

Capacity

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During your clinical work with patients who have a dementia you will likely encounter a situation where you or someone else is wondering about the capacity of one of your patients. The first thing to establish is what specific capacity is being questioned. Just because someone has a diagnosis of dementia does not necessarily make that person incapable and the specific capacity in question needs to be assessed. There are many different arenas of capacity, but for this newsletter I will focus on the capacity to consent to treatment.

In Ontario, the Health Care Consent Act (HCCA) governs health practitioners including physicians. This act sets the standard used to determine whether someone is capable of consenting to treatment and who may act as a substitute decision maker (SDM) if the person is incapable. The Act is available at www.e-laws.gov.on.ca. Physicians are encouraged to consult the Act in order to familiarize themselves with the legislative provisions. The goals of the HCCA include promoting individual autonomy and decision-making capacity, and facilitating communication between health care practitioners and their patients.

A person is presumed to be capable with respect to treatment decisions unless reasonable grounds to suspect incapacity exist. What constitutes reasonable grounds is not spelled out, but you may become concerned based on your observations during a clinical assessment or from information obtained from family or other caregivers. If you are proposing treatment, it is your responsibility to obtain consent. Treatment means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic, or health-related purpose and includes a course or plan of treatment.

According to the HCCA one is capable of consenting to a treatment if the person is able to understand the information that is relevant to making a decision about the treatment, and appreciate the reasonably foreseeable consequences of a decision or lack of decision. The key words are understand and appreciate. Therefore the person needs to have the cognitive abilities to process, understand and retain pertinent facts; to communicate his or her understanding; and the ability to weigh risks and benefits of different options in the context of his or her personal circumstances. It is not the presence of risk that is important, but the appreciation of risk that matters. One must take into account the individual's personal beliefs and values, his or her religious beliefs and cultural background and be aware of one's own potential biases. Simple things such as ensuring that the person's sensory deficits are optimally accommodated and providing privacy and time for the individual to consider the information are essential. Above all, we do not want to infringe on someone's right to self-determination inappropriately.

In my experience as a geriatric psychiatrist treating individuals with dementia, these evaluations are often straightforward, but can sometimes be very difficult particularly if the consequences of accepting treatment or not accepting treatment are grave. If you are uncertain about your assessment, a second opinion may be requested. It is important to remember that a person may agree with your treatment plan, but may not in fact be capable of consenting to the plan according to the standard set out in the HCCA. It is of course also possible for capable patients to refuse recommended treatment.

It is important that adequate information about the treatment has in fact been given as consent must be informed, and given voluntarily. You are expected to review the nature of the treatment, expected benefits, material risks and side effects, alternative courses of action and likely consequences of not having the treatment. Questions or requests for additional information also need to be addressed. It is often helpful to ask the person to tell you what they have understood from your discussion. If at the end of your assessment you find the person incapable of consenting to the proposed treatment, the person must be advised of his or her legal rights, unless the situation constitutes an emergency as defined by the HCCA. According to the College of Physicians and Surgeons of Ontario, physicians must tell the incapable person that a substitute decision maker will assist the patient and will

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be responsible for making the final decision. You should involve the patient as much as possible. If the person disagrees with your finding of incapacity or disagrees with the need for a SDM you must advise the person of his or her options. This includes finding another SDM of the same or more senior rank as listed in the hierarchy in the HCCA and or applying to the Consent and Capacity Board for a review of the finding of incapacity. The information given to the person and his or her response should be documented in the health record.

In Canada, it is a fundamental right of individuals to decide which medical interventions will be accepted and which will not. Physicians have the obligation to secure consent and patients have the legal right to consent to or refuse treatment. It is important that individuals at high risk of becoming incapable, such as someone who has a progressive dementia, are given opportunities to discuss their future care. As a physician, you are in a position to review the potential benefits of obtaining a power of attorney for personal care and who would be the person's SDM according to the HCCA if no power of attorney for personal care exists. I have found that having this discussion early on helps to ease the transition of including the SDM in health care decisions once the person is incapable and sometimes individuals request this prior to any incapacity as a way of ensuring everyone is aware of the treatment plan.



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THANK YOU

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