

Ethical  
and  
conceptual  
aspects  
of  
capacity  
assessments

in  
psychiatry

Toshi  
Kitamura  
and  
Noriaki  
Takahashi

Purpose  
of  
review

To search the literature on conceptual and assessment  
issues of patient capacity.

Recent  
findings

Current literature shows that many instruments have been  
developed in the last decade to measure patient capacity.  
Although these measures provide a rank-ordered scale of

capacity, they cannot categorize patients into competent and incompetent, which relies heavily on the concept of authentic autonomy. The latter, however, should be carefully examined after considering the patient's cultural and subcultural background, and the quality of the doctor's communication skills.

## Summary

Academic and clinical psychiatry are posed with such questions as to how to categorically classify capacity and incapacity as well as to evidence the admissibility of measuring instruments when used in a civil commitment.

## Keywords

capacity assessment, competency to give informed consent, ethics, evidence admissibility

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Psychiatry

20:578.581.

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Williams  
&  
Wilkins.  
Clinical  
Behavioral  
Medicine  
(Psychological  
Medicine),  
Kumamoto  
University  
Graduate  
School  
of  
Medical  
Sciences,  
Kumamoto,  
Japan

Correspondence  
to  
Professor  
Toshi  
Kitamura,  
Clinical  
Behavioral  
Medicine  
(Psychological  
Medicine),  
Kumamoto  
University  
Graduate  
School  
of  
Medical  
Sciences,

1-1-1  
Honjo,  
Kumamoto  
860-8556,  
Japan  
Tel:  
+81  
96  
373  
5181;  
e-mail:  
kitamura@kaiju.medic.kumamoto-u.ac.jp

Current  
Opinion  
in  
Psychiatry  
2007,  
20:578.581

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Introduction

The rationale for introducing the concept of competency in a medical practice arises from the ethical imperative of respecting patient autonomy. If a patient is competent, then doctors should respect a patient's decision about medical matters based on his or her autonomy. If, on the other hand, a patient is incompetent, then doctors should protect the patient from undue exploitation and in certain circumstances force medical care on paternalistic grounds. Thus, the concept of competency and its application in clinical practice is of increasing importance.

Competency

vs.

capacity

The legal concept of competency covers a fairly wide range of abilities of an individual: competency to consent to research, competency to manage one's own affairs, competency to make a contract, competency to make a will, competency to make treatment decisions, competency to stand trial, competency to waive counsel, competency to refuse insanity defense, competency to testify, competency to confess, competency to plead guilty, competency to be sentenced and competency to be executed. Although they all share a common ability of the human mind (general competency), these competencies are very specific to the tasks a person is requested to perform [1]. Thus, the main focus of the present review is on psychiatric patient competency to make treatment decisions and to consent to research.

While competency is a legal concept, its application in a clinical setting requires the assessment of a patient's ability

to practice his or her autonomy. To avoid confusion many researchers use competency as the legal ability and capacity as the psychological ability.

Measurements  
of  
competency  
to  
give  
informed  
consent

The last decade has seen rapid progress in the development of instruments to measure clinical capacity.

Dunn et  
al.

[2] have identified 10 instruments to assess clinical research-related decision-making capacity and 15 instruments to assess treatment-related decision-making capacity. The instruments are not without limitations, but the MacArthur Competence Assessment Tools have the most empirical support [3].

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Determinants  
of  
competency  
to  
give  
informed  
consent

The concept of capacity consists of understanding, appreciation, reasoning and expressing a choice. These elements may be correlated with an individual's cognitive function. Moye et al.

[4] have reviewed the literature on the relationship between the capacity to make a treatment decision and a variety of cognitive tests. They have concluded that the construct of understanding has the strongest relationship with neuropsychological test performance, while appreciation has the weakest relationship with such test performance, for which the findings have been replicated [5]. These results suggest that understanding reflects a general competency, whereas appreciation reflects competency specific to a task required for a patient in an individual situation.

In the field of surgery there is a concern that patients taking narcotics may have impaired judgment owing to the effects of the drug. This possibility has been refuted by Lucha et

al.  
[6].

Structure  
of  
capacity

A few studies have examined the internal structure of  
capacity. For example, Dunn et

al.

[7] have applied the

MacArthur Competence Assessment Tool for Clinical

Research to 91 patients with schizophrenia. They

reported that most of those patients with impaired understanding

also had impaired reasoning, but that impaired

reasoning and impaired appreciation do not necessarily

overlap with each other. Further studies should use

a greater number of patients and explore the factor

structure of capacity.

Cut-off  
point  
of  
capacity  
and  
the  
concept  
of  
autonomy

Despite the recognition that capacity varies continuously  
from complete incapacity to complete capacity, the  
clinical situation (e.g. involuntary admission to a psychiatric  
hospital) often needs a dichotomous determination



of patients into either competent or incompetent. Instruments to measure capacity can provide an interval measure, but cannot give a dichotomous decision without a cut-off point. The level deemed as competent, however, may depend on the risks of the medical procedure or medical research [8]. As there is no gold standard for such a cut-off point of competency and incompetency, recent arguments have centered around the definition of autonomy, which is used as a reference to assess competency.

