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The Assessment of Stated versus Demonstrated Capacity: A Consideration for Patient Care and Public Safety

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ABSTRACT

Psychiatrists are frequently asked to assess decisional capacity, the ability of healthcare recipients to make their own medical decisions. Capacity assessments are often complicated, forcing providers to balance the tension between the uncertainties of these cases against protecting patient autonomy. It can be unsettling to observe a patient repeatedly make illogical decisions not only increasing acute and chronic medical risk but also potentially threatening the general public. We review a case that provides a platform to review the concept of stated versus demonstrated capacity, a topic on which the literature is essentially silent. The differences between stated and demonstrated capacity will be examined along with a discussion of the ethical dilemma arising when an apparently capable patient's untoward decisions pose not just a personal, but a public health risk, and the responsibility and potential liability involved in these cases.

Key Words: capacity, bioethics, consultation-liaison psychiatry, public health

INTRODUCTION

In psychiatry, a frequent consultation request is assessment of decisional capacity (Sorrentino, 2014), defined as the ability of healthcare subjects to make their own healthcare decisions (Charland, 2011). A patient is deemed to retain decisional capacity if she is able to voice a decision, demonstrate

an understanding of the medical issues, demonstrate an appreciation of likely consequences of making that choice versus the alternatives, and rationally manipulate information provided (Applebaum, 2007). Although any licensed provider can assess a patient's capacity, consult psychiatrists are often asked to provide expert opinion in challenging capacity-related cases. Considering these explicit parameters, one might assume capacity assessment would be rather straightforward; however, that is often not the case, leaving psychiatrists to sift through vague uncertainties while protecting the patient's autonomy when possible. Although tools have been created in hopes of providing a standardized method for capacity evaluations, there are currently no formal practice guidelines from professional societies to direct these assessments (Applebaum, 2007). It can be uncomfortable for a provider to observe a capable patient repeatedly making untoward decisions potentially placing herself at increased medical risk; however, what happens when those decisions affect not only the patient, but are also potentially threatening to those around them?

CASE REPORT

A 37-year-old man with poorly controlled hypertension resulting in several complications including end stage renal disease requiring tri-weekly hemodialysis, seizures and posterior reversible encephalopathy syndrome was admitted for hypertensive urgency and Clostridium difficile infection. Review of his medical record revealed repeated medical admissions for inpatient management of hypertensive crisis, Clostridium difficile infection, or other complications related to treatment noncompliance. Upon admission to the medical intensive care unit, he began refusing specific medications and routine care modalities, including blood pressure monitoring, and eventually refused dialysis. Further complicating his presentation, he frequently refused to speak to caregivers or to explain his rationale for refusing. The Bioethics service was consulted to assess his capacity to refuse medical care and found that he retained decisional capacity in that regard; he was able to communicate his choice, the reasons for refusing his care, and the potential consequences affiliated with his decisions. Despite this determination, the primary team continued to express concern about his decisional capacity, given his limited participation in care and his history of repeated admissions due to noncompliance.

Psychiatry was initially consulted to assess whether his selective mutism was secondary to a primary mood disorder. Evaluative efforts were challenging, as he refused to participate in repeated attempted interviews. Emergency contacts listed in his record could not be reached, and he refused

to provide alternatives. Unable to assess formally for depression or other potential causes of his presentation (e.g., encephalopathy) through interview, psychiatry tediously reviewed extensive records related to previous admissions. These demonstrated a pattern of chronically poor judgment and defiant behavior which appeared unrelated to a primary mood disorder and more likely related to longstanding characterological traits.

Despite eventual normalization of hypertension, he continued to refuse treatment for his infection, prompting a careful review of his history of recurrent C. difficile infections. Chart documentation and discussion with hospital staff familiar with the patient's previous hospitalizations revealed concern that he was not completing recommended antibiotic treatment, leading to his repeated admissions. Further, his choice to truncate antibiotic courses placed not only the patient at risk, but also endangered others, as he was attending thrice weekly hemodialysis at an outpatient dialysis center where he was surrounded by immunocompromised patients.

Despite continued intermittent treatment refusal, his health stabilized and he was eventually discharged, normotensive and without diarrhea. To our knowledge, no warning was provided to his outpatient hemodialysis center regarding the risk of C. difficile infection.

