Assessing Capacity

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General practitioners are sometimes requested under the Protection of Personal and Property Rights Act (PPPR Act) to report on a person's ability

- to make personal decisions about self care and to give informed consent to medical procedures (welfare)
- to manage property
- to appoint an Enduring Power of Attorney (EPOA).

The PPPR Act 'provides for the protection and promotion of the personal and property rights of persons who are not fully able to manage their own affairs'.

Its aim is 'to tread the line between overly-paternalistic forms of intervention which restrict people's rights unnecessarily and non-intervention which may leave people or their property vulnerable or open to abuse'.[1] For more information on the Act itself, refer to my article in the February 2001 issue of this journal.[2]

'For the purposes of this part of the Act, every person shall be presumed, until the contrary is proved, to have the capacity...to understand the nature and to foresee the consequences of decisions in respect of matters'.[3]

General issues

Although the GP will know about the patient's physical, mental and cognitive status, this information will not usually generate *specific* answers to competency questions. A diagnosis (such as dementia, schizophrenia or intellectual disability) does not usually shed light on specific aspects of capacity. A person will almost always need to be formally assessed.

However, the general medical background may help in other ways. For example, knowing that someone has a UTI means that assessment should be left for another day when the person's mental status is not clouded by delirium. Being aware of a person's psychosis can warn you that he might be basing judgements on delusional beliefs. Diagnosis is essential when the court needs prognostic information to determine the type of order made and possible review dates.

Steps in the capacity assessment

Step 1: Perform capacity assessment only when there are valid triggers

There is almost always some event that triggers the request for an assessment of capacity. If this is not obvious, then find out why the particular request is being made at this time. If the request is a vague one about 'assessing competence' then ask 'competence for what?'

Examples of triggers would be a request from a lawyer because the person wants to appoint an EPOA, or a family wanting to place their mother in a safe environment against her wishes. Once you know the trigger your assessment can be directed specifically towards the issue in question. This avoids unnecessary work assessing some area, which is not being questioned, and failing to address the main issue. If there is no such trigger, there is little point in undertaking an assessment. Later, when the person wants to take a legal decision, your assessment will be out of date.

Step 2: Find out about the context in which decisions are to be taken

The GP needs to have information about the background to the request. This can come from family members, other health care professionals, solicitors or financial advisors. This will form a basis for targeted questions, e.g. 'Your daughter worries that if you fall at home you won't be able to contact help... How would you manage?' You will get an idea of which values are in conflict (often safety vs independence) and can address these during the assessment. The context will inform you about the person's usual mode of functioning, attitudes and values and help determine whether the person is doing something out of the ordinary. This sounds time-consuming, but the GP can ask the person requesting the assessment to supply the necessary background information before the person is seen.

Step 3: Education

The assessor should try to make sure that the person has been told what is going on.

As we know, in gaining informed consent for medical treatment, people must be told, in language they understand, the options available, the side effects and the prognosis with and without the various kinds of treatment, *before* they are able to make a rational decision. Otherwise, ignorance can be mistaken for incapacity.

In other areas of decision-making the person needs to be informed of the risks, benefits and options in any proposed course of action, e.g. does the person know that a company such as The Public Trust could manage his affairs? Or his lawyer? Or one of his relatives? That an EPOA may be revoked or limited etc.? Ideally, this should be done by whoever initiated the assessment. However, surprisingly often, this has been omitted. You may need to contact the lawyer, social worker or family to find out what information has been given to the person, or delay the assessment until you know the subject has been fully informed.

Step 4: Involving the person

It does not make sense to ask the person to *consent* to the assessment (they may not have the capacity to consent) but the assessor needs to gain cooperation if possible. You can explain why the capacity needs to be checked, and that it will be in the person's best interests to participate. Often people are offended by the suggestion that they may not be able to make their own decisions, but will accept that it is ultimately better to document that they are competent, or have some protection if their capacity is impaired. It helps to explain that the procedure can save arguments later. You can acknowledge that the process may seem rather intrusive, but that you are only going through it because you think there are good reasons (the triggers) for checking things out.

Step 5: Make conditions of examination as good as possible

If a person has a reversible illness it is best to delay the assessment, if possible, until they are well and will perform better.

Try to minimise communication difficulties. The deaf person should wear his or her hearing aid (turned on!) Even dysphasic people may be able to communicate accurately enough for you to do an adequate interview.

The person should be seen on his or her own to avoid subtle coercion from another party. If you need someone to interpret because of speech or language difficulties, note the subject's comfort with that person and record the presence of the third party in your report.

If the person cannot communicate in some way, then for the purposes of the PPPR Act they are incapacitated, even if you suspect they could be cognitively intact.

Step 6: The assessment

It is best to start by asking open questions ('How are you managing at home?') becoming more specific ('Do you need help with the cooking?') if the person fails to answer adequately, going on to 'yes-no' answers if necessary ('Would you agree to having Meals on Wheels delivered?').

To have capacity, the person needs to understand the *context* in which a decision is to be made, to understand that he or she has a *choice* and know some relevant choices and the *consequences* of the choices.

Context

The person should be able to explain the current situation and demonstrate an understanding of the triggers, e.g. a competent person may be aware that her situation living at home is tenuous and acknowledge possible risks relating to living on her own. This compares with the person with dementia who lacks insight and believes she is coping as well as she did 20 years ago.

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Choice

The person needs to know that he or she can make a choice and what are the *personally relevant* options, e.g. stay at home alone, stay at home with help, live with daughter, move into residential care. The person needs to be aware of the context to appreciate the choices. They should be able to describe how they would pick from the choices.

