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Clinical Practice

The Bedside Capacity Assessment Tool: Further Development of a Clinical Tool to Assist with a Growing Aging Population with Increased Healthcare Complexities

Maria Torroella Carney, Brian Emmert, and Brian Keefe

ABSTRACT

Background

As the population of the United States ages, chronic diseases increase and treatment options become technologically more complicated. As such, patients' autonomy, or the right of patients to accept or refuse a medical treatment, may become a more pressing and complicated issue. This autonomy rests upon a patient's capacity to make a decision. As more older, cognitively and functionally impaired individuals enter healthcare systems, quality assessments of decision-making capacity must be made. These assessments should be done in a time-efficient manner at a patient's bedside by the patient's own physician. Thus, a clinically practical tool to assist in decision-making capacity assessments could help guide physicians in making more accurate judgments.

Objectives

To create a clinically relevant Bedside Capacity Assessment Tool (BCAT) to help physicians make timely and accurate clinical assessments of a patient's decision-making capacity for a specific decision.

Setting

The Department of Medicine, Division of Geriatrics and Palliative Medicine, Zucker School of Medicine at Hofstra/Northwell.

Participants

Geriatric medicine fellows, palliative medicine fellows, and internal medicine residents (n = 30).

Measurements

Subjects used the BCAT to assess the decision-making capacity of patients described in 10 written, clinically complex capacity assessment vignettes. Subjects' conclusions were compared to those of experts.

Results

The subjects' and experts' assessments of capacity had a 76.1 percent rate of agreement, with a range of 50 percent to 100 percent. With removal of three complex outlier vignettes, the agreement rate reached 83.2 percent.

Conclusion

The strong correlation between the two groups—one of physicians in training utilizing the BCAT and the other of specialists in this area—suggests that the BCAT may be a useful adjunct for clinicians who assess decision-making capacity in routine practice. The range indicates that further refinement and testing of this

Maria Torroella Carney, MD, is Chief of the Division of Geriatrics and Palliative Medicine, Zucker School of Medicine at Hofstra/Northwell in Hempstead, New York. *Mcarney@northwell.edu*

Brian Emmert is a Medical Student at Zucker School of Medicine at Hofstra/Northwell.

Brian Keefe, MD, is Medical Director of Zucker Hillside Hospital at Northwell Health, Department of Psychiatry, Zucker School of Medicine.

tool is necessary. The potential exists for this tool to improve capacity assessment skills for physicians in clinical practice.

INTRODUCTION

As the U.S. population ages, chronic diseases increase, and treatment options become technologically more complicated. As such, patients' autonomy, or the right of patients to accept or refuse a medical treatment, may become a more pressing and complicated issue. The doctrine of informed consent has its philosophical roots in the bioethical principle of autonomy and is the basis of the view that every competent patient has a right to make decisions about his or her medical care. Informed consent in healthcare requires that the patient be provided sufficient information to make a decision, be free from significant coercion in the decision-making process, and be competent to make decisions. In modern terms, *competency* is a broad concept, a product of the legal system, and declared by a judge. *Capacity* to make healthcare decisions, on the other hand, is the product of a clinical assessment—one that uses legally defined criteria, but is nevertheless offered by healthcare providers in a specific context and pertaining to a specific decision.

Primary care physicians and careproviders are increasingly consulting psychiatrists to assist with determining the presence or absence of the components of decision-making capacity.[1] All physicians are trained to and, therefore, should be able to describe and determine a patient's capacity to make decisions.[2] Therefore, it often is not advantageous for physicians, who may know a patient more thoroughly and perhaps over a longer period of time and understand the therapeutic options presented, to consult a new physician to evaluate a patient's decision-making capacity. This clinical assessment skill can be challenged by complex medical/surgical treatment options and individuals' level and ability to understand medical information.[3]

In practice, the components of decision-making capacity are often not well defined or articulated by clinicians. This is shown by the need to consult psychiatric specialists for decision-making assessments, which can contribute to delay in the delivery of care. As such, a variety of assessment tools have been developed to attempt to assist in capacity assessment.[4]

