Determining Decision-Making Capacity & Beyond

Presenters:
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Objectives

- Recall federal and state legislative aspects related to medical decision-making
- Utilize tools for determining a patient's decisional capacity in the clinical setting
- Acknowledge the legal and ethical standards associated with surrogate decision-making.
- Apply decision-making capacity concepts through case studies.

Legal Aspects

What do healthcare professionals need to know about the legal aspects of healthcare decision making?

Rachel

US Supreme Court

Nancy Cruzan case (1990):

Ruling #1:

- A competent person has a constitutionally-protected liberty interest in refusing unwanted medical treatment (including nutrition and hydration)

- However, this right is not absolute. The state's interest in preserving life can override the patient's wishes in certain circumstances, including:
  - Prevention of suicide
  - Protection of innocent third parties
  - Preservation of life
  - Preservation of the integrity of the medical profession
  - MCL 333.5660(c)

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US Supreme Court

- **Nancy Cruzan case (1990):**

  Ruling #2:

  - When the patient is incompetent, the state's interest in preserving life applies, and life sustaining treatment cannot be refused/withdrawn unless there is "clear & convincing" evidence that this is consistent with the patient's express wishes (when competent)

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Michigan Courts

- **In re Martin (1995): Michigan Supreme Court:**
  - Follows the logic of Cruzan.

- **In re Rosebush: Michigan Court of Appeals:**
  - Patient was a minor ("never competent") and in an irreversible coma. Court ruled that for a "never competent" patient, surrogate decision-makers must act in the patient's "best interests."
  - Withdrawing or refusing life-sustaining treatment may, or may not, be in the patient's best interests, depending on the circumstances.

Rachel

Multilayered Legislation

FEDERAL LEVEL

- **Patient Self-Determination Act** 42 USC 1395cc(f):
  - Requires health care facilities to inform patients, on admission, about their health care decision-making rights; ask if the patient has an advanced directive; and note the answer to that question in their medical record.

STATE LEVEL

- **Patient Advocate Designation Act** MCL 700.5506
  - Allows competent individuals to appoint a surrogate, referred to as a ***Patient Advocate***, to make certain medical decisions for the individual, if the individual later becomes unable to make those decisions.

Rachel

Michigan Legislation

Under the Patient Advocate Designation Act

- A patient advocate's authority to act on behalf of the patient requires activation of the designation.

➢ Patient Advocate Authority to Act Requires (MCL 700.5508):

1. The patient's attending physician and another physician or licensed psychologist have determined upon examination of the patient whether the patient is unable to participate in medical treatment decisions,
   - has put the determination in writing,
   - has made the determination part of the patient's medical record, and
   - has reviewed the determination not less than annually.

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Michigan Legislation

- **Dignified Death Act** MCL 333.5651
  - Applies only to patients diagnosed with an “advanced illness” (defined as a “terminal illness”).
  - Physician must inform their terminally ill patient in writing of their right to:
    - Appoint a patient advocate
    - Make an informed decision re: receiving, continuing, discontinuing, and refusing medical treatment for the patient's reduced life expectancy due to advanced illness
    - Choose palliative care treatment including, but not limited to, hospice care and pain management.
    - Choose adequate and appropriate pain and symptom management as a basic and essential element of medical treatment

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Michigan Legislation

- **Dignified Death Act** MCL 333.5651
  - Identifies who can act as a surrogate decision-maker for terminally ill patients in the absence of a patient advocate designation.
    - For minor patients: the parent or guardian
    - For adult patients: a member of the immediate family, the next of kin, or the legal guardian.

- **If patient is not "terminally ill," no statutory guidance in Michigan exists around who can serve as a surrogate-decision maker**
  - Most Michigan health systems (including MHC) have a policy on this topic.
    - Refer to the MHC *Healthcare Decision Making* policy.

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Clinical Aspects

Why is it important for healthcare professionals to understand about the clinical aspects of healthcare decision making?

Stephanie

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Decision Making Capacity

Healthcare practitioners are both ethically and legally obligated to support a patient's right to self-determination in as many decisions as their capacity allows - and to do so in the least restrictive manner possible.

