Legal Issues Arising in the Process of Determining Decisional Capacity in Older Persons

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There is a high and increasing incidence of dementia, depression and other affective disorders, delirium, and other mental health problems, such as psychoses, among older individuals in the United States today (Luijendijk et al., 2008; Rosenberg, Woo, & Roane, 2009). Accurate and timely clinical diagnoses of these illnesses is essential for the development of optimal treatment and management plans (Kapp, 2002b). Nevertheless, because the severity of mental illness, in terms of cognitive and behavioral impairment and therefore the illness' impact on functional ability, varies for different patients at different times along a continuum (Hachinski, 2008; Okonkwo et al., 2007), there is not an automatic, precise correlation between an older person's clinical diagnosis and a simple, dichotomous determination that the individual definitively does or does not possess sufficient present capacity personally to make various sorts of fundamental life decisions. Such matters include medical care, legal transactions like executing a will or entering into a contract (Streisand & Spar, 2007), financial transactions (Hebert & Marson, 2007; Moye & Braun, 2007), living location and arrangements, and research participation (Karlawish et al., 2008). "Neuropsychological tests do not map directly on to legal constructs" (Wood, 2007, p. 202). Put differently, there frequently is a huge difference between a general psychological assessment done for diagnostic and/or therapeutic reasons on the one hand and an evaluation done for purposes of determining a person's capacity autonomously to make specific kinds of decisions on the other (Moye, 2007).

Thus, a large amount of well-funded psychological and psychiatric research has been undertaken over the past few decades aimed at developing instruments useful for the specific purpose of reliably measuring decision-specific decisional capacity among older individuals (e.g., Lai et al., 2008). Decisional capacity assessment in the aged carries important implications both for the official adjudication of legal competence and for patient/client management in the vast majority of cases involving "bumbling through" rather than formal invocation of the guardianship or conservatorship process (Kapp, 2002a); because of those tangible legal and practical consequences, this corpus of research and its resulting output have received tremendous attention in the gerontological and geriatric literature.

A nice summary of the leading work in this arena has been gathered and commented on in *Changes in Decision-Making Capacity in Older Adults: Assessment and Intervention* (Qualls & Smyer, 2007), a volume in the Wiley Series in Clinical Geropsychology comprised of papers emanating from a conference of clinical and academic geropsychologists held at the University of Colorado at Colorado Springs on this subject. This book explicitly addresses the complicated and nuanced topic of capacity as one at the "intersection of legal doctrine, behavioral science research, and clinical practice" (Smyer, 2007, p. 5) and involving "three interacting elements: the person, the process, and the context" (Smyer, 2007, p. 6).

Changes in Decision-Making Capacity in Older Adults illustrates an interesting phenomenon. Almost all the organized attention that has been devoted to the creation and study of emerging tools and methods for assessing decisional capacity among older individuals and to the legal ramifications of these capacity evaluations begins with the implicit assumption that a mental capacity/competence assessment of the older person utilizing available appropriate assessment instruments will be done as a primary means of generating the necessary data going into a conclusion about the patient/client's actual and legal ability—and right—to make personal decisions. The assumption appears to be, "First, assume a proper assessment has been done." However, this assumption is not in every case borne out factually. Indeed, in many cases, making this assumption starts the story somewhere in the middle. Persons whose decisional capacity is questionable may be recalcitrant or uncooperative regarding participation in a systematic capacity evaluation. There are a panoply of salient but generally overlooked legal and ethical concerns and barriers immersed in gerontological practice by the health care or human services provider's attempt to evaluate the decisional capacity of a particular older patient/client. This article surveys the most important of those concerns and barriers that arise before we ever get to the point of applying assessment data to the relevant legal (Petersen, 2007) and ethical standards of decisional capacity.

INFORMED CONSENT FOR CAPACITY ASSESSMENT

Questions concerning an older person's decisional capacity may be raised initially by a variety of persons in the older person's life—family members, friends, neighbors, health or human services professionals, bankers, and business associates, among others—on the basis of their observations of the individual's behavior (Qualls, 2007b). "Capacity is a socio-legal construct

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that frequently arises . . . when there are concerns about the management of an adult's medical and financial affairs" (Newberry & Pachet, 2008, p. 439). "To date, virtually no published research exists regarding referral patterns for consent capacity evaluations" (Karel, 2007, p. 158).