The assessment of decision-making capacity requires, at its core, comprehensive evaluation and description.[5] Four common criteria for decision-making capacity have emerged, as described by Appelbaum and Grisso in their seminal article from 1988.[6] These four criteria have helped to standardize the measurement of decision-making capacity.[7] First, the patient must be able to *communicate* a stable choice related to treatment or a diagnostic procedure. Next, the patient must demonstrate an *understanding* of the information provided by the clinician, repeating or paraphrasing the risks, benefits, and alternatives associated with the choice made. Third, the patient must show an *appreciation* for both the situation at hand and how it affects her or him personally. This is evidenced by the patient's grasp of the acuity or severity of the decision and its likely consequences. The fourth and final criterion involves an assessment of the *reasoning* employed by the patient to reach a decision. Regardless of the clinician's opinion of the advisability of the decision, the patient must demonstrate a rational manipulation of the information considered to reach the choice made.[8] For a satisfactory determination of decision-making capacity, all of the aforementioned criteria should be met.

Since all clinical interventions (diagnostic or therapeutic) require informed consent, the ability to quickly and accurately make a determination of a patient's decision-making capacity is essential in a busy clinical setting. This assessment is usually performed intuitively by physicians or is influenced by a careprovider's global assessment of cognitive functioning. However, these methods, especially when based on an assessment of global cognitive functioning, can be inaccurate.[9] A specific decision-making capacity tool would focus the clinician on specific criteria and introduce the possibility of enhancing the accuracy and rationale of these determinations. Using the four domains outlined by Appelbaum and Grisso, a series of assessment tools have been developed. These include, but are not limited to, the Competency to Consent to Treatment Instrument (CCTI),[10] the Structured Interview for Competency and Incompetency Assessment Testing and Ranking Inventory (SICIATRI),[11] and the MacArthur Competence Assessment Tool for Treatment (Mac CAT-T).[12] These instruments most commonly utilize structured interviews,[13] semistructured interviews,[14] and abstract readings with patients (reading vignettes of hypothetical medical cases and asking patients about their decision-making process).[15] The Mac CAT-T is considered reliable and effective, especially in psychiatrically complex patient populations and is a validated resource for clinicians' assessments. Unfortunately, neither the Mac CAT-T nor other tools are currently utilized by busy, bedside clinicians on a routine basis to guide or assist in capacity assessments.[16] There is a need to have a careprovider-friendly guidance tool

for a fast-moving clinical setting, as it takes 20 to 30 minutes to complete a structured, validated capacity assessment.[17] As a result of the increasingly complex patient population and medical therapies and interventions, the capacity of a patient may be unclear to many careproviders and family members. As such, with the increasing focus on patients' autonomy, there in an increased burden on physicians to make accurate capacity assessments. Development of a brief tool (that takes less than five minutes), that guides careproviders through the decision-making capacity assessment components and also fits into their already established clinical protocol of care, is needed.[18] This would reserve specialized consultations by psychiatrists or the use of the longer and more nuanced tools, such as the Mac CAT-T, as the ultimate resource for more challenging situations.

Furthermore, other instruments have been designed based on the concept that decision-making capacity occurs along a spectrum, which generate results that represent intermediate designations.[19] This concept does not provide clear guidance to clinical practitioners who must have a definitive capacity assessment to move forward with a treatment plan or revocation of decision-making capacity for the decision at hand. Thus, the development of a brief, user-friendly tool to assist clinicians in making a dichotomous (yes or no) determination of decision-making capacity for the decision at hand, as well as to clarify the issues behind the need to utilize surrogate decision makers, would be an important contribution to patient care.

The present study strives to further develop the Capacity Assessment Tool (CAT) developed by Carney and colleagues, with a goal of being more concise, careprovider-friendly, and educational. The CAT independently measured each of Appelbaum and Grisso's four criteria of decision-making capacity. When comparing a cohort that used this instrument with the assessment of expert psychiatrists, a strong correlation was observed.[20] The Bedside Capacity Assessment Tool (BCAT) development and piloting are described in the present article.

METHODS

Development of the BCAT

A focus group of geriatric medicine fellows who used the original tool was held to discuss the benefits and challenges of use of the CAT. The group made the following observations and recommendations regarding bedside capacity assessments:

- Decision-making capacity is a daily challenge faced by careproviders.
- The group reported that, previously, only "major issues" required formal comment, but now even "minor" issues are beginning to need a formal statement.
- A tool should be short and limited to one page.
- The instrument should limit each domain to a Yes/No/Unsure designation.
- The tool should be decision specific.
- The tool should be able to provide additional support for a clinician's assessment of capacity.
- The tool should address communication barriers between the careprovider and patient (for example, hearing aids, glasses, language, *et cetera*).

