evidence exists to the contrary.

It is also crucial to note the feelings of the nursing and cardiology team. It will be important for the treating team to acknowledge that some patients are simply difficult to care for and that, as a team, all members have feelings around patients when care, given with the best intentions, is refused. Such reflection and open discussion can be crucial as future patients with similar presentations may inherit lingering negative assumptions about care. These negative assumptions can be destructive to having honest evaluations of key medical assessments such as decisional capacity.

References


Further Reading