DISCUSSION

Although extant literature describes the physician's role in completing decisional capacity evaluations, it is essentially silent regarding the concept of stated versus demonstrated capacity. "Stated" capacity refers to a patient who meets the aforementioned capacity criteria by verbalizing a choice after accounting for the risks, benefits and alternatives while rationally manipulating the information. The term "demonstrated" capacity refers to continuity between a patient's verbalized thought process and their actions or behaviors. Although a patient may be able to reasonably answer the questions ("stated capacity") allowing her to be determined decisionally capable, her behavior may demonstrate that she does not truly appreciate or comprehend the scope of her choice. In our patient's case, he was found to retain decisional capacity after examination by the Bioethics service, as he was able to demonstrate an understanding of the risks of refusing elements of his care. However, despite his verbalized understanding, his repeated hospitalizations and repeated decisions to place others at risk left multiple providers doubtful as to his actual comprehension of the severity of his illness and the potential impact of his behavior not only on himself but also on the public.

Importantly, demonstrated capacity does not represent patients making decisions that go against physician recommendations. Autonomy grants patients the right to make medical decisions that counter the treatment plan prescribed by their healthcare provider if they can demonstrate an appropriate risk-benefit analysis and arrive at their conclusion in a rational process; the protection of patient autonomy should be respected until it is determined that capacity is not retained. Demonstrated capacity differs from simple disagreement with recommendations when it is determined that the decision places the patient or others at increased risk of harm that she intentionally or unintentionally recognizes but does not value appropriately.

This becomes most concerning when a capable patient's unfavorable decisions pose a safety risk to the general public. Our patient's refusal to comply with his antibiotic treatment increased his risk of disease recurrence and increased avoidable risk to others in his immediate environment, including other patients receiving outpatient dialysis. The current practice of assessing rarely devotes attention to potential public health risks resulting from a patient's medical decisions. It is unlikely that our patient was asked to evaluate the risk of transmitting his infection to others during the capacity evaluation performed by the Bioethics service, though it is important to consider how this information could have altered his hospital behavior or participation in care. This proposes multiple ethical postulations regarding a physician's duty to warn the public of potential health risks as well as the public's right to know about these risks.

Physician's Duty to Warn and Protect

When a capable patient makes choices that potentially endanger public safety, we must consider potential ethical and legal obligations regarding provider reporting to the appropriate party. One of the most prominent and familiar legal statutes defining a provider's duty to warn is detailed in Tarasoff v. Regents of University of California (1976). In 1969, Prosenjit Poddar murdered Tatiana Tarasoff just months after revealing his intention to his therapist. The therapist notified campus police who briefly detained Poddar but released him shortly after. Tarasoff was never warned of the threat which prompted the lawsuit, ruling that "the therapist failed to exercise reasonable care to protect Tatiana in that they did not confine Poddar and did not warn Tatiana or others likely to apprise her of the danger." Per the ruling, "When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The

discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances" (1976).

When healthcare professionals are educated on the physician's duty to warn, it is typically in the context of a verbal threat made by the patient endangering another's life. However, what happens when the threat is not stated, but is behavioral? Our patient repeatedly placed others at risk of serious infection because of his choices without stating an intended threat. If clinicians apply the principles of the Tarasoff ruling, a provider would be required to warn potential victims of the risk. Here, the provider would be responsible for notifying the outpatient dialysis center as to the increased risk of infection to other patients receiving treatment, which could lead to reinforcement of hand-washing protocol for employees and increased vigilance to disinfection of clinical areas.

Under the Tarasoff ruling, physicians and therapists not only have a duty to warn but also a duty to protect. The ruling found the therapist at fault for not warning the potential victim and for not taking appropriate actions to confine the assailant after the threats were verbalized. In cases where a serious threat is verbalized, involuntary hospitalization is often pursued in order to protect the intended victim(s) until further investigation can be completed. Involuntary hospitalization is not always appropriate, and should only be considered when a threat is deemed sufficiently high and/or if any potential victim is unable to be contacted. Involuntary admission is included in the Tarasoff ruling under other steps that are "reasonably necessary under the circumstances" (1976). As in our case, the legal and ethical obligations are less well-defined when the threat is not verbalized, but rather potentiated through behavior. It is appropriately more difficult to find ethical or legal grounds to compel involuntary hospitalization absent serious explicit, specific threats towards a potential individual or group.

