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ARTICLE

Capacity Reconceptualized: From Assessment Tool to Clinical Intervention

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Abstract
Capacity evaluation has become a widely used assessment device in clinical practice to determine whether patients have the cognitive ability to render their own medical decisions. Such evaluations, which might be better thought of as "capacity challenges," are generally thought of as benign tools used to facilitate care. This paper proposes that such challenges should be reconceptualized as significant medical interventions with their own set of risks, side effects, and potentially deleterious consequences. As a result, a cost–benefit analysis should be implemented prior to imposing such capacity challenges, and efforts should be made to minimize such challenges in situations where they are unlikely to alter the course of treatment.

Keywords: autonomy; medical decision-making; decision-making capacity; decisional capacity; paternalism

The assessment of decisional capacity in the clinical setting has become a routine aspect of psychiatric practice since the President's Commission on Ethical Problems in Medicine urged the standardization of the practice in 1982. Up to 25% of psychiatric consultations in the hospital setting are for assessment of capacity, whereas nearly 10% of psychiatric inpatients are subject to such evaluations during the course of their admissions.[1,2] Various methods have been advanced for assessing capacity, but the most well-known and widely used is that proposed by Appelbaum and Grisso in 1988.[3] Their approach emphasizes the need for the patient to meet four distinct benchmarks to render a specific medical decision—the ability to express a clear choice, to understand relevant information, to appreciate the situation and its consequences, and to manipulate information rationally.[4] Often this method is coupled with a sliding scale model that determines the level of scrutiny used in the assessment based on such factors as the stakes of the decision and the degree to which it comports with the guidance of the medical providers.[5,6,7] What the Appelbaum and Grisso and sliding scale models share is the foundational belief that such assessments are a neutral and benign mechanism for maximizing patient autonomy, protecting patient welfare, and ensuring that "informed consent" is both informed and consensual. That assumption stands largely unchallenged in the literature of capacity evaluation, where debates focus almost entirely on *how* to assess capacity rather than *whether* to assess capacity. As a result, physicians are increasingly instructed that "assessing decisionmaking capacity should be thought of at every medical encounter" and that failing to do so is a disservice to the patient.[8] This instruction fundamentally fails to account for the fact that psychiatrists on average receive only one and a half lectures on capacity in the course of their training and self-appraise their training two on a five-point scale with 1 being "poor" and 5 being "excellent."[9]

The initial efforts to encourage capacity assessment in the 1970s and 1980s occurred as a response to the medical paternalism that had dominated the field in a previous era. Rather than having physicians render choices on behalf of patients, capacity evaluation was believed to be a tool that facilitated patients making decisions for themselves. Unfortunately, little, if any, attention has been directed toward the

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impact of the assessment process itself on patient welfare. Despite considerable scholarship that has focused on the inherent power imbalances in the physician–patient relationship, the potentially deleterious effects of questioning a patient's autonomy remain generally overlooked in both the literature and in clinical practice.[10,11,12,13] In particular, as discussed below, a considerable number of unnecessary capacity assessments occur in situations in which the outcome plays no role in subsequent medical decisionmaking or therapeutic actions.[14] This paper argues that capacity evaluation should not be thought of merely as an assessment tool, but also as a clinical intervention—one with its own set of risks and side effects. Acknowledging the legal presumption that patients have capacity, we will replace the language describing the capacity assessment to capacity "challenge." By embracing the intervention as a challenge, we advocate for explicit recognition of the intrusiveness of the encounter to the patient's legally established capacity. Then, we discuss a range of potential negative consequences of the challenge process itself. Finally, we offer a reconceptualized approach to the capacity process designed to mitigate these risks and side effects while still striving to maintain the important beneficial aspects of capacity challenge.

