Decision making capacity

Autonomy allows patients to direct the course of their medical care and it is a core principle of medical decision making in the United States. Respecting autonomy enables patients to make decisions that are consistent with their lived and stated values, even if the decision (such as withdrawal of life sustaining treatment) results in their death. An important component of autonomy is decision making capacity (DMC) as patients must have DMC to make truly autonomous decisions. DMC may be evaluated by any physician or by a clinical ethicist performing a clinical ethics consultation.

DMC is different from the legal concept of competency. DMC is a clinical assessment while competency is a legal designation made by a judge regarding the ability of a person to make financial or healthcare related decisions. DMC relates to a specific decision while competency applies to all decisions that occur after the legal ruling. Physicians or clinical ethicists should clearly educate the patient and/or the patient's family about the difference between DMC and competency.

In general, patients aged 18 and older can make their own decisions. The presumption should be that the patient has DMC unless he or she demonstrates otherwise. Disagreement with the recommended course of medical treatment is not, by itself, necessarily a reason to doubt the patient's DMC. All clinicians should assess for DMC regardless of whether the patient's decision is in accordance to the medical team's recommendations. For someone to possess DMC, they must be able to communicate what their condition is, what the treatment options are for that condition, the benefits versus burdens of those treatments, the consequences of foregoing those treatments and then be able to articulate a decision that is consistent over time and aligns with their stated goals and values. DMC is situation specific meaning that a patient's DMC may wax and wane according to their underlying condition. For example, a hospitalized patient may have a temporary loss of DMC because of delirium resulting from his illness or medications. It is also contextual, meaning that a patient with a stable mental status may have DMC to make low risk decisions but not high risk decisions. For example, a patient may be able to choose what to eat for a meal but be unable to sign consent for a surgical procedure. It is important to remember that DMC is a dynamic, not a static condition and should be assessed (and reassessed) frequently. DMC assessments should also be specifically performed for the decision at hand – i.e. an assessment of insufficient DMC for a specific decision should not imply that the patient has a global deficiency in DMC.

Checklist in determining DMC:

Understanding does the patient understand the medication situation and the available treatment options?

Appreciation does the patient comprehend how the available treatment options will impact his life?

Reasoning is the patient able to rationally accept and manipulate relevant information about the decision?

Communication is the patient able to communicate his decision? Is the decision free of coercion?

Consistency with lived and stated values is the decision consistent with past statements or decisions? Is the projected outcome of the decision in line with the patient's stated goal? Is the decision a stable decision or has the patient wavered back and forth between two different options?

Physicians or clinical ethicists may disagree with each other's assessments of DMC. This does not indicate a flaw in the above process but illustrates the importance of obtaining multiple points of view from different disciplines within the medical team. Serious disagreements over a patient's DMC warrant careful and meaningful deliberations by multiple disciplines. This process is usually greatly aided by a clinical ethics consultation with an expect.

References

Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. N Engl J Med. 2007;357(18):1834-40.