Consequently, we revised the CAT to create the Bedside Capacity Assessment Tool (BCAT)—a more concise and user-friendly assessment of decision-making capacity components.

The BCAT separately assesses each of Appelbaum and Grisso's four domains of decision-making capacity:

1. The ability to communicate a stable choice to make a specific decision. (Can the person communicate a choice, verbally or nonverbally, in a clear and understandable manner?)
2. The ability to understand relevant information about a treatment choice as well as the risks and benefits of the decision. (Is the patient's description of the relevant information about a treatment choice or medical/healthcare decision accurate? Does the patient understand the consequences of the decision on him- or herself?)
3. The ability to appreciate the situation and its consequences regarding the decision at hand. (Does the patient acknowledge the presence, nature, and severity of illness as it relates to him- or herself? Can he/she assess the effect of the illness and treatment options?)
4. The ability to manipulate information rationally and logically. (Has the patient been able to delineate sound reasoning and weigh the risks and benefits of a treatment that are consistent with the pre-existing personal, cultural, and/or religious values and beliefs held by the patient?)[21]

The BCAT must not replace the physician or careprovider's own clinical conversation regarding a treatment option and clinical evaluation of the patient. The BCAT tool should guide the clinician through the components of decision-making capacity, allowing the careprovider to determine if she or he has addressed each component sufficiently, as it pertains to the decision at hand. If the patient's ability is not clearly demonstrated in all four domains,

the careprovider, in practice, would have the ability to re-address and clarify further or explain more clearly why a surrogate decision maker would be needed for this clinical situation. Deeming a person to lack capacity to make that particular decision may need to be further evaluated. Thus, this tool should allow for both a decision-specific determination and a framework for further evaluation.

Once the tool was refined, we began to examine its efficacy through its use with complex clinical case vignettes as an initial step to pilot.

Subjects. This project to pilot test the BCAT was approved by the institutional review board (IRB). Thirty English-speaking subjects consisting of geriatric medicine fellows (different fellows than those in the tool development focus group), palliative medicine fellows, and internal medicine residents volunteered to participate in this study. Written informed consent was obtained from each subject. Subjects were debriefed and educated on the tool following completion of the task.

Vignettes. The research team developed 10 hypothetical clinical case vignettes that highlighted capacity determination dilemmas, based on referrals to inpatient psychiatry consult teams, thus representing more challenging cases. Each vignette consisted of a short medical history, background, and select observations of the patient, as well as an abridged transcript between the patient and the house officer (see appendix). Cases were written to invoke each of the four criteria of decision-making capacity and varied in degree of difficulty. Vignettes were written and edited by a team of six psychiatrists and geriatricians. Cases were written to meet a range of difficulty, from less challenging to highly complex.

Test Phase, Subjects used the BCAT to determine the decision-making capacities of the patients described in the 10 vignettes. The tool was developed to be self-explanatory, and therefore no instruction was given to subjects prior to the task; they were simply instructed to use the tool to make a capacity assessment. The subjects' capacity assessments were compared to answers provided by the expert authors of the case vignettes.

Analysis. The authors compared individual subjects' performance across all cases assessments to the experts' results. They also calculated the percentage of agreement on each case.

RESULTS

The mean rate of agreement between all of the subjects' and experts' assessments across the cases was 76.1 percent. The scores ranged from 50 percent to 100 percent agreement (sensitivity = 68.68 percent; confidence interval of 61.0-76.4 percent and specificity = 83.87 percent; confidence interval of 76.5 to 91.4 percent, standard deviation = 13.3 percent; see figure 1).

The authors calculated the agreement scores between subjects and experts for each case. The mean agreement rate for each case, across subjects, had a wide range. Case 7 had the lowest mean agreement, with a mean of 50 percent. Case 1 had the highest, with a mean of 100 percent (see figure 2).

In a *post hoc* analysis, we observed that three cases (cases 3, 7, and 10) had low concordance rates of 60 percent or less. We completed a secondary analysis without these three cases to examine the effectiveness of our tool in more clear-cut but challenging cases. With the removal of these cases, the mean agreement across the other seven cases was 83.2 percent (confidence interval of 72.9 to 93.4), with a range of 67 to 100 percent.

Of note, further analysis demonstrated that there was no mean difference in the rate of agreement

FIGURE 1. Agreement with research team assessments by trainee

across postgraduate year (F-ratio = .5151, $p = 0.7622$) (that is, postgraduate year one to postgraduate year four).

