

Competence and Compassion:
The Ethical Evaluation of Decision-Making
Capacity in Geriatrics

**We hold these truths to be self-evident, that allare endowed
...with certain unalienable Rights, that among these are Life, Liberty
and the pursuit of Happiness.**

Learning Objectives

- 1. When to initiate an evaluation and when to leave it alone**
- 2. How our own values can cloud our judgment of
competency**
- 3. Learning to craft the precise referral question for the evaluation**
- 4. Knowing which cognitive domains should be assessed**
- 5. Identifying the complexities of various real-life
competency decisions.**

Oklahoma Statutes

Incapacitated person : 18 or over and impaired by reason of:
mental illness, developmental disability, physical illness or
disability, drug or alcohol dependence AND whose ability to receive
or evaluate information effectively OR Make and communicate
responsible decisions is impaired to the extent that they lack
capacity for physical health/safety or ability to manage financial
resources.

Oklahoma Statutes

Capacitated (Competent) person:

1. Adult
2. Able to receive (hear, read, watch)
3. Evaluate information, make responsible decisions
(comprehend, remember)
4. Communicate decisions (speak, write)
5. Regarding:

(a) physical health/safety

(b) management of financial resources.

- Historically Capacity was “All or Nothing”
- Modern concept emphasizes personal autonomy --retaining as many rights as possible.
- “CAPACITY” is the ability to perform a specific task
- there is no such thing as General Capacity

Prime Directive
Protect the Patient

1. The patient is competent until I find evidence to the contrary.
1. Evidence of incapacity in one area does not prove incapacity in another.
1. Prior incapacity does not prove current incapacity.
1. Family report is “hearsay”, subject to confirmation if possible and only one source of information.

Physical health/safety

- Medical Decisions & Informed Consent.
- General Health and Self Care
- Home Safety

- Understanding the Risk

- Freedom to Assume That Risk

Medical Decisions

1. Expressing a treatment choice
2. Making a “reasonable” treatment choice
3. Appreciating the consequences
4. Evaluating the options logically
5. Verbalizing a thorough understanding

Financial

- Nonverbal and more complex
- Basic monetary transactions, bank interactions, complex investments
- Varies widely across intact populations

- Bill Paying
- Excessive Spending
- Long term planning
- Fraud and Exploitation
- Testamentary Capacity

Testamentary Capacity

- Capacity to Make a Will, Choose a guardian, enter into contracts.

- Understand nature of the act
- Understand and recollect nature of property
- Knowledge of persons to benefit
- Manner of disposition of property

Knowing When to Leave It Alone

- When the patient is already making “reasonable choices”.
Example, a patient might be competent if they accept recommendations yet incompetent if they refuse.
- When the consequences of their decision aren’t critical.
- When they already have Power of Attorney in place.
- When they are delirious

Evaluation

- The Competency Question
- The Interview (In their residence)
- Collateral Information (Family)
- Formal Testing (office)
- Time, time, time

The Referral Question
Do they have capacity for:

- Independent living
- Refusing or directing medical care
- Informed consent for surgeries
- Making a will, choosing guardian
- Managing their finances
- Revoking a Power of Attorney or Guardianship
- Driving

Examiner Values

The Crooked Yardstick of our Values

A competent person has the right to make bad decisions and take risks.

- Smoking
- Drinking
- Sex
- Spending

Uncooperative Patients

Just because they're

ticked off, insulting,

uncooperative, combative and

hateful, doesn't mean they're wrong...or incompetent.

Interview

- Preferably in their home environment
 - This is the environment you're trying to predict – Environmental Validity
 - Best performance
 - “Historical Data”
 - Hygiene, Clutter, Smell, Safety, Cigarettes, alcohol, Medications
 - Temperature, Lighting
 - “Manners”

“You're Only as Smart as Where You're At”

Interview

Personal Hygiene

Wardrobe

Fingernails (manicured,brown,cracked, long)

Hair, Teeth

Clothing

Body wasting, lesions, excessive bruising

Smell

Glasses (new style or old)

Excretory Issues

Eccentric or Impaired?

