Decision Making Capacity

Background Informed consent is based on the principle that patients should be allowed to make decisions for themselves. Decision making capacity thus serves as a gatekeeper concept. Patients who have it can make decisions for themselves; conversely, a surrogate is needed for patients who lack decision-making capacity. *Competency* is a legal term referring to a decision made by judge, although a clinician's opinion carries considerable weight in a competency hearing. In contrast, *decision-making capacity* ('decisionality') refers to a clinician's determination, based on clinical examination, that a patient can make medical decisions for him- or herself. Most state Health Care Power of Attorney (HCPOA) documents require a physician (or a similarly qualified individual such as a psychologist) to document that a patient is non-decisional and will need their surrogate, HCPOA, or guardian to make decisions for them.

Assessing decision-making capacity To be deemed 'decisional,' a clinician must be satisfied that a patient is able to do four tasks:

- Appreciate the clinical situation and its consequences to their health, and
- Reason through available treatment options, and
- Understand the relevant clinical information shared to them by the clinical team, and
- Communicate a treatment preference (e.g., the comatose patient is not decisional).

Clinicians should look for:

- Understanding**.** Does the patient adequately understand the information about the risks, benefits, and alternatives of what is being proposed? The patient does not have to agree with your interpretation but should be able to repeat what you have said. Ask, *Can you repeat to me the options for treating X I have just discussed with you? Can you explain to me why you feel that way? What is your understanding of what will happen if we don't do Y?*
- Logic**.** Is the logic the patient uses to arrive at the decision "not-irrational"? One wants, as much as possible to make sure the patient's values are speaking, rather than an underlying mental or physical illness. Note: Severe depression or hopelessness may make it difficult to interpret decisionality; consult psychiatry for assistance with this or other complex cases.
- Consistency. Is the patient able to make a health care decision with some consistency? This means not changing one's mind every time one is asked. Is the decision consistent with the patient's values? If there is a change in the patient values, can the patient explain the change?

Decision-making capacity is contingent.

- **Task specific.** Deciding if the patient is decisional means weighing the degree to which the patient has decision making capacity against the objective risks and benefits to the patient. Some decisions are more complex than others, requiring a higher level of decision-making capacity. A patient diagnosed with mild dementia for example may be able to make decisions about less complex, less risky clinical issues (e.g., naming a HCPOA) but not others which are associate with more complexity and clinical risk (e.g., chemotherapy for metastatic lung cancer). This sliding scale view of decisionality holds that it is proper to require a higher level of certainty when the decision poses great complexity and great risk of harm.

- **Time specific.** Decision-making capacity may change dependent on the patient's clinical status. A patient that is encephalopathic may not be decisional in the moment, but after treatment and their encephalopathy resolves, decision-making capacity can be regained.

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