

Don't assume that psychiatric patients lack capacity to make decisions about care

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Some practitioners of medicine—including psychiatrists—might equate “psychosis” with incapacity, but that isn't necessarily true. Even patients who, by most measures, are deemed psychotic, nonetheless might be capable of making wise and thoughtful decisions about their life. The case I describe in this article demonstrates that fact.

While rotating on a busy consultation service, I was asked to evaluate the capacity of a woman who had a diagnosis of schizophrenia and was being seen for worsening auditory hallucinations and progressive weight loss. She had a complicated medical course that eventually led to multiple requests to the consult team for a capacity evaluation.

The question of capacity in this patient, and in the psychiatric population generally, motivated me to review the literature, because the assumption by many on the medical teams involved in this patient's care was that psychiatric patients do not have the capacity to participate in their own care. My goal here is to clarify the misconceptions in regard to this situation.

CASE REPORT

Schizophrenia, weight loss, back pain

Ms. V, age 67, a resident of a group home for the past 6 years, was brought to the emergency department (ED) because of weight loss and auditory hallucinations that had developed during the past few months. She had a history of paranoid schizophrenia that included several psychiatric hospitalizations but no known medical history.

The patient appeared cachectic and dehydrated. When approached, she was pleasant and reported hearing voices of the “devil.”

“They are not scary,” she confided. “They talk to me about art and literature.”

Over the past 6 months, Ms. V had lost 60 lb; she was now bedridden because of back pain. Collateral information obtained from staff members at the group home indicated that she had refused to get out of bed, and only intermittently took her medications or ate meals during the past few months. In general, however, she had been relatively stable over the course of her psychiatric illness, was adherent to psychiatric treatment, and had had no psychiatric hospitalizations in the past 3 decades.

Ominous development. Although the ED staff was convinced that Ms. V needed psychiatric admission, we (the consult team) first requested a detailed medical workup, including imaging studies. A CT scan showed multiple metastatic foci throughout her spine. She was admitted to the medical service.

Respiratory distress developed; her condition deteriorated. Numerous capacity consults were requested because she refused a medical workup or to sign do-not-resuscitate and do-not-intubate orders. Each time an



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Clinical Point

The ability of patients with schizophrenia to make competent decisions relates more to overall cognitive functioning than to the presence of specific symptoms of the disorder



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evaluation was performed, Ms. V was deemed by various clinicians on the consult service to have decision-making capacity.

The patient grew unhappy with the staff's insistence that she undergo more tests regardless of her stated wishes. The palliative care service determined that further workup would not benefit her medically: Ms. V's condition would be grave and her prognosis poor regardless of what treatment she received.

The medical team continued to believe that, because that this patient had a mental illness and was actively hallucinating, she did not have the capacity to refuse any proposed treatments and tests.

What is capacity?

Capacity is an assessment of a person's ability to make rational decisions. This includes the ability to understand, appreciate, and manipulate information in reaching such decisions. Determining whether a patient has the capacity to accept or refuse treatment is a medical decision that any physician can make; however, consultation-liaison psychiatrists are the experts who often are involved in this activity, particularly in patients who have a psychiatric comorbidity.

Capacity is evaluated by assessing 4 standards; that is, whether a patient can:

- communicate choice about proposed treatment
- understand her (his) medical situation
- appreciate the situation and its consequences
- manipulate information to reach a rational decision.¹⁻³

CASE REPORT CONTINUED

Although Ms. V's health was deteriorating and her auditory hallucinations were becoming worse, she appeared insightful about her medical problems, understood her prognosis, and wanted comfort care. She understood that having multiple metastases meant a poor prognosis, and that a biopsy might yield a medical diagnosis. She stated, "If it were caught earlier and I was better able

to tolerate treatment, it would make sense to know for sure, but now it doesn't make sense. I just want to have no pain in my end."

Misconceptions

In a study by Ganzini et al,^{4,5} 395 consultation-liaison psychiatrists, geriatricians, and geriatric psychologists responded to a survey in which they rated types of misunderstandings by clinicians who refer patients for assessment of decision-making capacity. Seventy percent reported that it is common that, when a patient has a mental illness such as schizophrenia, practitioners think that the patient lacks capacity to make medical decisions. However, results of a meta-analysis by Jeste et al,⁶ in which the magnitude of impairment of decisional capacity in patients with schizophrenia was assessed in comparison to that of normal subjects, suggest that the presence of schizophrenia does not necessarily mean the patient has impaired capacity.

Voluntary participation in research.

Many patients with schizophrenia volunteer to participate in clinical trials even when they are acutely psychotic and admitted to a psychiatric hospital. Given the importance placed on participants' voluntary informed consent as a prerequisite for ethical conduct of research, the cognitive and emotional impairments associated with schizophrenia raise questions about patients' capacity to consent.

As is true in other areas of functional capacity, the ability of patients with schizophrenia to make competent decisions relates more to their overall cognitive functioning than to the presence or absence of specific symptoms of the disorder.⁷ Documentation of longitudinal consent-related abilities among research participants with schizophrenia in the long-term Clinical Antipsychotic Trials of Intervention Effectiveness study indicated that most participants had stable or improved consent-related abilities. Although almost 25% of

participants experienced substantial worsening, only 4% fell below the study's capacity threshold for enrollment.⁸

What I learned from Ms. V

A diagnosis of schizophrenia does not automatically render a person unable to make decisions about medical care. Even patients who have severe mental illness might have significant intact areas of reality testing. Ethically, it is important to at least *consider* that the chronically mentally ill can understand treatment options and express consistent choices.

Healthcare providers might tend to exclude psychiatric patients from end-of-life decisions because they (1) are worried about the emotional fragility of such patients and (2) assume that patients lack capacity to participate in making such

important decisions. The case presented here is an example of a patient with a severe psychiatric diagnosis being able to participate in her care despite her mental state.

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