The "Capacity Challenge": A Medical Intervention

The capacity challenge is a high stakes encounter: In jeopardy is a patient's autonomy and the right to render her or his own medical decisions. While such challenges may—under certain circumstances, depending on the jurisdiction—be performed by clinicians who are familiar to the patients and part of their care team, they are often conducted by psychiatric consultants who are meeting the patients for the first time. For many individuals, *any* encounter with a psychiatrist is stigmatizing and has a negative valence. Mistrust of psychiatry is likely elevated among historically marginalized populations whose communities have been victimized by systemic mistreatment by mental health professionals, including many patients whose own previous encounters with such professionals have had adverse effects.[15] For many patients, especially those from racial and ethnic minorities, a psychiatrist interrogating their cognitive states and medical choices is far from benign. It is also worth considering that patients undergoing capacity challenges are often in a highly vulnerable state: medically ill, hospitalized, facing uncertainty in a healthcare system with whose rules and norms they may be unfamiliar. Under such circumstances, the capacity challenge itself may exacerbate a patient's sense of powerlessness. Such interactions also risk furthering mistrust and undermining the therapeutic relationship with the care team. As a result, the capacity challenge itself, if perceived as unwelcomed, may make the patient *less* likely to consent to the underlying proposed medical intervention.

What distinguishes capacity challenge from nearly all other physician–patient interactions in medicine is that no effort is rendered, either formally or informally, to provide informed consent to the patient regarding the capacity challenge itself. Ideal practice might involve having the care team explain the nature and implications of the capacity challenge to the patient in advance, thus ensuring that patients are informed. However, consent *free of duress* is largely impossible for capacity challenges because the decision to decline to participate—to refuse to render a consistent choice—leads to a determination that the patient lacks capacity under the Appelbaum and Grisso test. In other words, if patients refuse to consent to a capacity challenge by rejecting participation, they are by default determined not to possess the capacity to render the decision in question. This Catch-22 creates a moral imperative to minimize the risks to the patients by imposing a capacity challenge under compelling circumstances only.

Another risk of a capacity challenge is its coercive power—not just for the specific medical intervention in question but for future interventions as well. A patient who endures a capacity challenge that is subjectively disempowering or humiliating (even if objectively performed with respect and to the standard of care) may prove highly reluctant to undergo another such interrogation. As a result, such a patient may either refuse to engage in a future capacity challenge entirely and thereby lose decisionmaking power, or may accede to requests of the medical team inconsistent with personal values in order to avoid another capacity challenge. In either case, the patient's future autonomy is diminished. Unfortunately, these long-term potential consequences of capacity challenge are too often given short shrift.

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The risks outlined above argue for reconceptualizing capacity challenges as a medical intervention with significant psychological and medical implications and the potential to cause a patient considerable harm. Of course, capacity challenges may also prove essential in protecting the welfare of patients who are truly incapable of making informed decisions. However, like any other procedure with risks and benefits, and especially one which inherently prevents meaningful advance informed consent, providers must intervene judiciously. The very act of considering capacity challenges as an intervention rather than a tool may help protect patients from some of the worst downsides of the assessment process.

Reducing the Frequency and Impact of Capacity Challenges

Once one reconceptualizes a capacity challenge as a medical intervention that is not inherently benign, an impetus arises to minimize the use of capacity challenges to circumstances where it actually serves the interests of patients. Assessing the risks and benefits of the evaluation itself in advance of calling for a psychiatric consultation is essential. What follows are three specific recommendations that promise to reduce the frequency of capacity challenge without limiting its potential for benefit in appropriate cases.

Physicians Should Perform a Cost–Benefit Analysis Prior to a Capacity Challenge

Prior to requesting a formal psychiatric evaluation for capacity, a patient's care team should weigh the risks and potential negative consequences of such a challenge, as described above, against the risks and potential negative consequences of forgoing the proposed intervention for which a capacity challenge will be determined. Sometimes the calculus will favor forgoing both the challenge and the procedure. Giving the patient the benefit of the doubt in close cases, where decisional capacity appears intact but some uncertainty remains, may well be justified once the impact of the challenge itself is considered. The argument against capacity challenge is particularly strong in two specific circumstances. First, if an alternative course of care is available that may prove less efficacious or likely to succeed, but still has some efficacy or likelihood of success, and the patient is amenable to the alternative course of care, then the care team should weigh the negative impact of capacity challenge in determining whether to conduct such assessment in pursuit of the original treatment. Second, if a patient is likely to benefit from multiple medical interventions and/or interventions over a prolonged period of time and is amenable to most of these interventions, the choice to forgo a capacity challenge when a particular intervention is rejected must be weighed against the impact of such a challenge on the patient's overall course of engagement with care. In addition, the impact of multiple capacity challenge, particularly in short succession, should be viewed with additional scrutiny. Some capacity challenges are obviously necessary and appropriate in the context of patient care, but condensing multiple challenges into one integrated session may mitigate to some degree the interrogative impact of such questioning. Although close chronological proximity between the capacity challenge and the proposed medical intervention has long been considered a cardinal rule for such challenges, some flexibility with the timing to reduce the cumulative impact of multiple challenges can be justified under the cost–benefit principle.