Consequences

A person should have some idea of the outcome of the choices he or she identifies. Obviously this is difficult to predict, but most people can discuss what might happen, e.g. a manic person may lack capacity, failing to see the possible negative outcomes of risky spending.

Levels of competence, cultural issues and understanding of legal matters

How competent do you have to be to make a decision? The complexity of the choices and seriousness of possible outcomes varies enormously. A person might be able to agree to a simple test or treatment (such as a blood test) but not be able to understand the complexities of brain surgery. The greater the risk, the higher the level of competence required for decision-making.

The threshold for capacity should not be set too high unnecessarily depriving people of autonomy. Decision-making ability should be geared to the level of 'the common man'.

If in doubt, describe how you decided on the level when reporting.

The assessment looks at the *process* of decision-making. Different cultures have different ways of coming to decisions. You may have to check with other members of that culture. Even if the outcomes seem odd or foolish to you, the way of getting there should be understandable.

As you proceed through the assessment, you will get an idea of the person's communication difficulties and understanding of legal processes. You should note in your report whether the person would be able to understand legal documents and court proceedings and whether the proceedings would be distressing.

Specific Issues

Welfare (Welfare Guardian, Section 10 PPPR Act)

Personal care (or welfare) involves both the ability to perform the *practical* tasks of daily living, and the *cognitive* function of making decisions regarding these tasks.

Problems with the *cognitive* aspects will trigger the assessment. Someone who cannot manage the practical tasks, but is cognitively intact, will be able to modify the environment to continue coping.

Often a person with failing cognitive abilities denies problems with

practical care (the context), or when confronted with these generates inadequate responses to the problem, e.g. an older woman denies that she forgets pots on the stove thereby risking fire (context). When the problem is raised with her says it is not an issue and does not see the point of making other arrangements (failure to make choices).

Making a decision about medical treatment is a cognitive task with few practical aspects. The person needs to know what needs treating (context) and some alternative (say two) management strategies (choices). The person needs to demonstrate awareness of likely outcomes (consequences).

Property Part III

Managing property has *functional* and *cognitive* components.

The functional tasks involved in managing property are writing cheques, signing documents or going to the bank. A person with physical limitations, e.g. blindness or severe arthritis, may be unable to perform these tasks while still knowing what needs to be done. Under the PPPR Act, such a person could be seen as being 'partially incapacitated' and could have a Property Manager appointed. However, it is likely that this person would be able to appoint an EPOA to do the necessary tasks.

The cognitive components of property management are: knowing assets, debt, income and expenses or outgoings and any other obligations. The person needs to be able to make choices about what to purchase and how to invest. Ask the person what their income is (roughly), how much they spend on groceries, rent etc., what they own. Near enough answers are good enough. You may have to check the accuracy with someone else.

Making calculations, balancing income and expenses and paying the bill on time require both cognitive and functional abilities.

Different *types* of ability are relevant to different people. A businessman with a portfolio of shares will require different skills from a woman living on the pension, buying a small amount of shopping each week.

A person may adequately handle small day-to-day purchases where the financial risk is not great, but need a manager to deal with the major decisions. This person would be partially incapacitated.

An older woman agrees to sell her home to a neighbour for $30 000, not realising that the market value is now five times the price. This triggers an application for a property manager when the family discover what is happening.

The procedure is to check that the person knows the *context*, including the trigger problem, (What is the value of the house? Might the family want to buy it?) can make reasoned *choices* (Why selling at this time to this particular person? Would it be better to get a valuation? Sell via a land agent?) and be aware of possible *consequences* (Is there a possibility that she is being cheated? Where will she live when the house is sold; what will she do with the money?).

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Enduring Power of Attorney

If there is any doubt as to the person's competence, it is prudent to assess him/her, before signing the EPOA, although law does not require this.

A person may be unable to make decisions in several of the above areas yet still be able to grant a power of attorney to someone they trust.

The person needs to understand that an EPOA can be specific or general, for property or welfare. An EPOA will be activated when the person becomes incompetent. It can be revoked at any time while the person is competent. The person should know who are potential attorneys and explain why he or she is choosing one person over the other. You need to be alert to possible coercion, especially when a property attorney is being appointed.

Although the Act does not specifically require this, you may be asked to decide whether the person has become incompetent so that the previously appointed attorney should take over the management of the donor's affairs. The assessment of the area under question (e.g. property) is as above.

There will be occasions when even with excellent information and careful assessment you still cannot decide whether the person is competent or not. People with frontal lobe damage are often tricky as they present with apparently adequate knowledge, good verbal skills but poor judgement and insight. Difficult cases can be referred to an expert: psychiatrist, psychologist or geriatrician. It is always worth recording your findings and the source of your dilemma, as this may be valuable information at a later date.

Key points

- Although the GP will know about the patient's physical, mental and cognitive status, this information will not usually generate specific answers to competency questions.
- The person should be seen on his or her own to avoid subtle coercion from another party.
- There will be occasions when even with excellent information and careful assessment you still cannot decide whether the person is competent or not.

References

1. Dawson, Bray et al. The Implementation of the PPPR Act 1988. The report of a Pilot study in Dunedin 1994.
2. Perkins CJ. Personal and Property Rights Act. NZFP 2001; 28 (1): 23–26.
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4. Molloy DW, Darzins P and Strang D. Capacity to Decide. Newgrange Press (Australia) 1999.