On Competency and Capacity of Older Clients to Make Decisions[1]

By

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"People do not consist of memory alone. They have feeling, will, sensibility, moral being. It is here you may touch them, and see a profound change."[2]

Personal autonomy is a foundational American value, and making choices is the experience of autonomy, in matters every-day or life-defining. Whether expressed in the language of lawyers as informed consent, autonomy and self-determination or in the language of human services professionals as a component of person-centered planning,[3] the right to make decisions about our lives, to exercise control – about where and how we live, with whom we form professional and personal relationships, what help we accept or reject from medical and social services providers, how we spend our time and money – is held dear.

For a decision to have personal, legal or ethical significance, however, the individual must have the capacity to decide. Capacity in this sense refers to the individual's functional ability to understand the significance for himself of making a particular decision, with or without extra help. For the geriatric care manager to take a client decision as the basis for services or

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[1] Prepared for publication in the Journal of Geriatric Care Management, Spring 2013.

[2] Neurologist A.R. Luria, from The Man Who Mistook His Wife for a Hat and Other Clinical Tales, by Dr. Oliver Sacks.

[3] "Person-Centered planning" as defined by the Centers for Medicare and Medicaid "is a process, directed by the participant, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant." http://www.medicaid.gov/mltss/docs/PCP-CMSdefinition04-04.pdf.

advocacy, he or she must be confident that the decision is the result of the client's application of reason and discretion.

A word on terminology. Legal competency usually refers to the client's status as either being or not being under guardianship by decree of a court. The terminology and the distinction are useful only to an extent. First consider the false negative cases. A person with a clinically diagnosed condition warranting guardianship may not be under guardianship for many reasons unrelated to capacity. Initiating the process requires volunteers to petition the court and to serve as guardian. The process is inherently adversarial, and there is concern about the impact of the process of appointment may have on the on-going relationships of the people and agencies involved. Alternatives to guardianship, particularly in a durable power of attorney and health care proxy, coupled with present formal and informal supports, may be deemed adequate. The process is time-consuming and costly.

Next, consider the false positives. Being under guardianship does not equate to incapacity to make a particular decision or type of decision. Plenary guardianship, where the person under guardianship retains no area of autonomy in decision-making, is now the exception under the Uniform Probate Code and the laws of most states. Instead, the individual may be permitted to retain rights in areas where essential life interests are not at risk. Limited guardianship has become the norm. Formal guidance of the Massachusetts probate courts suggests that, in appropriate cases, the person under guardianship might nonetheless retain the right to determine her residence, to drive, to seek and obtain employment, to plan a schedule of daily activities, to choose home health providers, to choose a long-term care facility, and so forth.[4] A common formulation involves empowering the guardian to make decisions about medical treatment only. The extent of

[4] Massachusetts Probate Court Form 903B. http://www.mass.gov/courts/courtsandjudges/courts/probateandfamilycourt/documents/mpc903b-limitations-to-guardianship-and-conservatorship-for-judges-attorneys.pdf

the guardian's authority should be spelled out in the decree issued by the court, which are usually matters of public record.

In real life, the spectrum of capacity ranges from those whose capacity is taken for granted, to those altogether lacking in the capacity to make or communicate any decision of significance. Many reflected a capacity that is diminished to a degree, to the point where at least on initial reflection we lack confidence in the decision at hand. The confidence problem is compounded by the fact that deficiencies in capacity are often not global. The question is not, "is he competent?" but "is he capable of making the particular decision to be presented to him?" Sign a health care proxy? Sign a durable power of attorney? Hire me as a care manager? Live independently at home? Admit herself to an assisted living facility? Drive a car? Transfer assets to another family member? Apply for government benefits? The same individual may be capable of making decisions autonomously in some domains, capable only with assistance in others and incapable altogether in yet others. For example, an individual may be able to manage day-to-day with most requirements for daily living, but not have the ability to make meaningful decisions about his or her medical care. An individual may be incapable of making decisions on alternative treatments for cancer, but understand enough of what is involved to execute a health care proxy. So, in assessing capacity, we have to begin with a specification of the nature of the decision to be made, and then identifying and evaluating functional elements constituent to the capacity. Some examples.