Inherent Aspects of Decision-Making Capacity:

1. It's an essential element of the informed consent process.
2. Supports the ethical principle of patient autonomy
3. Upholds the patient's right to participate in medical decision making

Stephanie

Core Standards

At minimum, Providers should be familiar with the core standards of decision-making capacity. These standards must be applied at all patient's decisional encounters.

Core Standards:

1. *Understanding* the nature of their circumstance
2. *Appreciation* for their medical condition & options
3. *Reasoning* behind their decision
4. *Choosing* from the available options

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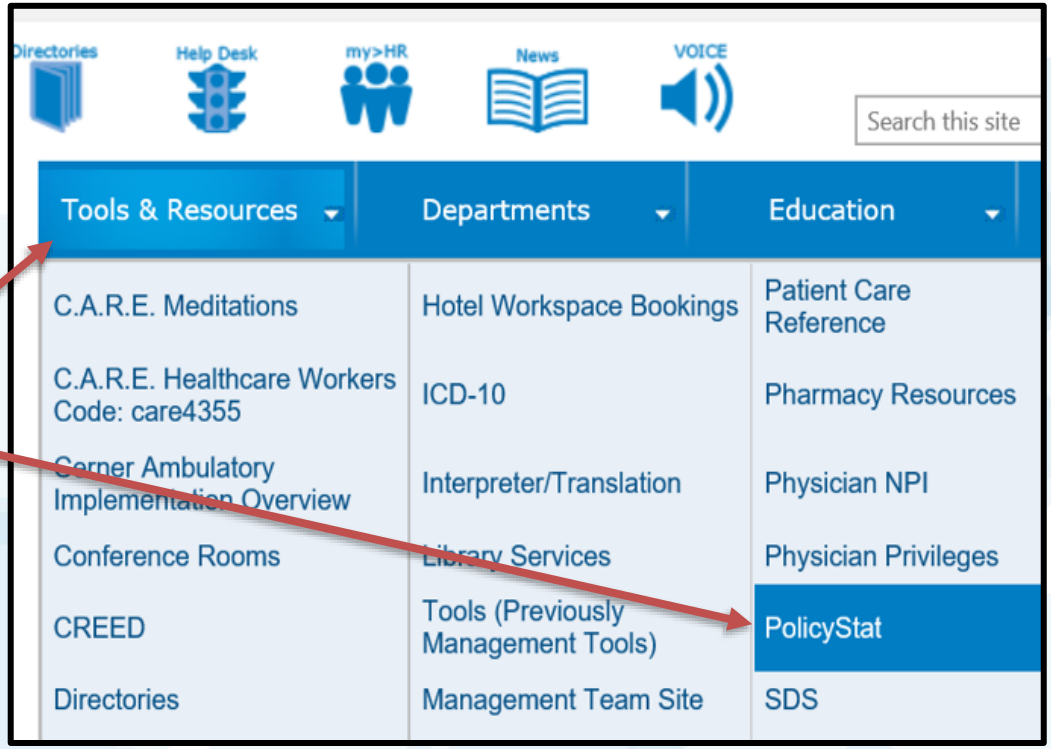
Decisional Capacity Tools

There is no standard mechanism for determining decision making capacity. Therefore, clinicians are encouraged to utilize a variety of tools and publications that increase the reliability of the assessment.

Providers are encouraged to review the tools attached to the Determination of Decision-Making Capacity Guidelines in PolicyStat.



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False vs. Fact

FALSE	FACT
Only psychiatrists and psychologists can assess decision-making capacity.	Assessing DMC is the responsibility of any provider treating the patient.
There's no need to assess DMC unless a patient makes an unusual decision or refuses recommended care.	A patient who consents may lack DMC, therefore, it is essential to assess DMC to ensure an informed decision is made.
Patients with a diagnosis of dementia, mental illness, or other cognitive impairment lack DMC.	While some illnesses may cause cognitive impairment, DMC refers to the process of decision making; not a disease process.
DMC is an "all or nothing" determination	Decisions carry a variety of risks, benefits, and complexities, and patients may exhibit sufficient capacity in one clinical context but not in others.
Once a persons is determined to lack DMC, there is no need to reassess it.	DMC is fluid and affected by many factors such as sleep, state of wellness or illness, medications, environment, etc..

