

## Virtual Mentor

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### JOURNAL DISCUSSION

#### How Reliable is the Competency Assessment Process?

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**Appelbaum PS. Assessment of patients' competence to consent to treatment. *N Engl J Med.* 2007;357(18):1834-1840.**

Within reason, it is every adult American's legal right to make his or her own decisions. Included in this right is the freedom to make decisions about one's physician, medical treatment plan, and other health care matters. A democratic society does, however, provide moral, ethical, and social guidelines within which these decisions must fall—medical and health care choices are no different. The goal of this framework is to optimize personal freedom and autonomy, while ensuring that individual choices are within the guidelines for safe, acceptable behavior and practice. The imposition of limits is a complicated matter, though, particularly when it comes to health care, where a patient must demonstrate decision-making capacity, often measured by his or her physician.

In his *New England Journal of Medicine* article, "Assessment of Patients' Competence to Consent to Treatment," Paul Appelbaum explores the criteria for determining patient competence and the tools that are commonly used for such assessment. Appelbaum recognizes that there is no tool that is "perfect" for determining competence, but offers some suggestions for maximizing the resources physicians have.

Physicians are required, according to law and medical ethics, to obtain a patient's informed consent before the patient undergoes any nonemergency procedures or receives any treatment [1, 2]. While physicians may attempt to gauge a patient's ability to make treatment-related decisions through regular communication during the clinical encounter [3], they often rely on the "experts" (e.g., psychiatrists) to determine competence. Requests for inpatient psychiatric assessment of competency account for 3-25 percent of all requests for psychiatric consultations [4]. These requests demonstrate the physicians' awareness of the importance of accurately judging patient capacity. Still, nonpsychiatrist physicians overwhelmingly determine patient fitness to make treatment decisions on their own.

Appelbaum reviews two well-known tools for establishing patient competency, the Mini Mental State Exam (MMSE) and the MacArthur Competence Tool for Treatment ("the MacArthur tool") [5]. Each method seeks to assess a patient's ability to: communicate a choice, understand relevant information, appreciate the

consequences of treatment versus nontreatment, and reason about treatment choices [3]. The MMSE “has been found to correlate with clinical judgments of incapacity and it may have some use in identifying patients at the high and low ends of the range of capacity” [5]. The MacArthur tool (Appelbaum discloses he helped develop the tool and receives fees from the sales of the manual, forms, and training tapes), “incorporates information specific to a given patient’s decision-making situation” [5]. Both tests, however, ultimately rely on the subjective judgments of the physician, and, Appelbaum admits, there is a professional “divergence of opinion about which criteria should be applied and how” [6].

Regardless of the assessment method, Appelbaum believes that “examiners should first ensure that patients have been given the information that is relevant to making an informed decision about their treatment” [5]. He says that disclosure should include information about the patient’s condition, nature of the proposed therapy, the risks and benefits, and alternative treatments [5]. For patients who are receiving mind-altering medications or those experiencing fluctuations in mentation, more than one evaluation may be necessary [7].

Overall, Appelbaum’s recommendations tend to favor finding the patient competent. In his model, physicians are encouraged to “make treatment decisions...[that] reflect a societal judgment about the appropriate balance between respecting the patient’s autonomy and protecting the patient from the consequences of a bad decision” [8]. He offers strategies to alleviate patients’ fears and anxieties and, when possible, suggests evaluating a patient several times before labeling him or her incompetent [6]. Appelbaum believes that the stringency of the test should vary with the seriousness of the likely risks and benefits of patients’ decisions [8]. In practice, this means holding patients who are facing more serious procedures and therapies to higher standards of competence. Recognizing that some may find fault with this “sliding scale” approach, Appelbaum defends it by pointing out that it has been endorsed by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research and the courts [9]. Still, it is reasonable to ask that physicians take the positive endorsement and the criticisms of this “sliding scale” into account before applying it into clinical practice.

### **Critiquing Appelbaum’s Approach**

While Appelbaum’s approach to assessing competency using the MMSE and the MacArthur tool and using a generous threshold for competency may be reasonable on balance, I can see several problems with his model. First, by what standards is the physician basing his or her judgment of the patient’s understanding? Furthermore, reliance on the standardized tools assumes that the physician has taken the time to explain the patient’s condition adequately and answer his or her questions—something that perhaps should not be assumed. In short, I believe that the overarching question is: how reliable are these assessments?

