Medicolegal pitfalls when assessing decision-making capacity in people with cognitive impairment

CPD

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Background
The global population of older adults will double over the next three decades, and one in 10 will have dementia.

Objective
This article examines medicolegal pitfalls when assessing the decision-making capacity of cognitively impaired patients.

Discussion
Be aware of the pitfalls while completing the five steps of the assessment. Step 1, the request for a capacity assessment, alerts the clinician that this is more than an administrative form-filling task and that the consultation is not therapeutic. Step 2, initiation of the consultation, requires being prepared for a new diagnosis of dementia, explicitly obtaining consent and understanding the expectations of all involved. Step 3, the clinical assessment, requires avoiding assumptions about the patient and the law, completing tests of cognition, including executive function, and ensuring a detailed understanding of the matter requiring a decision. Step 4, the formulation of opinion and documentation, requires documenting and addressing the legal questions about function and impairment. Step 5, review and reflect assuming somebody will contest the opinion.

DISCOVERING and enumerating the medicolegal pitfalls in assessing the decision-making capacity of cognitively impaired patients continues as society wrestles with addressing and respecting older people's rights.[1] International initiatives to recognise and respect the rights of older people are growing.[2]

The increases in longevity and in the prevalence of dementia are creating a society where a substantial proportion of the population consists of older people with cognitive impairment. By 2050, the global population of older adults aged 65 years and older will have doubled (compared with 2019), reaching 1.5 billion people, equating to one in six individuals.[3] Over that same period, we expect there will be 153 million people with dementia.[4] Clinical practice must adapt by incorporating a better understanding of the law applicable to an ageing population, particularly for those with dementia and other forms of cognitive impairment.[1]

Key principles

The following key principles provide a foundation for understanding the potential pitfalls when assessing decision-making capacity.

- Assessing a patient's capacity must be decision specific. Examples of decision-specific situations include medical treatment, appointing a power of attorney, sexual intimacy, entering a contract, making a will and voting in an election.
- The structure of the assessment is the same regardless of the (decision-specific) reason for the assessment.
- The process during the assessment must be different, so it is tailored to each specific situation.
- There are different legal tests for each situation.
- The object of the assessment is to determine decision-making capacity, not the merits of the actual decision.

Structure for assessing a patient's decision-making capacity

A five-step chronological structure for determining a patient's decision-making capacity illustrates some medicolegal pitfalls facing clinicians. These pitfalls also apply to requests made to a medical practitioner to provide a retrospective assessment of the decision-making capacity of their patient, most often related to testamentary capacity. A retrospective assessment has additional challenges and pitfalls.

Step 1: Request for a capacity assessment

Although this article focuses on responding to a third-party request for

a capacity assessment, the patient's treating medical practitioner will often initiate the assessment to obtain consent for medical care.

A request to assess a patient's decision-making capacity arrives in various ways. The request might be a formal written legal letter, an 'off-the-cuff' comment by family or a telephone call from a distressed community services provider. These are not simply administrative, bureaucratic form-filling tasks. These ad hoc requests are challenging and completed to a highly variable standard.[5]

The first medicolegal pitfall is simply accepting the request at face value. A request to determine a patient's capacity should raise a 'red flag' with the clinician. These requests are often a prelude to significant and substantive decisions about the patient's current and future financial affairs, accommodation, lifestyle and healthcare matters. In addition, after every capacity assessment, regardless of the outcome, the flow-on effects might be profound for the patient, their family and others. It is also common for there to be a disaffected party.

The second pitfall is assuming the consultation is the usual clinician–patient therapeutic relationship. In this situation, the clinician's role is to provide a legal evidentiary base of a person's cognitive ability. Capacity is a legal construct generally considered present when we reach adulthood. The request to a clinician, although not directly specified, seeks to determine whether a person lacks capacity. As such, it is vital to understand the background and context for the request, because it often arises when there is an impasse in a matter or a third party disagrees with a patient's decision. The clinician must be alert to the potential for a framing bias and consider whether there are any unspoken motivations for the request.

Step 2: Initiation of the consultation

The third pitfall is entering the consultation being task focused or tunnel visioned. Assessing a patient's decision-making capacity does not negate the health implication that might arise if cognitive impairment is demonstrated. Cognitive impairment, in particular dementia, is generally under-recognised and underdiagnosed.[6] A consultation that began as an administrative task might quickly and unexpectedly evolve into one where the patient and their family are dealing with a new diagnosis of dementia.