DISCUSSION

The determination of a patient's decision-making capacity is an important aspect of patient-centered care. In a fast-paced clinical setting, in which the clinical burden on careproviders is increasing, a primary careprovider needs a way to rapidly and accurately assess a patient's decision-making ability. The BCAT shows promise as a practical tool to address this unmet need. In this study, answers from relatively inexperienced physicians on a series of difficult clinical situations, that were expressed in hypothetical case vignettes, correlated well to expert-derived answers to the case vignettes. Thus, there is evidence that physicians are able to use this tool to assist in determining patients' decision-making capacity. Furthermore, as longitudinal careproviders, primary care physicians usually know individual patients better than independent consult teams do, as they often provide care on an episodic, problem-focused basis. Equipped with the knowledge of a patient's longitudinal preferences about care and quality of life, an appreciation for the patient's family's involvement, and an understanding of the patient's medical issues and treatment options, primary careproviders are often in the best position to ultimately judge a patient's decision-making capacity. In turn, primary careproviders may be better able to determine the need for surrogate decision making in the context of patient-centered care.

Our pilot study did observe vast variation in agreement between subjects and experts across three particular case vignette (case 3, case 7, and case 10), with agreement rates less than or equal to 60 percent. These cases were designed to be the most challenging and ambiguous. The rate of agreement for the remaining seven cases equaled 83.2 percent. It is possible that the vignettes with lower concordance rates were more ambiguous and challenging, not unlike real life, and would be better served by the use of a more detailed tool, such as the MacCAT-T, or a specialty evaluation by a psychiatrist. Another potential limitation in generalizing these data is that only one medical specialty was represented in the residents and fellows who participated in the study. As such, we cannot conclude that physicians of all specialties would have performed similarly using the tool. Since decision-making capacity assessment is typically done intuitively, we postulate that this tool, with fair agreement rates, will be effective for all specialties. It simply provides a format and structure for the assessment of capacity. However, future studies should utilize a wider spectrum of medical-surgical specialties, along with physicians with varying years of experience.

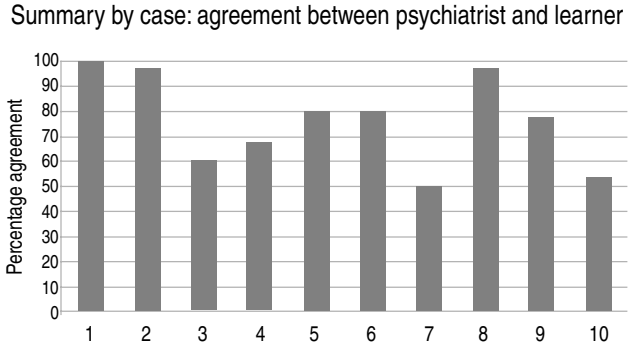

FIGURE 2. Learner assessment agreement with research team assessment, by case

Another potential limitation in the interpretation of the data is that the subjects were not given any instructions about how to use the BCAT before the test phase began. Rather, they just followed the instructions on the tool, leaving room for potential misinterpretation or misuse. In the future, it may be beneficial to provide education to subjects before they use the tool, thus removing any potential for varying application. However, our goal is to provide a self-sufficient and user-friendly clinical tool that requires little formal training, broadening the accessibility of formalized decision-making capacity assessments.

This study only provides information on how closely the subjects' results compared to the results of the team of experts. This study did not evaluate if the tool helped learners improve their accuracy against themselves or other physicians not using the tool. A study is currently underway to evaluate if the tool helps to improve assessment accuracy. Despite the absence of a study design that could demonstrate improved accuracy for BCAT users, we nevertheless postulate that the BCAT has potential as an educational instrument. When using the tool, clinicians are sequentially prompted to consider each of the four domains of decision-making capacity. Each category is clarified by a guiding question for the interview, intended to help elucidate the meaning of ability in that area. Thus, this tool can be used as a scaffold to teach students about the tenets of decision-making capacity.