Collateral Information

- Family (multiple sources)
 - Personality Traits
 - Recent functioning, illnesses,etc
 - Decline in Function over months

But:

- Consider Agendas (Who benefits)
- How much “face time” contributors have
- Examinees opinions about those sources
- Medical Records, labs, etc.

“Formal” Psychometric Testing

- Primarily for support or contrast of information from other sources
- Advantages
 - Objective
 - Good Age Norms
 - Differential Diagnosis – Why is this person incompetent (Temporary, Reversible, Permanent)

Age Related Changes

“Psychometric Testing

- Fluid Reasoning (52%)
- Crystallized (11%)
- Processing Speed (6%)
- Education (6%)
- Memory (< 1%)

Predictors of Everyday Task Competence

Sample Battery

Fluid

Trails A&B (& speed)

Digit-Symbol (& speed)

Similarities

Crystallized

Comprehension

Attention

Digit and Spatial Span

Mental Control

Memory

Orientation

Immediate & Delayed

Academic

Reading/Word Recognition

Basic Math

Misc

Reitan-Indiana Aphasia Scr

Affect

Geriatric Depression Scale

Sensory-Perceptual(as need)

Neurobehavioral Cognitive Status Examination

83 year-old female, hyponatremia, psych issues

88 year-old female, Masters Degree

Decision and Outcome

- Answer the referral question about the specific capacity. Always play client advocate but evaluate the consequences of “bad outcome”. Balance Autonomy vs. Protection

- Describe what the patient CAN do as relevant to the question.

- Offer a diagnosis if relevant (i.e. Alzheimer's, delirium, etc.)
- Make reasonable recommendations

Decision and Outcome
Changing the Equation

88 year-old fem

+Fall history

+Hip fracture

+Wheelchair Walker Ambulater

+No Cog Issues

+No support

Unacceptable Risk

Decision and Outcome
Changing the Equation

88 year-old fem

+Fall history

+Hip fracture

+Wheelchair Walker Amb

+No Cog Issues

+No support

Acceptable Risk

Competent or Not Competent

Case Studies

- Alcoholic Physician
- Homeless Veteran
- Nursing Home Patient
- Long Walker
- Alzheimer's wanting wife for guardian

Long Walker

76 year-old female, No Medical Problems but prior hospitalization raised question of dementia.

History of psychiatric problems including depression and nighttime hallucinations.

Evaluation requested by Daughter regarding dementia diagnosis and driving capacity

Walker Test Battery

- **Attention: 65th Percentile – Average**
-
- **Processing Speed: 75th Percentile – High Average**
-
- **Memory: 80th Percentile – High Average**
-
- **Abstract Reasoning: 84th Percentile – High Average**
-
- **Motor Skills: Motor Speed (Right Hand) 65th Percentile – Average**
- **Motor Speed (Left Hand) 82nd Percentile – High Average**
- **Grip Strength (Right Hand) 61st Percentile – Average**
- **Grip Strength (Left Hand) 62nd Percentile – Average**
-
- **Depression Screen: Severe Depression**
-

Long Walker – 3 months later

76 year-old female, No Medical Problems.

- Keeping loaded guns in the house
- Maybe drinking

- Walking too far (driving was refused)
- Daughter requesting her to be committed.

Renewal of Guardianship

- Mr. Slack, 84 year-old Vulnerable. His status is scheduled for review and APS requested evaluation of his cognitive status for review.
- Residing in nursing home
- Medical includes COPD
- Psychiatric includes mild depression, treated with Celexa

What is the Referral Question?

OBSERVATIONS

- presented in his wheelchair
- friendly and cooperative.
- ready recall of my name and at ease.
- No deficits in expressive speech, vision, hearing, or upper extremity movement; transfers were unassisted
- Memory for personal information was fine
- Pathfinding was good.

