Assessing Patient Decision-Making Capacity: It's About the Thought Process

Author: Melanie A. Mitchell, BSN, RN, Everett, WA

Clinical Scenario

Fred Jones is a 64-year-old man who presents to the emergency department with visual changes and left-sided facial numbness that started 2 hours earlier, after an argument with his wife. He states, "I want to make sure I'm not having a stroke." His medical history is significant for hypertension. His medications include lisinopril, hydrochlorothiazide, and simvastatin. He is being evaluated for a cerebral vascular accident (CVA) with an onset of symptoms of less than 4 hours. Nursing assessment finds a National Institutes of Health Stroke Scale score of 1, with the loss of left upper quadrant peripheral visual fields. A computed tomography (CT) scan of the head demonstrates normal findings. A plan is made to admit Mr. Jones to rule out a CVA and obtain a magnetic resonance imaging (MRI) scan. While the patient is waiting for the MRI, he informs the nurse, "I do not want to stay if the CT and the MRI are negative." Mr. Jones does not want his managers to know of his admission if he is not having a stroke. He states, however, "I will come back if things get worse."

The physician plans to admit Mr. Jones for CVA, but Mr. Jones has decided to leave against medical advice (AMA). Does this patient possess the decision-making capacity (DCM) to leave AMA?

Against Medical Advice

Recent studies suggest that approximately 2% to 6% of inner-city facilities discharges are performed AMA.[1,2] Patients who leave AMA have higher readmission rates and may be at increased risk for adverse outcomes.[2] As a general principle, patients are voluntarily admitted to the hospital, and leaving AMA is a recognition of the patient's withdrawal of consent for treatment.

It is a common occurrence for patients to leave AMA in the emergency department, and thus it is imperative that emergency nurses know how to effectively assess and communicate a patient's DMC in order to appropriately advocate for the patient. Taking the time to talk with patients to understand how they have made their choice(s) is foundational to this advocacy and assessment. This process can be difficult and may seem counterintuitive in the fast-paced environment of an emergency department, where time is a rare commodity.

Nurses are usually the first to recognize that a patient is considering leaving prior to completion of treatment and may lack DMC. Patients who do not have DMC cannot leave AMA because they would not be able to make an informed decision regarding refusal of care. Conversely, physically impeding a patient who has DMC and is attempting to leave AMA can legally be construed as battery. The balance between respecting a patient's autonomy and ensuring the patient's safety requires advocacy in a more primary way—effective communication between the patient and medical staff regarding the patient's medical choice(s) and between the nurse and the provider regarding the patient's DMC assessment.

Fundamentals of DMC (The Patient's Right to Self-Determination)

Patients are assumed to have the capacity to make medical decisions (ie, consent to or refuse treatment) until proven otherwise.[3] Providers have an ethical obligation to prove the patient does not have DMC given its inextricable relationship to informed consent and informed refusal. According to Ganzini,[4] "Clinicians have both an ethical and legal obligation to ensure patients are informed about and allowed to participate in choices regarding their health care. This obligation is rooted in the principle of respect for autonomy." Exceptions to informed consent exist under certain circumstances; most notable are emergency interventions needed to prevent serious or irreversible harm. Removing a patient's ability to make medical decisions removes his or her right to self-determination and places the patient's medical decisions into the hands of another person,

Melanie A. Mitchell, *Member, WA ENA Chapter*, is Direct Care Nurse, Emergency Department; Chair, Coordinating Council Nursing Governance; and Member, PRMCE Ethics Committee, Providence Regional Medical Center–Everett, Everett, WA.

For correspondence, write: Melanie A. Mitchell, BSN, RN, 1700 13th Street, Everett, WA 98201; E-mail: Melanie.Mitchell@providence.org.

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who should be a legally recognized surrogate decision maker (SDM) and not a member of the medical team.

DMC and competency are frequently used synonymously. Although patients who lack DMC and/or competency must have a designated and legally recognized SDM, DMC and competency represent entirely different judgments about a patient's ability to live and make choices.