Sometimes, an adequate assessment of an individual's decisional capacity may be accomplished just by observing and listening to the questioned person. "The assessment of the patient's capacity to make decisions is an intrinsic aspect of every physician-patient interaction. Usually, the assessment will be implicit" (Appelbaum, 2007, p. 1837). Such informal—essentially stealth—evaluations rely on circumstantial or inferential evidence. The circumstantial evidence may be supplemented by

> a number of collateral interviews that may include family members, caseworkers, attorneys, and law enforcement personnel depending on the referral question. These interviews provide a history of cognitive and functional abilities and assist in ascertaining the course of the alleged cognitive impairment. [Additionally,] . . . evaluations often require extensive record reviews including legal records, medical records, and psychological records depending on the case. (Wood, 2007, p. 198)

In many instances, though, a thorough capacity evaluation process would require many more components. "Although there is no agreed-upon, published standard for the evaluation of competency, most [psychologist] practitioners would probably agree that an exhaustive assessment of competency with the most far-reaching outcome would include most, if not all of the following four components": (a) clinical and diagnostic interview, (b) neuropsychological testing, (c) functional ability assessment, and (d) review of legal standards (Moberg & Rick, 2008, pp. 404–405).

Stated more fully:

> Regardless of the skill being queried, evaluation of competency in an elderly patient requires a multi-pronged approach to assessment. As there is no single "capacitator" or determinant of an individual's capacity for any given skill set, the clinician needs to utilize a variety of standardized measures and approaches to ensure adequate coverage of the skills and attitudes necessary for a competent person to function in day-to-day life. (Moberg & Rick, 2008, p. 411)

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Along with the other possible components of a capacity evaluation, a comprehensive medical examination may be necessary to detect such capacity altering (on a temporary or permanent basis) factors as infections, endocrine disorders, cardiovascular disease, chronic obstructive pulmonary disease, sleep apnea, inflammation, chemical imbalances, vitamin deficiencies, chronic pain, and drug/drug interactions (Kaye & Grigsby, 2007). As noted previously, a comprehensive evaluation might also require the individual's consent to and cooperation with the conduct of a formal interview or the administration of structured testing instruments (Chodosh et al., 2008; Hurst, 2004). Even when such instruments can be administered, "conclusions made on the basis of screening tools . . . should be regarded as preliminary evidence. . . . Screening tools may be useful in getting a sense of a client's overall level of functioning but cannot provide the diagnostic or functional piece of evidence that should accompany all capacity evaluations" (Wood, 2007, pp. 202–203).

Moreover,

> consideration of an individual's values, preferences, and perspectives is equally important as an assessment of his or her decision-making abilities. This is because information on values provides key contextual information for the treatment decision and may reveal important information about what is guiding a treatment decision that is not elicited in a more technical consideration of cognitive processing. (Moye & Braun, 2007, p. 217)

"The judgment of capacity or competence must always be balanced by the needs and values of the patient" (Moberg & Rick, 2008, p. 412). Such consideration cannot occur in the absence of active participation in the evaluation process by the individual whose capacity is being evaluated. "Obviously, [one] cannot formally test a person who is uncooperative" (Kaye & Kenny, 2007, p. 308).

And therein lie the potential legal and ethical problems. "A capacity evaluation can be a particularly threatening clinical encounter because patients' basic rights to make decisions for themselves are at stake and patients are in a particularly vulnerable position (given some question about their cognitive or psychiatric functioning)" (Karel, 2007, p. 159). In the face of an express or implied request that one participate in a capacity evaluation,

> three outcomes are possible: the patient consents, the patient will not consent (refuses), or the patient cannot consent or refuse (lacks the capacity to consent to the evaluation). In the latter situation, some patients assent to the evaluation but show questionable comprehension of the risks and benefits. These same decisional deficits may be affecting the patient's capacity to consent to treatment. (Moye, 2007, p. 185)

Ordinarily, before any kind of intervention—diagnostic or evaluative as well as therapeutic or investigational—may be done to an adult (of any age above legal majority), legal and ethical principles require the consent or permission of the person on whom the intervention is to be done (Henry, 2007). Consent may be manifested expressly (in actual words, either spoken or written) or may be implied by the individual's conduct. In the decisional capacity evaluation context, implied consent might be created by the individual's action in answering the questions or performing the tasks posed by the evaluator. However, because the results of the capacity evaluation may be used for legal (forensic) purposes, such as providing evidentiary support for an adjudication of incompetence as a prelude to judicial appointment of a guardian, express consent is much preferred. According to Kaye and Kenny (2007), "In all cases, you should have written authorization before you begin to directly examine a person for forensic purposes" (p. 308).