My first point concerns the standards that physicians use to draw a conclusion regarding competence. While physicians who base their judgments on current legal

standards or on standardized question sets increase their interrater reliability [5], are they in agreement about what constitutes patient decision-making capability? Appelbaum admits that the MMSE is quite helpful for confirming that patients are almost surely competent (those with a score of 23 or higher on the 30 point scale) or that are almost surely incompetent (those scoring 19 or lower), but there is a three-point “gray area” that is completely reliant on physician judgment [5]. As Appelbaum notes, “no single cutoff score yields both high sensitivity and high specificity” [5]. The MacArthur tool also has a serious shortcoming: “evaluators must integrate the results with other data in order to reach a judgment about competence” [5]. Exactly what “other data” should be collected and included in the assessment is not specified. Appelbaum indicates that administration of the test can be laborious, too, if one is unfamiliar with the tool [5].

One can see that the tests, while potentially helpful, are plagued by limitations, not the least of which is how to administer them more consistently. In order to achieve greater uniformity, a physician must know how to execute the exams properly. But do physicians receive specialized training for the specific assessment they will give? If the test itself is standardized, what are the procedures for administering it? Appelbaum states that “there are currently no formal practice guidelines from professional societies for the assessment of a patient’s capacity to consent to treatment” [6], forcing one to ask, how useful are these assessment tools?

### **The Informed Consent Process**

My second point has to do with informed consent process. Appelbaum gives this little attention in the article, speaking about it specifically only when discussing situations in which an outside evaluator is called upon. He writes:

Whatever approach to assessment is used, examiners should first ensure that patients have been given the information that is relevant to making an informed decision about their treatment...such disclosure cannot be presumed...the evaluator should ask a physician responsible for the patient’s care to disclose the relevant information again in the evaluator’s presence or the evaluator should undertake such disclosure [7].

Appelbaum’s willingness to gloss over this very important process is quite problematic. Before patients can be properly evaluated for competency, they must be given information related to their condition. If physicians fail to do their “due diligence” in this area of patient-physician communication, patient decisions will be based on incomplete, and perhaps incorrect, information, which can lead to unwarranted questions or negative assumptions about the patient’s competence. Further, physicians must do more than just tell patients about a proposed procedure or therapy and its risks and benefits. They must communicate in ways that patients understand, even if it means requesting a language translator or using terms that are understandable to those who are not trained in medicine. Physicians must also ask questions that compel the patient to demonstrate a deeper understanding of the treatment proposals, not merely prompt the patient to parrot information back.

Another consideration that doctors must factor into their competency determination is how a patient's financial situation impacts the decision-making process. According to the American Medical Association's "Voice for the Uninsured" campaign, 1 in 7 Americans is without health insurance [10]. I think that it is entirely possible that, for some patients the decision about an elective procedure may be more difficult to make than the decision about whether to undergo treatment for a life-threatening condition. When a patient is uninsured or underinsured, he or she is likely to have more than just the risks and benefits to consider. The patient might also weigh which procedure is least expensive, which will be best covered by his or her insurance, or which has the quickest recovery time so that he or she can return to work. Because interventions for life-saving illnesses are more likely to be subsidized by insurance, patients may be willing to undergo those procedures more readily than they would less serious or preventive procedures that, while important, are not covered by insurance. The combination of necessity and health insurance can thus significantly simplify or complicate the patient's decision-making process. Physicians must carefully judge whether a patient's decision—especially if it is suboptimal in the doctor's opinion—is one of incompetence and negligence or of pragmatism and personal choice.

### **Conclusion**

Appelbaum has provided a good overview of the tools used for assessing patient competence. This article assumes that the physician has communicated effectively with the patient about the latter's diagnosis, treatment options, and the risks and benefits of those options—including the option of no treatment at all. Assuming that the informed consent process was managed effectively, as this article does, leaves a big piece of the competency assessment puzzle missing. Readers will have to make use of Appelbaum's many bibliographic references to complete the picture.

### **References**

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