

Assessing competency in the elderly

JEFFREY S. JANOFSKY, MD

The doctrine of informed consent requires that a patient understand the medical procedure being proposed, that consent be voluntary, and that the patient be competent to give consent. Because of declining cognitive functioning, elderly patients are at significant risk of becoming incompetent and, therefore, unable in the eyes of the law to give informed consent. Advance directives allow competent patients to tell their doctors and the world in general what their health care choices are should they not be able to make their choices clear in the future. The living will and durable power of attorney are two types of advance directives that are legally binding in most states.

Janofsky JS. Assessing competency in the elderly. Geriatrics 1990; 45(Oct):45-48.

It behooves the primary care physician, whose practice may include a large number of elderly patients, to understand the clinical and legal concepts behind competency. This article advises the physician on what to do when a patient is clearly not competent to make medical decisions; it also offers suggestions to help the vulnerable elderly do simple preplanning to maximize autonomy should they become incompetent.

What is competency?

The legal concept of competency is most simply defined as the ability to handle one's affairs in an adequate

manner. The many different types of competency include: competency to be a parent, to be married, to be divorced, to be a witness, to make a will, and even to be executed.

Informed consent and the patient. In the area of medical decision making, the key competency question revolves around the patient's ability to understand informed consent. The doctrine of informed consent has many legal sources, but was first directly defined after the Nuremberg war crimes trials of Nazi doctors who conducted "medical experiments" on unwilling victims. The military tribunal stated, "the voluntary consent of the human subject is absolutely essential. This means that the person involved should have the legal capacity to give consent."¹

Over the years, the theory of informed consent has evolved to include three essential elements:

- The patient must understand the medical procedure and, specifically, understand a description of the procedure, its risks, its benefits, and its alternatives.

- Consent must be voluntary.

- The patient must be mentally competent to give consent.

Originally, the physician was obligated to communicate as much information about the procedure as was the normal standard of professional practice amongst other physicians,² known as the "medical custom." Since 1972, the physician has been obligated to disclose what a hypothetical, reasonable patient would find necessary to make an informed decision about his own medical care.³ Today, some states still use both tests for informed consent rulings. The physician is advised to check the state law to determine which applies.

Physicians must remember that judging a patient's competency to make medical decisions is a legal issue, and therefore one that may ultimately be decided in court. As a practical matter, however, physicians routinely perform the first step in competency assessment by making a clinical examination. Such so-called clinical competency, sometimes called medical capacity, is determined by physicians.

Clinical competency: The physician's role

All adult patients are presumed competent to make any treatment

Dr. Janofsky is assistant professor of psychiatry and behavioral sciences, the Johns Hopkins University School of Medicine.

decision. The issue of competency usually comes up in the clinical setting when someone in a doctor/family/patient triad brings it up, usually because someone disagrees on the best course of action. The physician can play a key role in helping to clarify the situation.

The first clinical question that should be asked by the physician to assess clinical competency is "competent to do what?" For example, a patient may have the clinical capacity to consent to a minor treatment with a high benefit/risk ratio, but not the capacity to consent to a major treatment with a low ratio. In short, the physician has to decide in what context he is trying to determine the patient's competency.

Good history taking is required, as is close attention to the patient's mental status, particularly psychotic symptoms such as hallucinations, delusions, and formal thought disorder (a defect in the form, rather than content, of the patient's speech and thought), and how these might impinge on the patient's decision making. A simple screening exam for cognitive function should be performed, as well, such as the Mini-Mental State Examination. The findings here too are relevant to an assessment of the patient's decision-making capability in an informed consent situation.

The physician should *think clinically before thinking legally*. Using clinical skills, the physician can reframe the competency problem as a problem in the treatment team's relationship with the patient, the treatment team's relationship with the patient's family, or the family's relationship with the patient. By using such skills the physician may sometimes be able to reassess the problem as a problem in systems communication and not a true competency issue.

In geriatrics, however, there is a high risk of true cognitive impair-

ment, and a correspondingly high risk that patients may truly lack the medical capacity to make decisions regarding their own health care. Physicians in such cases have three choices:

- They can take no action until the patient returns to competency. Such a course is most useful when the intended medical treatment is not urgent and the patient is suffering from a disorder, like delirium, which should eventually self-resolve.

- Alternatively, the physician could do the procedure anyway, without informed consent. This course of action is legally and ethically permissible only when there is an immediate, life-threatening emergency and the physician does not know of the patient's prior refusal of a similar procedure. The law assumes that any rational person, when confronted with a life-threatening situation and unable to competently consent, would desire life-saving treatment. This is known as the doctrine of presumed consent.