Having a durable power of attorney may be critical in protecting the decision-making rights of the older client facing the risk of future incapacity to decide matters on her own. Therefore, the question of the client's capacity to make a durable power of attorney deserves special attention. It generally involves:

1. An understanding of the general nature of a durable power of attorney, which is to say, that it is a written legal document:
   a. By which one person (the principal) names and authorizes

another person (the attorney-in-fact) to perform certain legal and financial functions listed in the document on the principal's behalf.

   b. In which the authority conferred continues notwithstanding the subsequent disability or incapacity of the principal.
   c. In which the principal is free to revoke or modify the arrangement, including changing the person named, at any time.
   d. Which terminates at death.

2. A general understanding of the individual's personal and financial circumstances.
3. A knowledge of the persons related to him by ties of family, personal friendship, or professional acquaintance who would be the usual persons to be considered as attorney-in-fact.

Note that the functional capabilities required to sign a durable power of attorney do not include the capacity for the actual management of legal and financial affairs. An individual may well be incapable of the latter while capable of the former.

Similarly, having a health care proxy safeguards medical decision-making by allowing the selection of a trusted substitute decision-maker and providing guidance on treatment preferences. The standard of capacity to make a Health Care Proxy is also much lower than capacity to make medical decisions themselves. It is defined as requiring:

1. An understanding of the general nature of a Health Care Proxy, which is to say, that a HCP is a written legal document by which one person (the principal) names and authorizes another person or persons (the health care agent and any alternates) to make health care decisions on the principal's behalf, in the event that the principal becomes unable to make or communicate health care decisions for himself.
2. A knowledge and general appreciation of the persons related to him by ties of family, friendship and professional acquaintance who

would ordinarily be considered as health care agent.

This is a lesser standard than that involved the making of a decision about medical treatment, or informed consent. Informed consent requires the capacity to appreciate one's current medical status, the likely course if the treatment is refused, and the risks, benefits and uncertainties of alternative treatments.[5]

Determining capacity to self-admit to an assisted living facility or nursing home raises a host of complex issues. An admission agreement is a form of legal contract. Capacity to contract is not uniformly defined in state law, but generally involves consideration of whether the individual can appreciate the personal and financial significance of the basic mutual obligations involved in the admission. However, under the Americans with Disabilities Act, such facilities have a corresponding responsibility not to discriminate by refusing admission and deny services on the basis of incapacity. This obligation may arguably extend to proving accommodations consisting of special assistance to the applicant in the admissions process.[6]

The capacity to drive a car involves, aside from physical skills, complex decision-making on many levels, taking into account the rules of the road, road and traffic conditions, evasive maneuvering, short-term memory, attention and processing speed.[7]

A formal assessment of capacity may be necessary in close,

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[5] Practical Guide to Health Care Decision-Making, by Betsy Johnson, in End of Life Care for Children and Adults with intellectual and Developmental Disabilities, Copyright 2010 by the American Association on Intellectual and Developmental Disabilities.

[6] Kim Thrasher, Admission to Nursing Facilities for Persons Who are Isolated and Incapacitated, March 27, 2012. http://www.ltcombudsman.org/sites/default/files/norc/mn-memo.pdf

[7] O'Connor, M.G., Kapust, L.R. & Hollis, A.M. (2008). DriveWise: An Interdisciplinary Hospital Based Driving Assessment Program. Gerontology & Geriatrics Education, 29(4), 351-362.

contested or high-risk situations, but may involve cost, delay, confrontation and embarrassment.[8] As a practical matter, dealings with older clients by professionals of all sorts – social workers, nurses, lawyers, accountants, financial planners, bank officers – must be informed by informal "field" assessments of capacity in the course of everyday interaction. This paper is intended to provide a basis for GCM's and other elder service professionals to do informed but informal assessments in the field.

What should we consider in thinking about a client's capacity? Consider the extent to which he:

- Understands his role in the decision-making process; that is, that he has a choice.
- Possesses the requisite basic cognitive skills to receive, store, recall and process information necessary for meaningful decision-making in the context at hand.
- Has the capacity to appreciate of the likely results of a decision, as well as less-likely but possible results.
- Has the capacity to appreciate the implications of alternative courses of action for his objective future well-being, as well as his individual goals and values.
- Has the ability to weigh the advantages and disadvantages of alternative courses of action.
- Has the ability to maintain stable choices long enough for them to be effectively implemented.
- Possesses the capacity to formulate short-term and long-term objectives in relation to the matter at hand.
- Has the ability to distinguish between immediate and long-term

[8] For those seeking guidance on the formal assessment of capacity, and on deciding when formal assessment may be warranted, see "Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologist." Copyright (c) 2008 by the American Bar Association and the American Psychological Association, hereinafter "Handbook." Available as a free download. http://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf

needs, and to plan accordingly.