Similarly, capacity evaluators cannot obtain and review a person's medical records in the absence of either the person's express permission or an applicable exception to the consent requirement. This barrier is discussed further in the section "Confidentiality Considerations."

Legally and ethically, legitimate consent—for a capacity evaluation or any other type of intervention—entails three distinct elements. First, the consent must be voluntarily given (i.e., not the product of undue duress or coercion) (Garrison, 2007). Second, the consent must be based on an adequate presentation to the individual of all material information (i.e., information that might make a difference to a reasonable patient in similar circumstances) (White, Rosoff, & LeBlang, 2007). Thus, it would seem that a person who is asked to cooperate in a decisional capacity evaluation ought to receive a truthful explanation of the reason for the proposed evaluation as well as the reasonably foreseeable risks entailed—including the risk that the individual may formally or informally lose the right personally to make certain kinds of life choices as a result of a finding of decisional incapacity or legal incompetence.

The third element of valid consent to an intervention is decisional capacity; it makes little sense to honor—on the basis of the principle of self-determination—a decision purportedly made by a person who is not presently capable of engaging in an autonomous decision-making process. The requirement of decisional capacity to consent presents a "catch-22" dilemma (Heller, 1990). Namely, we must ask whether, if a person needs to have his or her decisional capacity evaluated because someone has questioned its status, that person can autonomously, hence validly, consent to participate in the evaluation process.

One way to handle this dilemma, at least in theory, is by relying on surrogates to make the decision regarding a person questionably capable of consent to participate in a decisional capacity evaluation. This is the logical but somewhat circular idea that formal decision-making surrogates (such as guardians or conservators appointed by a court, agents or attorneys in fact appointed under a durable power of attorney by the now-questionably capable person earlier while that person was still clearly capable, or an agent named in a state's surrogate consent statute) or informal surrogates (most commonly family members and friends) may consent to a formal capacity evaluation on behalf of the person about whom capacity is being questioned. This solution will work in practice, of course, only when the alleged incapacitated person is willing to respond affirmatively to interview queries and/or the administration of capacity assessment instruments; without this willingness to respond, a surrogate's expressed consent would be meaningless in a practical sense.

Another possible strategy, alluded to earlier, is to be satisfied with the implied consent of the individual whose decisional capacity is being evaluated. This approach draws an assumption of positive or affirmative consent, despite the absence of a specific expression in that regard, from the passive failure of the individual actively to object to or veto the assessment process, coupled with cooperative behavior on the part of the evaluated person. In many situations, this state of affairs has to suffice for service providers and family members who are doing their best to walk the ethical and legal tightrope between intervening too early in the older person's degenerative process (thereby restricting the person's autonomy prematurely) and intervening too late (thereby allowing risks to the person's safety to materialize and cause injury) (Qualls, 2007a).

An additional, desirable approach to the challenge of obtaining valid informed consent for the carrying out of decisional capacity assessments is to encourage individuals, while still unambiguously decisionally capable, to execute advance directives pertaining to this matter. Advance planning for the contingency of capacity assessment could take the form of a written instruction directive basically stating, "In the event that my decisional capacity is questioned in the future, I hereby authorize the conduct of a proper assessment of my capacity at that time." Advance planning could also take the form of proxy directives stating the equivalent of, "In the event that my decisional capacity is questioned in the future, I hereby authorize X to consent on my behalf to the conduct of a proper assessment of my capacity at that time." However, as noted previously, this solution will work in practice, regardless of the existence and content of advance planning documents, only when the alleged incapacitated person is willing to respond affirmatively—at the time of the attempted capacity evaluation—to interview queries and/or the administration of capacity assessment instruments. Otherwise, the evaluation will need to proceed on the basis of whatever data can be collected without the positive cooperation of the alleged incapacitated person.

CONFIDENTIALITY CONSIDERATIONS

The conduct of decisional capacity evaluations necessarily entails the release, collection, and management of personally identifiable information about the individual whose capacity is being

questioned. An evaluation may involve the capacity assessor's receipt of personally identifiable information from the individual's current or previous health care providers and others and the assessor's revealing of such information to the person's present health care providers and formal and informal surrogate decision makers.