The fourth pitfall is the failure to obtain consent for this capacity assessment. Obtaining consent is often overlooked because much of clinical practice relies on the concept of implied consent for healthcare. That is, the patient has consented by attending the consultation. Recall that this examination is for a medicolegal report, not for the patient's healthcare. Further, it is naïve to ignore the potential sinister spectre of elder abuse,[7] particularly financial abuse, which is far more common than most health professionals realise. It is important to seek consent by asking the patient directly when alone to remove any potential source of duress from their family.

Gathering collateral information might reveal underlying motives; do this by asking, 'Why now?'. The timing might be consistent with the patient's life stage. Alternatively, a logical and overly conscientious offspring wants 'everything sorted out now while in town'. Perhaps, there is underlying disharmony in the family about the distribution of the patient's wealth or accommodation and care needs.

The fifth pitfall is a mismatch in expectations[5] in what is being sought and what the clinician is willing to deliver. A legal practitioner completes the vast majority of wills, property and other financial contracts; appointments of powers of attorney occur daily without any medical practitioner involvement. Always ask, 'Why is a medical assessment needed?'. The answer might change the approach or willingness to complete the task. Perhaps the patient's lawyer is being cautious because of the patient's age or a known diagnosis of dementia; perhaps there is discontent within the family; or perhaps the patient's decisions appear irrational or bizarre. Formulating an approach requires considering the level of information we are comfortable providing, including:

- confirmation of a diagnosis – clinical, straightforward and uncontroversial (eg Alzheimer's disease)
- delineation of a disability, which requires clinical and functional assessments (eg Alzheimer's disease with deficits predominantly in new learning and memory)
- assessment of how the disability impairs decision making, which requires an opinion and conclusion (eg Alzheimer's disease with deficits predominantly in new learning and memory that impairs decision making in complex healthcare management matters; however, they can make financial, accommodation and lifestyle decisions).

Step 3: Clinical assessment

The sixth pitfall is making assumptions about a patient's function. A capacity assessment is time consuming because it must be tailored to the subject matter. Relying on general information gathered from previous consultations about a patient who is well known to the clinician might overestimate the patient's functional status. In contrast, a pre-existing diagnosis of dementia creates the potential for confirmation bias about lacking capacity rather than an objective assessment of function.

The seventh pitfall is failure to complete a global or general patient assessment. Concurrent physical, psychological and emotional states might negatively impact cognitive function and decision making. Consider whether postponement to a later date is more appropriate under these circumstances. A short delay that allows the patient to participate fully at a later date is always preferable and less contentious. It is essential to exclude other conditions that might be amenable to treatment or create disturbed thought processes, such as acute or severe mental illness, psychoses and delirium.

The eighth pitfall is a failure to examine the executive function domain in detail. Executive function includes problem identification, planning, judgment and response regulation. The other five cognitive domains are perceptual motor function, language, learning and memory, complex attention and social cognition.[8]

Executive dysfunction is typically the first area of cognitive impairment to develop, and clinicians might dismiss the changes assuming that the person is becoming more eccentric or obtuse. The reason to highlight executive dysfunction is that it might not be obvious when it occurs. Unfortunately, the most commonly used screening test for cognitive impairment in older people, the Mini-Mental State Examination, does not measure executive function. Including other tests, such as clock drawing or the Montreal Cognitive Assessment, is helpful because these provide information about executive function.[9]

The ninth pitfall is the failure to gather sufficient detail about the matter requiring a decision. Assessing whether a person can decide involves determining their understanding of the matter, the assets and rights (eg financial, physical, health status), the reason a decision is required, the range of options available to manage the matter and the consequences of the different options. This information must be specific to the person and their circumstances, which might require comprehensive information, not of any medical value.

Collateral history is essential; however, be wary because second-hand information is often framed and interpreted through another person's eyes. Sadly, it is also not unusual for the partner of an older patient with cognitive impairment to be cognitively impaired.[10] It is very vexing when both people in the patient–carer dyad have cognitive impairments, especially when their accounts of the same situation diverge. Establishing the veracity of the situation requires considerable effort and triangulation from multiple sources.

Compounding the situation is that health professionals often need detailed background knowledge to address non-health-related matters. For example, to what extent should the clinician understand the patient's estate and the range of potential beneficiaries when assessing testamentary capacity? Consider these examples:

- no immediate family, domicile is a rental property and receives an old age pension
- blended family with offspring from both marriages and stepchildren, domicile is a large farm property recently rezoned for urban development, has an extensive share portfolio and owns a beachside holiday house.