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Beyond Decision Making Capacity

What is important for healthcare professionals to know when a patient lacks decision making capacity?

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Acknowledging the Future

A growing and aging population will increase the demand of health care services, and many will face circumstances where they are incapacitated.

1. 44–69% of decisions for nursing home residents are made by surrogates.
2. 75% of decisions for hospitalized patients with life-threatening illness are made by surrogates.
3. 70% of deaths in a hospital ICU are the result of decisions to withhold or withdraw life-sustaining treatment- nearly 95% being made by a surrogate.
4. Surrogates experience decisional burdens/stresses

Stephanie

Decision Making Standards

Established standards exist to promote decisions in alignment with the ethical standard of autonomy & respect for persons.

STANDARD	APPLICATION
Subjective	Applies when the patient has spoken directly to the issue of medical treatment, expressing a preference for or against it in certain circumstances before losing DMC.
Substituted Judgement	Applies when others express the patient's views about life, how the patient has constructed his or her identity including attitudes towards sickness, suffering, and medical care.
Best Interest	Applies when there is no reliable evidence of the patient's expressed treatment preferences or goals and the autonomy of the patient shifts to the welfare/well-being of the patient.

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Advance Care Planning

Advance care planning is the primary mechanism that supports the ethical and legal aspects of medical decision making by allowing an individual to designate *WHO* they trusts most to honor *WHAT* is important to them.

The Clinician's Role:

1. Discuss the patient's health situation & WHAT matters to them
2. Ask patients WHO they trust most to honor what matters most
3. Encourage and assist patients with documenting this information in portable, legal documents

Rachel

Identifying WHO

Legal documents that identify WHO speaks for the patient should they be determined to be incompetent by a judge or lack decision-making capacity by a physician or licensed psychologist.

Patient Designated

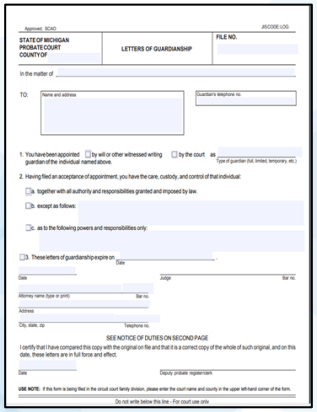
Advance Directive

Patient Advocate Designation

Durable Power of Attorney for Healthcare

Court Designated

Letters of Guardianship



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Identifying WHAT

Legal documents that identify WHAT decisions the patient has made. These documents fall under the subjective standard and should direct treatment during times when the patient lacks decisional capacity.

Michigan DNR Order

DO-NOT-RESUSCITATE ORDER

This is not a Code Status order for a person who is, or may become, hospitalized.
This order is an out of hospital medical order and serves as a communication tool for hospitalized patients.

D. GUARDIAN CONSENT

E. ATTESTATION OF WITNESSES

F. PHYSICIAN SIGNATURE

THIS FORM WAS PREPARED PURSUANT TO, AND IS IN COMPLIANCE WITH, THE MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT.

MI-POST

MDHHS-5836, MICHIGAN PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (MI-POST)
Michigan Department of Health and Human Services (MDHHS)
(Revised 7-22)

PART 1 – PATIENT INFORMATION

PART 2 – MEDICAL ORDERS

Section A – Cardiopulmonary Resuscitation (CPR)

Section B – Medical Interventions

Comfort-Focused Treatment

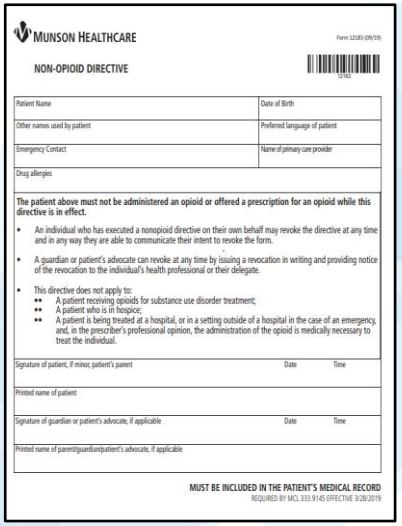
Selective Treatment

Full Treatment

Section C – Additional Orders (optional)

Send form with Patient whenever transferred or discharged.