When the receipt or release of such information is involved, confidentiality concerns are likely to emerge (Sanbar, 2007). Legal restrictions on the sharing of personally identifiable health information are imposed by, among other legal sources, common-law precedent, state medical privacy and testimonial privilege statutes, and the federal Health Insurance Portability and Accountability Act (HIPAA) and its implementing Privacy Rule. "It may not be possible because of HIPAA regulations to obtain information that allows the [capacity evaluating] expert to render a definitive opinion [about the decisional capacity of the person being evaluated]" (Streisand & Spar, 2007, p. 190).

45 C.F.R. Sections 164.502(a)(1)(ii) and 164.506(c)(2), parts of the Privacy Rule implementing HIPAA, create an exception to the general confidentiality provisions governing personally identifiable information in medical records when the information is disclosed for "treatment" purposes; whether the clinical evaluation of an individual's decisional capacity constitutes a "treatment" purpose within the meaning of the term as used in the Privacy Rule is thus far an unexamined question. Similarly, the applicability of "treatment" exceptions in state medical privacy statutes (e.g., Cal. Civ. Code Section 56.1007) to the capacity assessment context remains, at present, untested.

Presumably, testimony about a decisional capacity assessment would be admissible in court (e.g., in guardianship or conservatorship proceedings) on the basis of the evaluatee's waiver of confidentiality. One set of authors advises capacity evaluators as follows:

> Your consent form as an expert witness is different from the standard form for clinical work. . . . The forensic consent form should contain at least the following information: Explanation that the examination is not intended for treatment purposes and the information you obtain from it will not remain confidential. You should state that as part of your evaluation you will interview other individuals, review records, and so on, and prepare a report that will be provided to the referring attorney and eventually the court. (Kaye & Kenny, 2007, p. 308)

These authors continue,

> In forensic cases, you will release the report only to the retaining attorney, who will then release it to other attorneys involved in the case. You also may discuss your findings with the retaining attorney. . . . If you have evaluated a patient at the request of a family member or physician, you will release information (with the patient's signed consent) to the individual who made the referral. (Kaye & Kenny, 2007, p. 311)

STANDARDS OF PRACTICE AND LIABILITY RISK FOR ERRONEOUS ASSESSMENT

We may realistically anticipate a time, in the not-too-distant future, when test cases will be brought in the courts seeking to impose civil liability on psychologists and other professionals performing decisional capacity evaluations on older individuals on the grounds of professional malpractice. To succeed within the U.S. judicial system, a lawsuit in this category would require the plaintiff to prove the following discrete elements, each by a preponderance of the evidence.

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The first required element of proof would be establishing that the evaluator owed the alleged incapacitated person a legally enforceable duty of due care under the circumstances. In a clinical relationship the purpose of which is to diagnose the patient's problem and provide therapeutic treatment for it, the clinician's duty of due care to the patient would be unambiguous. The existence of a legal duty is cloudier when the professional/subject relationship has been established solely for forensic reasons (i.e., solely to generate a report potentially to be used in a legal proceeding (Moye, Karel, & Armesto, 2007), but it is likely that a court would find such a forensic evaluation relationship sufficient to create at least a limited legal duty of due care to the person whose capacity is being questioned.

Assuming that a sufficient relationship is found to establish a duty of due care owed by the evaluator to the alleged incapacitated person, the second element of the plaintiff's prima facie case would be proof that the evaluator breached or violated that duty, in

other words, that the evaluator acted negligently. Before the plaintiff can show negligence in the sense of the evaluator violating the applicable standard of care under the circumstances, the applicable standard of care itself must be delineated.

Historically, assessments of decisional capacity of older persons whose capacity had been questioned were conducted, if at all, in a crude, ad hoc manner leading to highly subjective and inconsistent opinions about the capacity of any particular individual. For all intents and purposes, health care professionals thrust into the role of decisional capacity evaluator were forced to operate—without any meaningful guidance, review, or accountability—in entirely separate vacuums when it came to fulfilling this task.

More recently, though, as explained earlier, we have begun to see dissemination of the results of a substantial amount of research aimed at developing more evidence-based, objective, reliable methods of assessing the capacity of older persons to make decisions regarding specific kinds of life challenges. This emerging body of professional literature and the specific methods and instruments verified therein are very likely to form the evidentiary foundation for a legal standard of care to which capacity evaluators may be held accountable in future litigation challenging the quality of professional performance exhibited in the process of assessing an older person's decisional capacity. Ordinarily, the contemporary "state of the art" in a particular sphere is not enforced as the legal standard of care when current customary practice among the actor's peers still substantially differs from (i.e., lags behind) the developing "state of the art." However, in exceptional circumstances, courts do retain the authority to impose requirements setting a higher standard than customary or prevailing practice. As Judge Learned Hand held in the famous *The T.J. Hooper* case (1932):