The decision made by a patient's 'free will' occasionally gives the impression to doctors that it should not be taken for granted as his or her authentic choice (e.g. a patient with anorexia nervosa refuses to ingest any food). Citing Diana Myers, Atkins [9□□] has claimed that individual free will does not equate to autonomy. She notes that

autonomy should be respected when it is in harmony with the authentic self. Free will may reflect the patient's 'first-order' desire [10], but respect should be directed to the patient's 'second-order' desire: the desire to have certain desires. First-order desires are influenced by temporary conditions. Thus, the choice of a patient should be evaluated in the light of their beliefs, emotions, desires and values.

Applying Frankfurt's 'first-order' and 'second-order' desires, people with heroin addiction are viewed as lacking the capacity to make an autonomous decision because heroin coerces them to choose only the drug ('first-order' desire) rather than abstaining from it ('second-order' desire). Foddy and Savulecu [11□□] have criticized this notion by pointing out that drug-oriented desires are strong, but regular, appetitive desires just like food, tobacco and water. The 'second-order' desire of people with drug addiction to abstain ('I really want to quit') may

be an externalization of responsibility ('I crave because of the addiction'). They conclude that people with addiction have competency for treatment decisions.

## Communication skills

Medical settings often make authentic autonomous decisions difficult because of unfamiliar circumstances in which one's health and life are at stake. Among patients who said that they received adequate explanation about a bladder tumor operation, one in five did not know what operation was performed, while one in three did not know how the operation was performed and one in two did not sufficiently recall possible complications [12]. Thus, an autonomous decision should be assisted so that it can really be authentic. Here, the communication skills of doctors are of vital importance. Improving the method of information disclosure is very important, e.g. among people with learning disabilities [13]. The medical information should not only be disclosed, but also be shared by the doctor. There are reports about barriers to the practice of informed and shared decision making [14].

The perception on the sufficiency of disclosure may affect a doctor's behavior when obtaining informed consent from patients. Doctors who thought that information on the informed consent sheet was sufficient to obtain consent were significantly more likely to obtain informed consent from patients for a antihypertension drug trial [15].

## Cultural and subcultural

aspects

The principles of bioethics now prevailing in the world have their foundation in Western cultures. Despite the globalization of medical technology, ethics related to human care should be viewed from the cultural framework where people who care and who are cared for share their values. Thus, both universal and culture-specific

580 History  
and  
philosophy

ethical principles and applications in clinical settings  
must be examined [16,17].

Even in Western societies, there are groups of people  
who deserve special attention. For example, minors  
should be provided with extra caution when obtaining  
their assent [18]. Patients with severe psychiatric illness  
should be considered as vulnerable to exploitation when  
participating in clinical trials. Welie and Berghmans [19]  
have made a case that, in order to promote public  
accountability, research publications ought to include a  
paragraph describing the informed consent process as  
well as the assessment of mental capacity. Elderly adults  
are another group of people who need care in protecting  
their decision-making capacity assessment. Financial  
capacity is an issue that is important in a clinical setting  
[20]. In a possible exploitable population, there must be a  
balance between the rigorous procedure (thus increasing  
the attrition rate) and the advance of evidence-based care  
[21].

Use  
of  
competency  
assessment  
for  
involuntary  
treatment  
and  
admissibility  
of

evidence

Whether patients should be respected for their medical decisions that include refusal of treatment or they should be treated involuntarily on paternalistic grounds relies heavily on the assessment of the patient's capacity to give informed consent. Such judgment, however, has long been left to the discretion of doctors. Moreover, 'scientific' testimony rather than just clinical judgment has increasingly been requested. In the US, for example, having dispensed with the Frye test of 'general acceptance', the Supreme Court in *Daubert v. Merrell Dow Pharmaceuticals Inc.* (1993) articulated that 'general acceptance' was not a necessary precondition to the admissibility of scientific evidence under the Federal Rules of Evidence, and that expert testimony should both rest on a reliable foundation and be relevant to the task at hand. It also noted that 'publication (which is but one element of peer review) is not a sine qua non of admissibility' nor does it necessarily correlate with reliability. In some cases, some propositions are too particular, too new or of too limited interest to be published. Several years later, the Court in *Kumho Tire Company, Ltd v. Carmichael* (1999) held that Daubert's requirement applies not only to 'scientific', but also to all expert testimony. From these two holdings it is clear that expert testimony made by clinicians as to a patient's competency must be based on a reliable foundation and relevant to the issue at hand.

Krauss [22] has applied the Daubert doctrine to the US Criminal History Score of the Federal Guidelines to

conclude that the Guidelines are insufficient as scientific evidence to predict recidivism on which the Guidelines

indicate to determine the sentence. Like criminal sentencing, involuntary admission is a civil commitment without a person's consent. Thus, involuntary admission must be based on sufficiently admissible scientific evidence. This may become an important issue of capacity and capacity assessment in psychiatry in the years to come.

## Conclusion

The last decade has seen the development of many instruments to measure patient capacity. These instruments cannot, however, determine the cut-off point with which to categorize patients as competent or incompetent. The latter depends on the concept of authentic autonomy by which to execute the patient's own 'secondorder' desire. The patient's cultural and subcultural background and the quality of the doctor's communication skills are also of vital importance. Capacity assessment may become a target of academic and practical debate because it often results in deprivation of patients' rights as in the form of civil commitment.

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and  
recommended  
reading

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of special interest

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of outstanding interest

Additional references related to this topic can also be found in the Current World Literature section in this issue (p. 637).

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