The BCAT highlights the importance of an "all-or-none" determination of the ability to make a spe-

cific decision in the clinical setting. While informed consent scholars have sometimes viewed decision-making capacity as a continuum,[22] this view is clinically impractical. Intermediate values would not inform how to proceed in caring for a patient. Furthermore, each subcategory (communication, understanding, appreciation, and rationalization) that comprises the overall assessment also lies on a continuum. Thus, when patients falter in one of the subcategories, they may not have a full comprehension of the decision at hand, challenging their ability to make an informed decision. However, care-providers who ignore the fact that capacity lies on a continuum may too hastily challenge a patient's autonomy. Therefore, it is important to only award capacity for the clinical decision at hand and not to make a global determination. Capacity assessment in the healthcare context is decision specific, leaving open the possibility that patients can make other decisions. In the setting of fluctuating mental status, patients can be re-assessed at a different point in their illness, allowing for the possibility of restored capacity.[23] Practically speaking, if the clinical decision is not urgent, but nevertheless complex, more than one assessment may be needed before initiating the therapy or procedure or to seek support from surrogates to assist the patient in the decision-making process.

With an aging population and an increasing number of patients with multiple co-morbidities, an accurate and user-friendly bedside capacity assessment tool would be a useful addition to ensure the most rapid, appropriate, and informed treatment for the patient. The present study highlights the potential for the BCAT to fill this need, allowing physicians to more confidently make assessments of their patients' decision-making capacities and to help determine when further evaluation is needed, such as with use of the MacCAT-T or a psychiatric consultation. This study demonstrates an adequate correlation in decision-making capacity assessment between experts and physicians using the BCAT, but also demonstrates that further evaluation on some cases might be needed. A larger study utilizing a greater mix of physicians' subspecialties and experience level is needed to more confidently generalize the data from this study, as well as to determine its utility as an educational instrument.

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APPENDIX

Case Vignettes for the BCAT Study

Case 1: An 88-year-old widowed male is admitted to the medical service for a work up after he was found down on the floor at home by his neighbor. The patient has a history of type II diabetes mellitus, early congestive heart failure, and essential hypertension. The patient is able to articulate that he is "diabetic and high blood pressure" but cannot name the medications he is taking. A discharge summary from the year before notes "dementia" in the discharge diagnoses, but patient denies problems with his memory. On exam, he is gaunt, malnourished with bilateral edema of the lower extremities, and mild respiratory distress. He has bruises indicative of prior recent falls. He states he has no next of kin or any family to contact. The treatment team recommends nursing home placement. Upon bringing this information to the patient, and informing him, he states, "I don't really care." Asked if he could articulate why he thinks the treatment team may be recommending nursing home placement, he says only, "I don't know. I don't care. I won't discuss it." Further attempts at reviewing the option of discharge to a nursing home are met with persistent refusal to have such a discussion. Does this patient have the capacity to make a decision regarding nursing home disposition?

Part I: Components of decision-making capacity (check best answer):

1. The ability to communicate a stable choice to make a specific decision:

Can the person communicate a choice (verbally or nonverbally) in a clear and understandable manner?

☐ YES ☐ NO/NOT SURE

2. The ability to understand relevant information about a treatment choice:

Is the patient's description of the relevant information about a treatment choice or medical/healthcare decision accurate?

☐ YES ☐ NO/NOT SURE

3. The ability to appreciate the situation and its consequences regarding the decision at hand:

Is the patient generally aware of the medical condition and the nature of the severity of the medical condition and the likely consequences of his/her decision?

☐ YES ☐ NO/NOT SURE

4. The ability to manipulate information rationally:

Has the patient been able to delineate reasons for his/her decision that are consistent and in keeping with existing personal, cultural, and/or religious values and beliefs?

☐ YES ☐ NO/NOT SURE

Part II: Based on your answers and Part I, with using the BCAT, please indicate if the patient DOES have capacity or DOES NOT have the capacity to make the decision at hand.

☐ DOES have the capacity to make the decision. Must answer "YES" to 1, 2, 3, AND 4.

☐ DOES NOT have the capacity to make the decision. Any "NO/NOT SURE" answer on 1, 2, 3, or 4.

Comments: _____

_____

_____

_____

[This query section follows every case in the original BCAT. The text of this appendix continues next page.]