For some, assessing a patient's capacity to manage their financial affairs requires an understanding of the entirety of their estate and the risks and benefits of their current and proposed different investment strategies. Not a simple task with the wealth accumulated by the baby boomer generation. Others argue this comprehensive level of detail for testamentary and financial capacity is not necessary. Unfortunately, the actual detail required in each case is judged when the matter is contested in a court of law.

The 10th pitfall is assuming the laws around capacity are the same regardless of the matter or jurisdiction. The legal test for capacity varies depending on the matter in question; for example, there are different criteria for medical treatment, advance directives (for medical treatment decisions), appointment of a power of attorney, appointment of a guardian, consent to treatment under the *Mental Health Act*, sexual intercourse, entering a contract, making a will and voting in a federal election.[11] Complicating the situation is the variation between the laws in each state and territory of Australia. It is essential to know the specific law for the relevant jurisdiction as these apply to the patient.

Step 4: Formulation of opinion and documentation

The 11th pitfall is when the clinician formulates their conclusion. The absence of capacity is a legal determination. The clinician assesses a person's cognitive function and offers an opinion about their functional performance. Although a diagnosis is a critical step in patient management, the legal system does not require the aetiology of the condition that causes the disability. The primary consideration is whether a disability is present, whether it is permanent or temporary and whether impaired decision making is present. The presence of cognitive impairment does not equate with a lack of capacity. In addition, lacking the capacity for one type of matter does not imply a lack of capacity in all decision-making areas.

A court of law determines the absence of legal competence; it is not the role of the clinician. This approach protects the patient from clinicians' propensity to value rational, objective and logical decisions. The rationale an individual provides for their decision making is highly individual and personal;[12] it does not need to be reasonable or logical. Individuals do not need to explain their choice, only its consequences.

The 12th pitfall is that the written report requires a different approach to clinical-style documentation. The report does not convey therapeutic information, is intended for a non-clinical audience, addresses legal criteria and might be contested in court with potentially substantial impacts on unknown third parties.

The academic literature has standardised guides and criteria for assessing capacity, which should be read in preparation for patient consultation.[13] Be cautious in transferring the criteria to other countries and jurisdictions, because these might need to be validated. In Australia, it is essential to check for publications by the jurisdictional government departments[14,15] and the statutory officer responsible for safeguarding the rights of people with a disability, such as the Office of the Public Advocate[16] or law institute.[17]

Document in a manner and level of detail that another clinician could replicate the consultation. The documentation describes the procedural aspects, such as the patient providing consent, being a voluntary participant, the mode and comprehension of the communication (verbal, written, non-verbal), the use of an interpreter and the presence of any other third party and their role.

Provide objective data that support the conclusion. These data might include noting the clinician's questions and patient's responses verbatim. It is not enough to state a conclusion. It is essential that how the clinician arrived at their conclusion is explained.

Step 5: Review and reflect, assuming somebody will contest the opinion

The 13th pitfall assumes there will not be a direct legal challenge to the clinician's opinion of a patient's capacity. Reasons for initiating legal action are plentiful. The clinician must prepare with the understanding that adjudication of a contested opinion will occur within the legal system and that often there is a substantive lapse in time between assessment and event. If in doubt about a particular patient assessment:

- document what information was not obtained that would have been of value
- document the limitations of the assessment
- revisit the assessment at a later date to confirm initial impressions
- refer to other clinical experts, such as psychologists, neuropsychologists and psychiatrists.

Capacity for criminal matters is beyond the scope of this article, and it is best to refer these matters to a clinical forensic physician or forensic psychiatrist.

Conclusion

The need to assess the decision-making capacity of cognitively impaired patients as part of healthcare practice will continue. Understanding and acquiring the skills necessary to help our patients through their life course should be a rewarding experience for all. As health professionals, we should be able to guide patients through the spectre of additional administrative, regulatory and legal requirements to make their lives better. Remember, when something goes wrong, the law is most prominent – prepare accordingly.

Key points

- Increases in longevity and in the prevalence of dementia are creating a society where a substantial proportion of the population is older with cognitive impairment.
- Clinicians will increasingly assess the decision-making capacity of cognitively impaired older people.
- Capacity assessments are complex, with potentially profound consequences for the patient and their family.
- A proactive, structured and informed approach is required to avoid the substantial medicolegal pitfalls within the process of each structural step.
- The presence or absence of capacity is assessed based on the specific circumstances applied to the individual patient within the laws applicable to the jurisdiction.
- The presence of a neurodegenerative condition, such as dementia, in a patient should not be assumed to equate to a lack of decision-making capacity.
- The presence of executive dysfunction is often overlooked, so examine this domain expressly and carefully.

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