Current PSYCHIATRY

Assessing capacity

We agree with Drs. Meraj and Poje in "Capacity assessment: A fundamental skill" (Current Psychiatry, September 2011, p. 72-73) that clinical judgment often is used in addition to or in lieu of quantitative scales when evaluating medical decision-making capacity. We further agree that the formulation by Appelbaum[1] is invaluable in such cases.

However, we disagree with the authors' emphasis on "ability to retain information" as 1 of 4 criteria for decision-making, because long-term declarative memory is irrelevant to a patient's ability to reason from stable values and preferences.

We use the mnemonic **CURA** to recall Appelbaum's criteria: the patient must Communicate a choice; Understand relevant facts; Reason about information; and, importantly, Appreciate the consequences.

We add that the stringency for demonstrating decision-making capacity should increase with greater consequences of the patient's choice. A clinician may judge a patient to have capacity to consent to low-risk diagnostics, and then the same clinician might appropriately judge that patient lacks capacity to refuse life-saving treatment. A useful model is a "sliding scale" of capacity evaluation,[2] wherein the threshold for a given decision is proportional to the likely outcome at stake.

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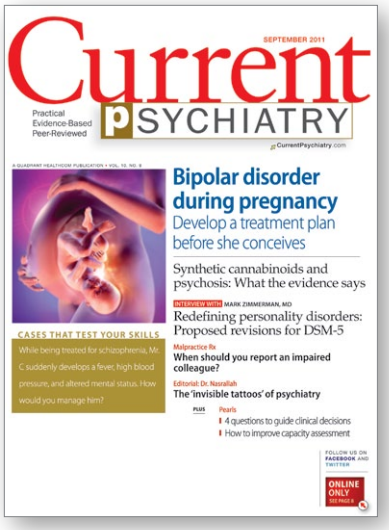

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References

1. Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. N Engl J Med. 2007;357(18):1834-1840.
2. Drane JF. Competency to give an informed consent. A model for making clinical assessments. JAMA. 1984;252(7):925-927.

The authors respond

Thank you for your letter. We emphasize that memory deficits should be implicated in any condition that negatively affects capacity (eg, delirium, dementia). Memory would be beneficial to a patient undergoing capacity evaluation.

For example, consider a 70-year-old male with a history of dementia who is admitted to the neurology service with delirium and refuses a procedure in the evening despite frequent reassurance. The next morning the same patient doesn't remember seeing you and denies refusing the procedure. His decision-making is greatly affected by fluctuating cognition and memory.

Another scenario would be a patient with such a significant impairment in short-term memory that she is unable to follow the basis of the argument. How could a patient unable to recall the basis of an argument be entrusted to make an intelligent decision?

We argue that memory should be taken in account in these evaluations. Although we agree in principle with the comments made by Drs. Kreider and Aggarwal, it is important to make capacity evaluations on a case-by-case basis and our article presents basic principles to help guide a typical clinician making those assessments.

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Negative symptoms

I read and enjoyed Dr. Nasrallah's excellent summary of schizophrenia symptoms in "The primary and secondary symptoms of schizophrenia: Current and future management" (Current Psychiatry, supplement to September 2011, p. S5-S9).

I have a suggestion to add to the list of secondary negative symptoms based only on my observations: demoralization caused by repeated failures in all dimensions—self, interpersonal, social, and industrial. I have seen demoralization in schizophrenia patients manifest as low self-esteem, hopelessness, apathy, and self reproach.

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