Case 2: A 74-year-old married woman with a history of transient ischemic attacks and peripheral vascular disease is admitted to the orthopedic service after a fall at home that yielded a fractured hip. An Open Reduction Internal Fixation (ORIF) has been recommended for treatment. The patient has been amenable to the pre-operative work up, and appears to visit appropriately with family in the hospital. Three hours after being provided information about the indications, risks, benefits, and alternatives to the surgery, the patient is asked to describe in her own words her understanding of the procedure. She acknowledges, "I need to get my hip fixed by the surgeons." Asked what that might entail, she says, "I have no idea what they do." Pressed further for basics on the procedure, she says, "I just hope they decide to do it in the operating room instead of my hospital room, since there are a lot of germs in here. And they better put me out for it, I am nervous. I don't know what they are going to do. I just want to be out for it." Does this patient have capacity to consent to hip surgery?
[See case 1 for the queries that followed this case in the BCAT.]

Case 3: A 62-year-old woman with a history of atrial fibrillation on warfarin therapy presents to emergency department at her own initiation with bright red blood per rectum. An initial complete blood count (CBC) reveals severe anemia, prompting admission to the medical service for sequential CBCs and a colonoscopy. A second CBC six hours later demonstrates a continued drop in hemoglobin and hematocrit. Ten hours later, when the doctor is called due to the patient's fainting from symptomatic orthostasis, the patient requests discharge from the hospital, saying she has important business to manage at home. Asked specifically about this "business," she replies, "I need to meet the cable guy, and you know how difficult they are to schedule." An intern had informed her that her "blood counts had stabilized," after a third hemoglobin/hematocrit demonstrated no significant change from the second (Hgb/Hct = 6.8/28). Previous records indicate no anemia at baseline. The doctor asks the patient to stay for a colonoscopy, scheduled for later that morning, pointing out that there could be "an internal bleed that we need to find and correct." The patient acknowledges the possibility, but states, "I don't think I was bleeding, I'm pretty sure it was a mistake in the tests. They make mistakes, you know, and I don't think my blood tests are that bad. Doctors tend to exaggerate things so they can do more tests and make more money. I'm certain there's nothing seriously wrong; if there is, I can always come back." Does this patient have capacity to elect to leave against medical advice?
[See case 1 for the queries that followed this case in the BCAT.]

Case 4: An 84-year-old married woman without a psychiatric history, but with a recent diagnosis of dementia of Alzheimer's type, is brought in by her husband for shortness of breath and reduced exercise tolerance. Her hospital work up reveals a severely calcified aortic valve, prompting cardiothoracic surgery to recommend transthoracic aortic valve replacement. The surgeon provides the relevant information on the operation to the patient, to which she said, "I'd like to think about it." Several hours later, when asked about her decision, she politely declined, saying, "Well, it's a risky surgery, especially for someone my age, and my husband would prefer it if I died anyway." Further evaluation reveals a belief the patient has maintained for the last six months that her husband has been unfaithful to her, carrying on an affair with a 65-year-old woman. The patient is able to articulate the reason she needs the procedure, the expected benefit, the major risks, and even a basic description of the technique to be used. During the conversation, she intermittently glares at her husband, and says, later, "I might as well not talk about this matter any longer and just give him what he wants." This statement prompts her devoted husband of 47 years to ultimately throw up his hands in disgust and leave the room. Does this patient have capacity to refuse the recommended cardiac surgery?
[See case 1 for the queries that followed this case in the BCAT.]

Case 5: A 56-year-old male with a known history of schizophrenia and multiple psychiatric hospitalizations presents to the emergency department with weight loss, nausea, and vague complaints of abdominal pain. The admission work up reveals pancreatic cancer. The patient is offered palliative radiation therapy, with its indication, benefits, and limitations explained. Asked to articulate his understanding of the proposed treatment, the patient replies, "Oh, I know my predicament. I'm going to die from this cancer. The radiation may help me feel a little better, and eat a little better, but in the end the result will be the same. I've made my peace with this life and am ready to go." He then thanks the house officer for her time, and proceeds to ask his nurse about proper attire for the "xenon show tonight." Does this patient have capacity to refuse palliative radiation therapy?
[See case 1 for the queries that followed this case in the BCAT.]