Non-Opioid Directive



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NON-OPIOID DIRECTIVE

Patient Name	Date of Birth
Other names used by patient	Preferred language of patient
Emergency Contact	Name of primary care provider
Drug allergies	

The patient above must not be administered an opioid or offered a prescription for an opioid while this directive is in effect.

- An individual who has executed a nonopioid directive on their own behalf may revoke the directive at any time and in any way they are able to communicate their intent to revoke the form.
- A guardian or patient's advocate can revoke at any time by issuing a revocation in writing and providing notice of the revocation to the individual's health professional or their delegate.
- This directive does not apply to:
  - A patient receiving opioids for substance use disorder treatment;
  - A patient who is in hospice;
  - A patient is being treated at a hospital, or in a setting outside of a hospital in the case of an emergency, and, in the prescriber's professional opinion, the administration of the opioid is medically necessary to treat the individual.

Signature of patient, if minor, patient's parent — Date — Time

Printed name of patient

Signature of guardian or patient's advocate, if applicable — Date — Time

Printed name of parent/guardian/patient's advocate, if applicable

MUST BE INCLUDED IN THE PATIENT'S MEDICAL RECORD
REQUIRED BY MCL 333.9145 EFFECTIVE 3/28/2019

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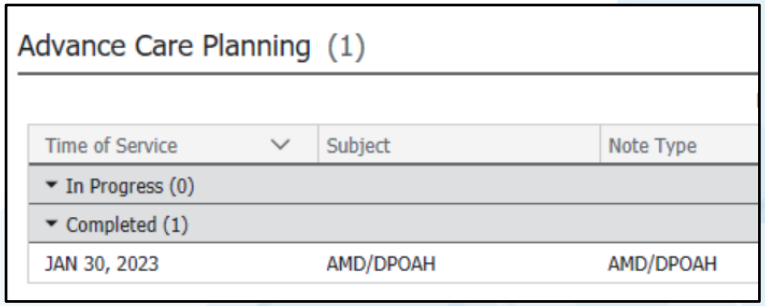
Finding Documents in the EHR

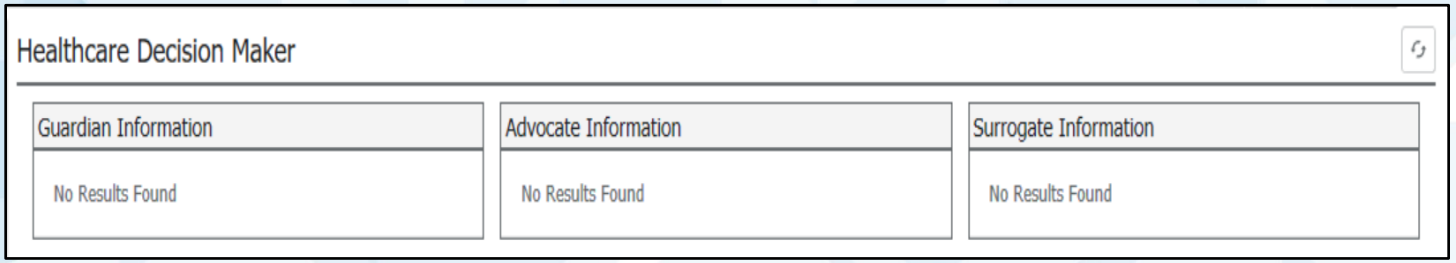
When patients provide copies of their documents, they should be stored within their EHR and clinicians should routinely check to see if the patient has any documents on file.