- Finally, and most frequently, a substitute decision maker can be appointed to make decisions for incompetent patients.

Appointing a guardian

Legal steps. Guardianship is the traditional method for legally appointing a substitute decision maker. Different states have different methods for appointing guardians with different limitations. Most states give a guardian of the person the power to consent for medical care or treatment.

At a guardianship hearing, the patient has the right to be present, to have counsel, and to present evidence and cross-examine witnesses. A judge then determines, after hearing all the evidence, whether the patient meets the legal definition of incompetency and, therefore,

whether a guardian should be appointed to make treatment decisions. The choice of guardian is defined differently in different states, but usually includes the spouse, parents, or other relatives of the patient. Brakel et al have compiled extensive tables referring to appropriate state statutory laws regarding guardianship.⁴

The guardianship process is expensive, complex, and restrictive. Because of these problems, some states, including Maryland, have devised a system to appoint a substitute decision maker for medical care decisions without court involvement.⁵

In Maryland, two physicians may examine the patient to determine if the patient "lacks sufficient understanding or capacity to make or communicate a responsible decision on health care."⁵ After giving their opinion on the cause, nature, extent, and duration of the disability, they may declare the patient incompetent to make medical decisions and then allow a relative to make the decision on the patient's behalf. Several restrictions and safeguards are present so that this procedure cannot be used to violate the patient's civil rights.

What can the guardian decide? Recently, the Supreme Court determined that a state could establish procedural safeguards to assure that the actions of a substitute decision maker "conform as best it may to the wishes expressed by the patient while competent"⁶ (see "The Cruzan case: An argument for advance directives," next page).

The Supreme Court's decision makes it clear that different states may set different standards as to how a substitute decision maker should exercise medical decision making for an incompetent patient. Some states have chosen a so-called subjective standard, where the substitute decision maker reflects what

The Cruzan case: An argument for advance directives

Nancy Cruzan, a woman in her twenties, lost control of her car. The vehicle overturned, and Ms. Cruzan was discovered lying face down in a ditch without detectable respiratory or cardiac function. It was later estimated that she had been deprived of oxygen for 12 to 14 minutes. Paramedics were able to restore her respiratory and cardiac function. She was taken to a hospital and had maximal acute care. She remained in a coma for 3 weeks, then progressed to an unconscious state where she was able to orally ingest nutrients. Later, a gastrostomy tube was implanted. Rehabilitative efforts failed, and her condition worsened. A persistent vegetative state was diagnosed.

After it became apparent that Ms. Cruzan had virtually no chance of regaining her faculties, her parents asked hospital authorities to terminate parenteral nutrition and hydration. Ms. Cruzan had *no advance directive*. However, she had made statements to her friend and roommate that "she wouldn't want to live [as a vegetable] because she knew it was usually up to the family whether you live that way or not."⁷

The hospital refused to honor the parents' request without court approval. The trial court approved the termination, but the state supreme court rejected the termination, noting that "no person can assume that choice for an incompetent *in the absence of the formalities required under Missouri's living will statute*."⁸ (Emphasis added.) The court rejected the roommate's statement as unreliable.

Ms. Cruzan's parents appealed to the United States Supreme Court. The Supreme Court accepted Missouri's standard, which requires that "clear and convincing evidence" be presented of an incompetent patient's prior wish to withdraw treatment before the substitute decision maker can decide to withdraw life-sustaining treatment.

Thus, because Ms. Cruzan had no advance directive, she will continue to receive parenteral hydration and nutrition and continue to exist in a persistent vegetative state, despite her previous oral statements.

JEFFREY S. JANOFKY, MD

the incompetent patient would have done under the same situation had he been competent. Other states use an objective "best interest" standard, allowing the substitute decision maker to make decisions about treatment based on what most people would decide in a similar situation. Still other states use a combination of both standards. It is imperative that physicians become familiar with their state requirements regarding the power of substitute decision makers.

Advance directives

Advance directives are legally binding documents that allow currently competent patients to document what medical procedures they would want to have done should they become not competent in the future. This avoids the need for guardianship and the guardian's corresponding need to make a health care decision based on inadequate infor-

mation. Two types of advance directives are permissible: the living will and the durable power of attorney.

The standards of competency for advance directives are very similar to standards of competency to make a will. Thus, the individual must be aware of his or her rights, know the powers to be delegated, have the intent to confer those powers, and, in the case of durable power of attorney, be able to make the designation of the attorney-in-fact.