INTERVIEW

- Oriented to and supportive of the exam.
- Stated he needs a guardian to “take care of things I might not know about”.
- Able to discuss in detail his prior living situation, what his assets had been and that they were sold.
- Unaware of the financial requirements of his current placement but aware that Medicare cover his expenses.

- Oriented to time and place. He is not well oriented to current events

Slack Test Battery

- **Attention: Borderline Deficient**
- **Memory: Low Average**
- **Processing Speed Deficient**
- **Abstract Reasoning: Low Average**
- **Social Reasoning High Average**
- **Reading & math 6th Grade Level**
- **Depression Screen: Mild Depression**

Collateral Information

- No Family Nearby
- Neighbors initially reported to APS
- Slack was down in his yard
- Multiple falls – No injuries
- House was essentially unkempt
- His personal hygiene was marginal

CONCLUSIONS?

Dr. Ethanol

- 74 year-old male, former physician
- Hospitalized for uncontrolled diabetes and uncontrolled hypertension
- Alcohol Abuse
- Sexually disinhibited at hospital
- Prior Power of Attorney for financial, that one died.

Referral Question?

Dr. Ethanol

Observations & Interview:

Loud, blustery, pressured speech

Frequent repetition of same information

No apparent insight – even physically

Will go home and drink 8 oz Wild Turkey a day, “whether I need it or not”.

Opening stolen apple juice while discussing his uncontrolled diabetes.

Session two completed Naked

Data for Dr. Ethanol

Collateral Information

- Neighbors jointly have to care for him
- Prior forced hospitalizations
- Home includes dried vomit, old food, several opened cans of same item
- 30 lbs weight loss in prior six months
- Scammed of over \$100,000
- Continues to drink and drive
- Exposing himself in front window

Homeless Veteran

- 73 year-old male living in front of abandoned building

- Upon ER Admission
 - Intoxicated
 - Core Body Temperature of 84 degrees
 - Blood Glucose of 833

- Currently Hospitalized and nearing DC

Homeless Veteran

Observations:

Disheveled, bundle of filthy clothes on bed

Upper left teeth missing – Not sure how

Cognitive status has been stable

Interview

Prefers homelessness

Unable to give chronology of major life

Gets two checks, unsure how much, where they're going, or how to get them

No knowledge of medical issues (diabetes)

No means of contacting family

Data for Homeless

Collateral Info

Verified Medicare, Medicaid, V.A.

No family available

No Psychiatric history

No significant therapy needs or physical issues (except diabetes)

Pleasant and cooperative

Conclusions?

Conclusions and Outcome

Capacity for simple learning

- + diabetes
- + no motivation
- + limited reasoning & Judgment
- + no family support
- + recent near death from neglect
- + multiple sources of funding

= Incapacitated Individual

Sweethearts

- 83 year-old male with moderate Alzheimer's
- Newly Weds, recently moved
- Daughter is current Power of Attorney and he doesn't like the way she does it and doesn't like the way she treats his wife.
- Referral Question: Wants to change Power of Attorney (son or wife) -- Testamentary Capacity

Mr. Sweetheart

Observations: (with and without wife)

Oriented time, place and purpose

Apartment is small but well organized

He is well groomed and cordial

He was able to recall a prior appointment with his wife, operate his scooter and locate her in dining room.

Sweetheart Interview & Testing

- Reported amount of monthly income
- Identified reasons he wanted to change
- Identified logical candidates and why.
- Testing
 - Reading and Math High School
 - Reasoning Low Average
 - Executive Function LA to Def
 - Attention Average
 - Memory (Immediate) Very Def-<1st
 - Memory (Delayed) Borderline

Sweetheart Conclusions

Need Guardian? YES!

Capacity to Change POA Limited

Verbalizes reason for change

Understands Process

Unable to evaluate their performance

Able to identify appropriate choices

Able to express a preference

Questions?

Thank You