- Has the ability to remember and apply past experience to new situations.
- Has the capacity to recognize the general quality of personal relationships, e.g., in distinguishing between relatives, friends, strangers.
- Has the ability to communicate decisions effectively whether through nonverbal or verbal means.

Many of these functional capacities depend on cognitive strengths that are in-born or at least persistent. They represent the "nature" of the "nature-nurture" formulation of the role of biology and environment on personal development, the "trait" of the "trait-state" formulation. However, in thinking about capacity, we must also take into account the mitigating or qualifying impact of transitory or remediable factors, especially those that we can affect in our design of the circumstances of the decision-making opportunity. An individual in familiar surroundings may be able to function adequately in decision-making, whereas the same individual, newly admitted to a hospital or nursing home, may be utterly confused. Capacity is not static, over the course of time or even the day – for many people, the difference in functioning between mid-morning and late-afternoon is substantial. If current functioning may be affected by fatigue or a recent stressful or unpleasant event, consider rescheduling. Consider the impact of untreated mental illness, the side-effects of appropriately prescribed and administered medications, and the potential effects of medications that are inappropriately prescribed or unevenly administered. More broadly, consider individual differences in education, socio-economic background, life experiences, background knowledge and cultural and ethnic traditions.[9] Plan to accommodate any physical constraints on vision, hearing or communication.

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[9] "Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers" p. 16-17. Copyright (c) 2008 by the American Bar Association and the American Psychological Association. Available as a free download. http://www.apa.org/pi/aging/resources/guides/diminished-capacity.pdf

By recognizing and dealing flexibly and creatively with such mitigating factors in the planning and execution of the decision opportunity at hand, the individual's capacity can be effectively enhanced. At the same time, we will be addressing our legal responsibility to take affirmative steps to facilitate participation – to make, in the terms of the Americans with Disabilities Act, "reasonable accommodations" to the individual's areas of incapacity.

Don't equate compliance with capacity. Passive compliance may or may not reflect consent or agreement. While we are naturally more concerned about the client whose incapacity is backed up by oppositional behavior, the incapacitated client who is passively compliant is really no less at risk of our overreaching and infringing on personal rights.

Don't assume that the person designated under a power of attorney or health care proxy has the authority to make a particular decision in place of the principal. Powers may be limited by the instrument. More basically, a power of attorney or health care proxy is basically a designation of an agent or representative. Signing a power of attorney is not ordinarily the relinquishment of ultimate authority in the principal. In many states, the authority of the health care agent does not begin until a written determination is made by the attending physician that the individual lacks the capacity to make or communicate health care decisions.[10]

Don't equate bad decisions with incapacity. An older client's decision to remain at home rather than go into a nursing home may be unreasonable and impractical, but it is the client's decision to make if she understands the decision and its possible consequences.

Don't underestimate capacity based solely on advanced age or diagnosis, including that of Alzheimer's Disease or mental illness. Despite the presence of a condition impacting memory or concentration, the individual may yet have the residual functional capacity to make meaningful

[10] MGL c. 201D, s. 6.

decisions affecting his life, and to communicate them if not verbally, then by expression, motion, and emotion.

Don't overestimate the impact of expectations. Treatment with dignity enhances self-respect and confidence, enhancing participation in decision-making. Not treating the client as the responsible decision-maker assures that he won't be.

As a practical matter, take the nature and degree of risk involved in the decision into account in assessing capacity. The greater the risk the greater the care that is warranted. We certainly do this in the context of informed consent, differentiating between low-risk preventative care and high-risk surgery. The case might similarly be made that greater care is warranted the farther the decision strays from substantive fairness and reasonableness, or the more inconsistent the decision with the individual's known long-term commitments and values.

Ultimately, your legal and ethical responsibility is to assist the client appreciate the objective and subjective factors weighing on a given decision, and to assist the client to participate in the process as meaningfully as possible.