> Indeed in most cases reasonable prudence [the legally enforceable standard of care] is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission. (p. 740)

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In any event, as an increasing number of studies are published and their results widely disseminated, we can expect professional capacity evaluators to incorporate those results and accompanying formal assessment instruments into their regular activities so that eventually the gap between customary practice and cutting-edge state of the art will narrow significantly. A cadre of psychologists can be expected to become available as experts in this arena whose testimony on the reasonable standard of care, based in large part on their familiarity with prevailing practice in the capacity assessment "industry," will be admissible in judicial proceedings to assist fact finders to determine whether a defendant has breached or violated the duty owed by the evaluator to the alleged incapacitated person.

The testimony of expert witnesses on techniques of decisional capacity evaluation will also be informed by reference to pertinent evidence-based clinical practice parameters as enunciated by qualified professional bodies. "There are currently no formal practice guidelines from professional societies for the assessment of a patient's capacity to consent to treatment" (Appelbaum, 2007, p. 1838). Neither are there extant formal professional practice guidelines or parameters established for the conduct of capacity evaluations regarding other kinds of decisions that might confront older individuals. It is foreseeable, however, that professional groups will soon enter into this arena with guideline development as research-generated evidence accumulates about the efficacy of different formal instruments and techniques for accurately and reliably assessing older persons' decisional capacity for particular domains of choice. When that happens, those published guidelines will be cited by expert witnesses testifying about the standard of care. Moreover, the professional literature reporting the underlying research findings will itself be admissible into evidence when validated as authoritative through the testimony of expert witnesses.

The third element of a professional liability claim is that the victim suffer legally compensable damage or injury. In the decisional capacity evaluation context, injury is possible for a false-positive evaluation (i.e., an evaluation resulting in the erroneous finding that the evaluated individual lacked capacity to make a particular type of decision when in fact adequate capacity was present). A false-positive evaluation injures dignity by depriving the evaluated individual of autonomy prematurely or unnecessarily. Conversely, a false-negative evaluation (entailing an erroneous finding that an evaluated person possessed sufficient capacity to make certain decisions from which that individual really should

have been protected) may cause injury by unnecessarily jeopardizing the safety of persons not capable of fending for themselves.

Finally, a successful lawsuit predicated on the theory of a negligently conducted evaluation of a person's decisional capacity would require sufficient proof of a causal connection between the evaluator's negligent behavior on the one hand and the damage or injury suffered on the other. Factual causation is established by showing either that "but for" (sine qua non) the evaluator's substandard care the injury complained of would not have occurred or that the evaluator's negligence was at least a substantial factor in bringing about the claimed injury. To meet the burden of proof regarding legal or proximate cause, the plaintiff would be required to establish that the type of injury actually suffered by the alleged incapacitated person was reasonably foreseeable by the evaluator (or was within the evaluator's scope of liability) and that no intervening, superseding (not reasonably foreseeable) events broke the chain of proximate causation between the evaluator's negligence and the evaluatee's injury. A decisional capacity evaluator would have a difficult time arguing convincingly that a court adjudicating an alleged incapacitated person as either competent or incompetent to make particular kinds of decisions constituted an unforeseeable, hence a superseding, event negating the element of proximate causation.

CONCLUSION

"Forensic evaluation [of decisional capacity] is not for the faint of heart, nor is it a suitable choice for individuals who have an aversion to detail or a low tolerance for ambiguity" (Kaye & Kenny, 2007, p. 299). Ambiguity pervades the field of decisional capacity evaluation of older persons in a variety of respects, including uncertainty about the informed consent, confidentiality, and standards of practice implications of the evaluation process itself. As summed up by one commentator,

> Although the issues raised [by the capacity evaluation process] are of great practical importance, they rarely enter the courts. Finding the exact balance between respecting autonomy and protecting the best interests of those of doubtful capacity presents a daily problem for practitioners and caretakers. . . . Unsurprisingly, relying on lawyers for solutions is not regarded as being particularly helpful. In part, this may be because the relevant legal principles do not seem appropriate for the day-to-day issues that arise. (Herring, 2008, p. 1623)

Liability issues for the capacity assessor are unlikely seriously to materialize today. Nonetheless, this is not a purely academic exercise. Both ethical imperatives and prudent risk management suggest that the matters discussed in this article be carefully considered and proactively anticipated by health care and human services professionals caring for older people in the days and years ahead.

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