PowerChart Users:

- To check for Documents or Healthcare Decision Maker information: go to Menu > Provider (or Nurse) view > **Code Status-Advance Care Planning mPage** > Advance Care Planning Section:



- Or the Healthcare Decision Maker Section:



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Utilizing the EMR

Meditech Users:

To check to see if documents is on file go to > Summary > Risk/Legal:

> Or “Other Reports”:

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No Documents, Then What?

When a patient does not have any documents identifying WHO and/or WHAT, clinicians are encouraged to take the following steps:

1. Be proactive; ASK
2. Detailed documentation.
3. Emergency contact(s) as a secondary; ASK
4. Primary care Provider or residential facility, as applicable.
5. Reference organizational tools/guidance
6. If all else fails, contact the legal department or request an ethics consult.

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Case Studies

Acknowledging approaches to DMC and Beyond through case studies

Case: Who is the decision maker?

Helen has a valid DPOAH in which she designated her husband, Bob, as her patient advocate (Bob passed away a year ago) and her son, Tony. Since Bob's passing Helen has moved into a residential facility to help meet her care needs and she also executed a MI-POST order indicating she does not want CPR attempted.

Sue, Helen's Daughter stops by the facility to visit Helen and finds her lying in bed. When Sue is unable to wake Helen, she calls for help and staff summon EMS. Staff are unable to find a pulse and Helen is not breathing.

When EMS arrives, Sue pleads for them to do everything to save her mother.

Who is the decision maker in this scenario?

Case: Who is the decision maker?

Helen

Helen has documented her medical decisions in a MI-POST indicating that she does not was CPR attempted. Therefore, under the subjective decision-making standard, Helen is the decision maker in this instance as evidenced by her communicating in a clear and convincing manner that she did not want CPR when she executed the MI-POST order.

There is no surrogate decision maker needed and Sue should not be allowed to override Helen's prior decision- which she made during a time when Helen had decisional capacity.

Case: Caring for Tom

Tom is a 66-year-old patient who is found down by a by-stander. He is unresponsive and the by-stander calls 911. Tom is brought to the ED and is determined to be in moderate respiratory distress; non-invasive respiratory therapies are initiated and admission to the critical care floor is indicated.

Upon arrival to the critical care floor, Tom remains unresponsive, and his respiratory status is steadily declining. Intubation with mechanical ventilation is considered, but Bob is unable to participate in this decision.

What is the FIRST step a clinician should take?

Case: Caring for Tom

Check to see if the patient has any ACP documents on file.

If documents exist, review them to identify WHO the patient designated as their Patient Advocate and/or identify WHAT matters most to Tom in this situation.

If there are no ACP documents, contact the emergency contact and seek to identify who can best provide information about decisions the patient would make for himself, if he were able.

Case: Cognitive Evaluation

You are caring for a 74-year-old patient who is admitted for progressive weakness and confusion. During a conversation about treatment options, he exhibits forgetfulness and is unable to remember the discussion from day before. You are concerned that the patient may not have decision making capacity to make an informed decision about his treatment.

True or False: A speech cognitive evaluation should be ordered to assess the patient's decision-making capacity.

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Case: Cognitive Evaluation

FALSE

While cognitive impairment may impact reasoning and appreciation abilities, decisional capacity and cognition are distinct. Decisional capacity is associated with a specific decision and in relation to the patient's personal values and goals.

A speech cognitive evaluation is associated with global brain functions, such as memory, language, visual problem-solving, abstract thinking, and attention.

Therefore, a speech cog eval does not negate the providers legal and ethical responsibility to assess the patient’s decisional capacity when a patient needs to make decisions about medical treatment.

In Summary

A. DMC is best determined by a face-to-face interview using a series of open-ended questions that relate to the medical decision at hand.

B. DMC is affected by many factors, can wax and wane, and should be assessed often.

C. It is the treating provider's responsibility to determine a patient's DMC, and to what degree, a patient is unable to exercise self-determination.

D. When a patient lacks DMC, clinicians should apply decision-making standards to simplify surrogate decision making.

E. When no ACP document exists, the healthcare team should refer to the Healthcare Decision Making policy or the Surrogate Decision Maker Flowchart.

F. Utilize the capacity determination tools.

G. When in doubt, contact a member of the legal department.

Stephanie

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