Steps Should Be Taken to Avoid Nonbeneficial Capacity Challenges

Since capacity challenges are not benign, it stands to reason that such evaluations should only occur when they serve a clinical purpose. If the care team will proceed in precisely the same manner whether the patient is found to possess or to lack decisional capacity, then the challenge itself serves no potential beneficial purpose. This situation is likely to arise when a patient declines an intervention that will prove impossible to impose involuntarily or whose involuntary implementation is too risky and damaging to justify pursuit. For example, standard of care may indicate routine imaging after certain orthopedic operations to identify complications, but in the face of patient resistance, the risks of sedating or strapping down the patient to obtain the imaging may significantly outweigh the potential benefits. A capacity challenge under such circumstances proves fruitless because unless the patient is amenable, the

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imaging will not occur whether or not the patient possesses formal decisional capacity. It is standard practice in the United States for care teams requesting psychiatric consults for capacity to specify the intervention for which challenge is requested and the reason that decisional capacity is in doubt. These two elements are not sufficient. In addition, the care team should be expected to explain how the course of management will change based on the outcome of the challenge. If nothing else, such an expectation should drive care teams to consider the implications and necessity of such challenges before subjecting patients to them. Ideally, if the evaluation is "non-actionable" (i.e., it will not impact care), it should not be conducted.

Capacity Challenges Should Be Integrated into the Routine Course of Care

An unfortunate aspect of many capacity challenges is that they are conducted by psychiatrists previously unfamiliar to the patients, so the interaction acquires an adversarial—almost inquisitional—quality. Instances will inevitably arise where such formal and detached challenges prove necessary, especially in cases with legal implications. However, the traditional capacity consult should be considered a last resort, rather than a "go-to" option. Instead, care teams should first attempt to ascertain a patient's decisional capacity, when possible, through routine interactions adjacent to the course of care. Often, such integrated interactions will clarity the presence of capacity without the need for more formal challenge. Alternatively, such ongoing engagement with the patient may help persuade him to agree to the proposed intervention—and the threshold for capacity to accept treatment, under the scrutiny level of the sliding scale model, may prove much lower than to reject it. Only in cases in which the patient is not persuadable and in which the care team's integrated exploration does not allay concerns about the patient's decisional capacity justify resorting to a more formal challenge process. Even when formal challenge is necessary, the primary care team—in cases where legally permissible—should attempt to conduct the challenge. Outside evaluators should only be recruited for two reasons. First, some cases will arise that require nuanced psychiatric knowledge or expertise, and calling in an experienced psychiatric evaluator under such conditions may be justified. Second, the care team may legitimately believe that the nature of a specific capacity challenge will inevitably turn confrontational and thus may wish to shift that responsibility to a psychiatric provider in order to preserve the patient's therapeutic relationship with their medical providers. In the absence of compelling reasons such as these, the providers who know the patient best are most suited to evaluate them. Psychiatric capacity challenge should be held in reserve until other, more integrated approaches to challenge have been meaningfully considered.

Conclusions

Many aspects of healthcare systems are dictated neither by medical need nor rational justification but by such factors as long-standing practice and inertia. Providers become so acclimated to certain aspects of care that they find themselves understandably blind the negative consequences of seemingly routine decisions. For example, when house officers order blood samples each morning on all of their hospitalized patients, they may easily forget that an actual human being is being stuck with a needle and is suffering pain for each box their doctor clicks on a computer screen. Obviously, many blood draws are necessary; others, of course, could be avoided with some intentionality and reflection on the part of providers. Capacity challenges offer a particularly concerning example of a potentially beneficial intervention becoming so routinized that its intrinsic consequences are largely disregarded. Fortunately, by reconceptualizing such assessments as non-benign interventions, care teams can minimize unnecessary challenges and limit the deleterious effects of an inherently intrusive evaluation process. Capacity challenge by default has no place in modern medicine, and the era of non-actionable capacity challenges must end.

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Ethical Standards. This special article involved no research of any living subjects.

Notes

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