Case 6: A 77-year-old married female with chronic obstructive pulmonary disease and documentation of dementia in past discharge summaries is admitted to the hospital for bilateral pneumonia. Review of the chart from this hospitalization reveals a pattern of increasing confusion in the evening, one such episode resulting in the provision of a prn antipsychotic for tranquilization. A pro-active house officer attempts to discuss do-not-resuscitate (DNR)/do-not-intubate (DNI) status with the patient on the morning of hospital day 3. The patient is pleasant and engaged, stating, "I've had a lot of life in my years, and I certainly wouldn't want to spend my last ones on a breathing machine, because that's no way to live." In further discussion, the patient indicates, "I wouldn't want those shock things on my chest either. If my heart stops, just let me be." In light of episodes of agitation and confusion described in the chart, the house officer then conducts a brief cognitive exam. This assessment reveals that the patient is disoriented (wrong hospital name, wrong location, month off by two, and

year off by one), and does not recall that she has been treated with an antibiotic. After the cognitive assessment, the patient is asked once again about DNR/DNI status. The patient is consistent and states she would not want to be on a "breathing machine or be shocked." Does this patient have the capacity to initiate DNR/DNI status?
[See case 1 for the queries that followed this case in the BCAT.]

Case 7: A 57-year-old male actor with no significant medical history presents to hospital with anorexia, weight loss, and marked change in bowel habits. Work up reveals stage IIb colon cancer, with histology and local invasiveness that make this particular disease riskier for recurrence and metastasis. Recommended treatment includes surgery to remove the cancerous tissue, along with adjuvant chemotherapy due to the high-risk nature of this tumor. The patient agrees to the surgery, but flatly refuses the adjuvant chemotherapy. He states that he understands the cancer diagnosis, as well as "the need for surgery to cut it all out." He says, "I get that you-all think this type of cancer is likely to return, but I don't think so. I've always been lucky in life, and I have every reason to think I will be here too." He also cites the likelihood of hair loss during the chemotherapy as a "deal-breaker. . . . I'm on-screen for a living, and need my hair to work." Does this patient have capacity to refuse adjuvant chemotherapy?
[See case 1 for the queries that followed this case in the BCAT.]

Case 8: A 72-year-old African-American male with a documented history of diabetes mellitus, cerebrovascular disease, and smoking is admitted to the hospital for work up of unstable angina. Cardiac catheterization is recommended to elucidate the nature and extent of likely coronary artery disease. The patient refuses to consent to catheterization, saying, "I'll take any medication or an IV or otherwise to get me better, but goodness knows what'll happen to me in here if I'm sedated. I already waited seven hours in the emergency room for a bed up here." Further interview reveals that the patient understands that his chest pain could relate to "blocked arteries in my heart," which is "a real possibility due to my diabetes and smoking." He understands the nature of the catheterization, as well as risks, benefits, and potential consequences of refusal. Asked why he nevertheless won't consent, the patient replies, "I'm just a little uneasy about a procedure with sedation. Bad things have happened to folks that look like me when they're sedated in hospitals. I want to go the blood thinner route and take my chances." Does this patient have capacity to refuse cardiac catheterization?
[See case 1 for the queries that followed this case in the BCAT.]

Case 9: An 84-year-old female who recently moved to an assisted living facility in the community presents to the hospital with lightheadedness and increasing lower extremity edema. The work up reveals severe mitral valve disease, with valve replacement surgery as the treatment plan. The patient quickly agrees to the procedure, saying, "Yes, something needs to be done, I can't walk around with my ankles this big," and then begins laughing raucously. The house officer entered her room 10 minutes after she signed the consent for surgery to discuss an unrelated health matter. At that time, the trainee noted that the patient was inappropriately jocular and confused. The patient knew she was in hospital for "my elephant ankles" and that "something is dreadfully wrong with my ticker!" She noted, "I think I'm going to have surgery, but who knows with doctors these days, they might just change their mind." She was unable to describe even basics regarding mitral valve replacement or what the surgery would entail, only insisting, "I should definitely have it." Did this patient have capacity to consent to the recommended cardiac surgery?
[See case 1 for the queries that followed this case in the BCAT.]

Case 10: A 70-year-old White male with known diabetes mellitus, coronary artery disease, and spinal stenosis is admitted to the hospital with swelling of hands and legs. Evaluation reveals an extremely elevated serum creatinine of 5.2 and limited urine output, even with Foley catheter placement. Urgent dialysis is recommended. The patient is lethargic, even intermittently sedated. When awake, however, the patient clearly and consistently refuses dialysis, stating, "I've been through enough with all my illnesses, and I'm just tired." He expresses an understanding of the treatment and its risks. Furthermore, he is able to explain that death is the likely outcome for such treatment refusal, and that hemodialysis could forestall this outcome. Does this patient have capacity to refuse hemodialysis?
[See case 1 for the queries that followed this case in the BCAT.]

Sources

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