Living wills are defined by statute in about three fourths of all states. (Although living will forms are sometimes distributed to the public, such as in drug stores, seeking sound legal advice is still recommended.) A typical living will statute allows a terminally ill individual to have life-sustaining procedures withheld or withdrawn should that individual be unable to direct their physicians to do so. Many states do not, however, allow

food and water to be withdrawn via the living will statute. Typical statutes also provide immunity to health care providers who execute the living will document.

Unfortunately, most living will statutes are very narrowly drawn and only apply to those individuals declared terminally ill. They are also of uncertain validity when executed in a state with an authorizing statute and implemented in a state without such a statute.

For these reasons, a durable power of attorney is often the preferred advance directive document.

Durable power of attorney.

A power of attorney is a written instrument in which one person (the principal) authorizes another person (the attorney-in-fact) to act on the principal's behalf. It may be general, authorizing the attorney-in-fact to manage all the principal's affairs, or specific, authorizing the attorney-in-fact to act only in specific matters, such as health care.

continued

Assessing competency

continued

A durable power of attorney for health care is available because, while a traditional power of attorney becomes invalid when the principal becomes incompetent, a durable power of attorney remains valid even after the principal becomes incompetent. The durable power of attorney must be *executed*, however, while the principal is still competent. The principal's competency when executing this document need not have been continuing, as the power of attorney can be executed on a "good day." If at all possible, though, the durable power of attorney should be executed before there is any real questions about the principal's competency.

The major advantage of the durable power of attorney comes from its being much more flexible than a living will. The principal can personally choose those who will have authority over his or her affairs. Furthermore, there is no need to have the principal declared incompetent. Also, drawing up the papers for a power of attorney document is inexpensive, and there is no court involvement.

Disadvantages to the durable power of attorney include the fact that, with only a few exceptions, current state statutes do not specifically authorize the use of a durable power of attorney to delegate health care decision-making powers. Consequently, anyone who wants to delegate authority to make health care decisions should do so with the understanding that the durable power of attorney might not be binding in jurisdictions that do not have explicit durable power of attorney for health care statutes.

However, this depends on the health care provider. If the provider accepts the advance directive, there is no problem. If the provider does not accept the advance directive, then the alternative is to go to court

for guardianship. The judge will probably then use the advance directive to define the limits of the guardianship. For physicians with long-term relationships with patients, the key point is for the physician to clarify with the patient before he or she becomes incompetent:

- whether the patient has an advance directive;

- whether the directive meets state legal requirements;

- what the patient intends; and finally,

- whether the physician finds those intentions acceptable.

The durable power of attorney becomes effective immediately on its execution, even if the principal is still able to make decisions. At first blush, this seems to be a grave risk, particularly in those patients who feel difficulty giving up control. In reality, however, any competent patient can void any durable power of attorney at any time.

One final thought and word of caution is in order: The attorney-in-fact should be carefully selected, since if a durable power of attorney for health care is accepted as a matter of law, the attorney-in-fact's decisions are binding on the principal, and there is no court supervision.

For the primary care clinician caring for a large number of older

patients, it is especially important to become familiar with advance directives: patients in special need are those in the early stages of Alzheimer's disease and early multi-infarct dementia. Advance directives will allow patients in a formal and legally binding way to tell you—their physician—and the world what their health care choices are, and relieve physicians, among others, from many of the discomforting possibilities of either overtreatment or undertreatment. **©**

For a related news item, see "Beyond the living will: 29 states enact durable powers of attorney laws," page 23.

References

1. *United States of America v Karl Brandt. In: Trials of war criminals: Before the Nuremberg military tribunal, vol. 2. Washington, DC: Superintendent of Documents, 1949:181.*
2. *Ratanson v Kline, 350 P2d 1093 (Kan 1960).*
3. *Canterbury v Spence, 464 F2d 772 (DC Cir 1972).*
4. *Brakel SJ, Parry J, Weiner BA. The mentally disabled and the law. 3rd ed. Chicago: American Bar Foundation, 1985:395-433.*
5. *MD Annotated Code, Health General Article, sec. 20-107.*
6. *Cruzan v Director, Missouri Department of Health, et al. —U.S.—, 1990 U.S. Lexis 3301 at 21 (1990).*
7. *Ibid. at 100.*
8. *Ibid. at 10.*

NEWS CLOSEUP

Patient care does not exist in a vacuum. Every day government agencies, legislators, or chief executives are making decisions or trying new programs that could have a direct impact on your practice. Social change, too, can directly influence the

type of patient and illness you see. In NEWS CLOSEUP—a regular GERIATRICS department—experienced journalists survey the "outside world," and seek to explain it and make it meaningful to you and your medical practice.