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Capacity Evaluation Requests in the Medical Setting: A Retrospective Analysis of Underlying Psychosocial and Ethical Factors

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Background: *Psychosocial and ethical variables influence physicians in requesting decision-making capacity (DMC) evaluations. Previous authors have classified certain DMC evaluation requests as "unwarranted" when there is no explicit suspicion or evidence that the patient might lack DMC.* **Objective:** *To explore psychosocial and ethical reasons motivating both "warranted" and "unwarranted" DMC evaluation requests by physicians in the medical setting.* **Methods:** *A retrospective electronic health record review was approved by the institutional review board. All psychiatric consultation requests identified as DMC evaluation requests between January 1, 2012 and December 31, 2012 were assessed independently by 2 reviewers. Each reviewer identified each DMC evaluation request as "warranted" vs "unwarranted." Unwarranted DMC evaluation requests were defined as those lacking explicit suspicion that the patient might lack DMC or those with explicit evidence of a patient with blatantly impaired DMC. We hypothesized that most (over half) DMC evaluation requests would be deemed unwarranted. Descriptive statistics, chi-square/Fisher exact tests, and t-test/ANOVA were used.* **Results:** *A total of 146 DMC evaluations were reviewed, and 83 (56.8%) of these were deemed unwarranted. Of these, most were likely driven by a previous neuropsychiatric disturbance ($p < 0.001$). Various other psychosocial and ethical patterns were identified (i.e., the practice of defensive medicine and guardianship concerns).* **Conclusion:** *Over half of DMC evaluation requests in a general medical setting were unwarranted. Many such requests were motivated by unarticulated psychosocial and ethical factors. DMC evaluation requests appear to serve as a means for indirectly resolving various psychosocial and ethical dilemmas beyond assessing DMC itself. Implications and future directions are discussed.*

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Key words: decision-making capacity, competence, consultation psychiatry, ethics, psychosocial.

INTRODUCTION

Determining whether or not a patient possesses decision-making capacity (DMC) is a fundamental task that is inextricably linked with the ethical and legal imperatives of informed consent. Defined as an individual's cognitive potential to form rational decisions, DMC is the ability to understand, appreciate, express a choice, and manipulate information in forming decisions.[1] Rather than a global assessment, however, DMC is time- and task-specific.[1,2] As such, a

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patient's cognitive ability should be assessed in an ongoing manner depending on the specific decision at hand and its consequences (e.g., whether to consent or refuse life-sustaining treatment).

Although in most jurisdictions any physician is capable of assessing DMC, assessments are being increasingly outsourced to consultation psychiatry; in fact, previous literature has shown a 5–9.4% increase in requests over a 10-year period[3,4] and another study showed that the percentage of consultation requests for DMC rose from 5–17% from 2006–2010.[5] Given this phenomenon, authors have questioned whether these requests are truly prompted by patients' uncertain cognitive abilities or if the requests have become stand-ins for something else entirely.[6–11] For instance, Umapathy et al.[8] reported that DMC evaluation requests were often motivated by a patient's refusal of recommended treatment, psychosocial concerns, fear of legal liability if a patient leaves against medical advice, or a breakdown in patient-physician communication, or all of these. Kontos et al.[9] further hypothesized that many DMC evaluation requests are driven by underlying psychosocial and ethical concerns having little or nothing to do with a patient's cognitive abilities, and have thus classified certain DMC evaluation requests as "unwarranted," although this term does not imply that the assessment performed by psychiatry did not provide other value.[12]

Our consultation psychiatry service has observed this phenomenon in the medical setting, and we hypothesize that most (over half) DMC evaluation requests are in fact "unwarranted" or not at all about the cognitive aspects of a patient's DMC. We furthermore hypothesize that explicitly stated psychosocial and ethical factors—such as pre-existing psychiatric diagnoses or legal concerns motivating requests—are likely driving such "unwarranted" consultations. We sought to test these hypotheses in our cohort of consultation requests from medical services and present our findings, followed by relevant discussion.

METHODS

This retrospective study used electronic health record (EHR) data from a large academic/tertiary care hospital. EHR review and extraction was approved by the institutional review board through an expedited process. All DMC evaluation requests in the consultation psychiatry database in calendar year 2012 were included. Cases in which no DMC question was evidenced or consultants documented or both, no clear DMC determination was excluded. To control for internal reliability, we divided the DMC evaluation requests into 2 sets of cases, and 2 reviewers evaluated each case set. Case extraction discrepancies were reviewed by a third reviewer from the alternate case set for mediation of any ties in how a case was coded. A pilot study ($n = 20$, cases not included in published study data) was performed to troubleshoot inter-reviewer accuracy and refine the protocol. The EHR information locations and extraction approaches of data were standardized.

For each DMC consultation, the full note by the consulting psychiatrist as well as up to 3 days of primary medical team notes preceding the consultation were closely reviewed. Variables collected included demographic (age, sex, and ethnicity) and other information (primary medical service, primary admission diagnosis, past psychiatric diagnoses, length of stay before the consultation, DMC evaluation reason, explicit ethical issues documented by the primary medical team, DMC determination documented by the consultation psychiatry attending physician, consultant recommendations, and other services consulted). All DMC evaluation requests were classified based on the presence or absence of acute or pre-existing neuropsychiatric features. Case psychiatric features were coded based on determination that a "previously diagnosed mental health disorder," an "acute neuropsychiatric disturbance," or neither of these directly prompted the DMC evaluation request. If both were present, the "acute neuropsychiatric disturbance" feature was coded.

DMC evaluation requests were also categorized as "warranted" if questionable DMC was documented by the primary medical team preceding the consultation and as "unwarranted" if documentation demonstrated no questionable features of a patient's DMC or demonstrated blatantly impaired DMC (e.g., grossly disoriented, delirious, unconsciousness/coma, and inability to communicate). This approach was used as either of these clinical situations raises the question of why a DMC evaluation is necessary. Baseline descriptive statistics were used to describe the patient population. Categorical factors were compared using chi-square or Fisher exact tests, and continuous measures were compared using *t*-test or ANOVA.