

Does this Patient Have Decisional Capacity? How Can We Tell? Does It Matter?

The Gold Foundation *Ethics for Lunch* Seminar Series:

A Difficult Case from the New York-Presbyterian Hospital Ethics Committee
Lunch was provided from a generous grant by the Arnold P. Gold Foundation

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12:00 noon - 1:30 pm

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Dr. Kenneth Prager presented the case of a 67 year old man with diabetes and hypertension who came to the Emergency Room (ER) with a painfully infected left foot. On dialysis for renal failure, with a history of a toe amputation, he has no known psychiatric history. A vascular surgery consult diagnoses gas gangrene, and a below the knee amputation is recommended. The patient balks at this, insisting on treatment by his naturopath.

The physicians refuse to discharge him, unless he signs out Against Medical Advice (AMA), and then request a psychiatry consult. The patient denies any psychiatric symptoms, but is suspicious of the hospital staff, refusing even to give contact information for his two children. However he understands that without suitable treatment his condition might worsen and that he even might die.

The psychiatric evaluation states that the patient is paranoid about the hospital staff, and irrational in his estimate of the efficacy of a natural remedy; concluding that he lacks the capacity to refuse the proposed amputation. However, psychiatry also believes that this does not mean that other interventions should not be considered, such as contacting his primary care physician, speaking with his children, or obtaining an ethics consult.

Dr. Prager then said that the doctors were faced with a dilemma. Does patient autonomy trump his right to reject or accept treatment? He cited Justice Benjamin Cardozo's decision in *Schloendorff v. Society of New York Hospital*, that "every individual **of sound mind** and adult years has a right to determine what should be done with his own body." Does this man have capacity to make a choice?

Paul Appelbaum began his presentation by saying that there is a difference between choice and *meaningful* choice: meaningful choice furthers the patient's well-being, and promotes patient autonomy. There is also the issue of global vs. *specific* competence in consenting to treatment. Until the 1960's it was an all or nothing phenomenon, but it is now considered unfair to a patient with partial capacity – as for example a person with Alzheimer's disease or traumatic brain injury – to be considered globally incompetent.

Informed consent requires task-specific competence, and such competence consists of four separate elements: 1) the ability to evidence or state a choice; 2) to have a factual understanding of the information; 3) to have a realistic appreciation of the nature of the situation and of a decision's

consequences; and 4) the ability to rationally manipulate the information in a way that is not impaired by the symptoms of the illness.

Ultimately, the issue is identifying the applicable standard; there are variations in state law as to which elements apply. In this case, Dr. Appelbaum said, there is a contrast between the second, understanding, and the third, appreciation. The patient needs to understand that the infection in the foot is related to diabetes and to appreciate that he is likely to die without suitable treatment.

But unless there is evidence of delirium, dementia, or psychosis, Dr. Appelbaum said he is not prepared to say a patient is incompetent. For certain cultural groups what is seen as an unconventional decision may indeed be a culturally-accepted norm.

Dr. Appelbaum concluded by saying that it is his inclination to try to manage such a case rather than to decide competency or incompetency. Indeed, he wouldn't even use the term because it has such grave implications. In these cases there is much that can be done; however urgent, the situation is not an emergency. He would, for example, call the naturopath, or have the patient work through what it's like not to have a leg. Dr. Appelbaum said that we are looking for evidence of mental disorder and brain damage.

During the question and answer period, Drs. Prager and Appelbaum were asked what the outcome might be in the case of parents who had made such a decision in the care of a minor child. Dr. John Lorenz, Chair of the Children's Hospital of New York-Presbyterian Ethics Committee, and a presenter at several previous *Ethics for Lunch* events, who was seated in the audience, responded that in the care of children, there are more limitations on allowing for cultural differences, such as when children of Jehovah's Witnesses are transfused against their parents wishes, because the children have not made the decision whether to accept the religious beliefs of the parents. Dr. Prager noted that in many states, Christian Scientists are not allowed to withhold treatment from children.

After conferring with the director of patient relations and hospital counsel, the ethics consult stated that the patient was fully aware of the risks he was taking in leaving the hospital and that he had a history of trying alternative medicine before agreeing to conventional medical intervention. [Indeed the patient said he would return to the hospital if the naturopathic treatment was not successful.] The alternative to allowing the patient to leave would be to force him to remain and undergo surgery against his will, which, aside from violating his autonomous right to assume the risks of delaying surgery, would result in an extremely angry patient who would forever feel that his leg might have been saved were it not for what he felt was a forced amputation.

In the end, the patient was allowed to sign out AMA. He went to the naturopath and, as predicted, the foot worsened. He returned to the ER the following day, agreeing to the amputation, and underwent a less drastic procedure - a transmetatarsal amputation of all five toes of the left foot. He was discharged home and readmitted several times for debridement of the wound but the leg was ultimately saved.

[Dr. Kenneth Prager: Video](#)