A competency declaration is a legal proceeding that usually involves evaluating such activities as a patient's ability to manage his or her finances, live independently, and enter into legal agreements. DMC is a clinical assessment made by health care professionals regarding the patient's thought process for deriving his or her choices in relation to health care decisions. With regard to DMC, the key concern is "how" the decision was made, which is determined through an exploration of the patient's thought process through dialogue with the patient; as Goldman[5] states, "…the decision does not have to be optimal, wise or in accord with the urgings of the treatment team or family, but it does need to be reasoned out in some logical fashion." DMC assessments are intervention specific and findings may fluctuate, such as for a patient with dementia who experiences "sundowning" or an acutely septic patient who is intermittently confused. As a result, recurring assessments may be needed if a patient exhibits inconsistent DMC.

Nurses have a deeply rooted identity as patient advocates and have become accustomed to patient acquiescence in the absence of their expressed consent.[6] As a result, beneficence, masquerading as patient advocacy, can quickly become nursing paternalism as it collides with a patient's right to choose which procedures and treatments he or she wishes to receive. Thus, as noted by Dudzinski and Shannon,[6] nurses can decide "…that poor judgment may be worse than lacking decision-making capacity and will attempt to rescue the patient from the consequences of their poor choices." Although nurses are not responsible for providing informed consent or informed refusal, nurses are obligated "to assist patients in authentically expressing their freedom of self-determination."[7,8] This situation is managed by validating that the patient has received the necessary information by the provider(s), that an opportunity was provided for the patient to ask questions, that these questions were fully answered, and that the patient has voluntarily given or withdrawn consent.

Assessing DMC

Applebaum and Grisso[9] established 4 guidelines that have become the medical and ethical standard to measure a patient's DMC. According to these guidelines, a patient demonstrates DMC when he or she is able to show the following characteristics:

1. Basic comprehension and knowledge of the facts
2. Appreciation of the nature and significance of the decision he or she is making
3. Reasoning that shows that manipulation of the information about the decision is being conducted in a rational fashion
4. The ability to express a choice

In the busy practice of an emergency nurse, the guidelines in the form of questions might appear as follows:

1. Can the patient communicate a choice?
   - A. The patient *must* be able to communicate a choice in order to assess for DMC.[10,11]
   - B. Once this first question has been satisfied in the affirmative, the next 3 questions can be asked.
2. Does the patient consistently make the same choice?
   - A. Consistency of choice must be stable long enough to be implemented.[12] A patient who suddenly changes his or her mind in the "right" direction should be questioned just as carefully as the one who suddenly reverses from the plan.
   - B. The consistency should be reflective of the patient's stated beliefs and values. This information is obtained through conversations that have already occurred while the patient has been receiving care.
3. Does the patient provide recognizable reason(s) for that choice in relation to his or her medical condition?
   - A. This question relates to "how" the decision was made and is manifested in the patient/nurse dialogue.
   - B. Lack of insight, denial of the medical condition, and/or refusal to provide reasons should raise suspicion for diminished capacity.[13,14]
4. Can the patient communicate in his or her own words (paraphrase) the risks, benefits, and alternatives to the medical treatment plan, including no treatment?
   - A. Using one's own words shows insight of the disease in relation to oneself.
   - B. Communicating alternatives to the medical treatment plan, including no treatment, ensures that the patient can choose no treatment.

Ethical consultations and/or mental health evaluations should be considered when there is a lack of consensus about the patient's DMC within the medical team. When patients are found not to have DMC, an SDM will need to be designated as specified by state law. Surrogates are authorized to make decisions on behalf of the incapacitated patient until capacity is re-established. Most states provide a hierarchy for SDM: a legally appointed agent/guardian, spouse, adult child, parent, or siblings. Variability can arise when there is no legally appointed agent/guardian or "next of kin"; for example, Arizona recognizes a close friend,

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