Preserving Patient Privacy

Any discussion of decisional capacity and a physician's duty to warn/protect would be incomplete absent a view to protecting patient rights. Patient privacy is an ethical standard that should be protected and preserved whenever possible; releasing sensitive health information could have detrimental effects. During a formal capacity evaluation, the physician should weigh the benefits and risks of withholding information in favor of patient privacy as compared to reporting risky behavior that

has potential to cause public harm. Tarasoff "does not require the clinician to warn the victim of the 'verbal threat' but rather of the 'danger' when victim warning is the appropriate measure" (Felthous, 2006). Thus, it may be more appropriate in cases of public health risk to warn of potential "danger" to other patients rather than revealing the specific disease, if doing so can adequately mitigate associated risk. This may maximize benefit while minimizing risk to the patient.

Rights of Potential Victims

It is vital to consider not only patients' rights but also the rights of potential victims. Does the public have the right to be notified or warned about a potential threat regardless of imminence? The existing literature argues that the duty to warn is "the result of a corresponding right of the endangered person to be warned, a right enforced by civil liability". (Felthous 2006) We argue that the threshold to warn should be based on the degree of risk to the population. Felthous writes, "The right of the victim to be warned weighs more heavily than either an individual's right to be protected or a clinician's duty to protect against future violence." For our patient, we propose replacing "future violence" with "future public endangerment in the form of infectious disease contamination." (Felthous, 2006)

Current Legislation

Although there is a lack of federal legislation detailing healthcare professionals' duties to protect public health, there are laws mandating medical providers' obligations to report communicable disease that vary by state. In Ohio, state law identifies reportable diseases and outlines the requirements for reporting persons with these illnesses to local or state health boards. Although these regulations exist, there remains ambiguity regarding whether certain diseases should be reported. In our case, although C. difficile is not explicitly mentioned as a reportable disease, it may fall under Ohio's Class "C" "healthcare-associated" infections that should be reported by the end of the following business day (Ohio Revise Code § 3701.3). The law states, "A health care provider with knowledge of a case or suspect case of a disease which is required by law to be reported...shall submit a case report." Another vague area is the section describing diarrhea in persons working in a "sensitive occupation" which states "a person with infectious diarrhea of known cause shall be isolated" (Ohio Revise Code § 3701.3). If the law requires persons with infectious diarrhea (e.g., C. difficile) be isolated to prevent the spread of infection to a "sensitive" population, would this also apply to patients attending outpatient centers populated by medically compromised individuals?

The majority of Ohio law on communicable disease focuses on Human Immunodeficiency Virus (HIV) and the legal repercussions associated with an infected individual's failure to report her status to partners. Ohio law on HIV criminalization contains a section regarding general sexually transmitted infections stating "it is a second degree misdemeanor...for a person who has a 'dangerous, contagious disease' to fail to take 'reasonable measures' to prevent exposing himself [or herself] to other persons" (2017). Though this verbiage is detailed under STIs, the law does not explicitly describe what "dangerous, contagious disease" entails. Clostridium difficile could be considered a dangerous and contagious illness requiring reporting to local health departments.

Additionally, Ohio has a law concerning "spreading contagion," which reads:

(A) No person, knowing or having reasonable cause to believe that he is suffering from a dangerous, contagious disease, shall knowingly fail to take reasonable measures to prevent exposing himself to other persons, except when seeking medical aid.

(B) No person, having charge or care of a person whom he knows or has reasonable cause to believe is suffering from a dangerous, contagious disease, shall recklessly fail to take reasonable measures to protect others from exposure to the contagion, and to inform health authorities of the existence of the contagion.

(C) No person, having charge of a public conveyance or place of public accommodation, amusement, resort, or trade, and knowing or having reasonable cause to believe that persons using such conveyance or place have been or are being exposed to a dangerous, contagious disease, shall negligently fail to take reasonable measures to protect the public from exposure to the contagion, and to inform health authorities of the existence of the contagion (Ohio Revised Code 3701.81).

Again, the applicability of the law in public health safety centers on the disease and definitions of "dangerous" and "contagious" according to state legal standards. The charge of "spreading contagion" has been invoked for those knowingly spreading STIs and other infectious diseases. From 2008-2010, fifty-five cases of "spreading contagion" were filed in Ohio with the most frequently associated infection being neither HIV nor another STI, but rather Methicillin-resistant Staphylococcus aureus (MRSA) (Chenneville, 2007).

RECOMMENDATIONS

Considerable uncertainty remains regarding the physician's ethical and legal requirements when it comes to the matter of stated versus demonstrated capacity, especially when public health safety becomes a concern. We recommend utilizing the following until more concrete guidelines or legislation become available:

- When there is concern that a patient's actions may be a potential risk to public health, practitioners should consider and evaluate the degree of risk.
- Determine the disease(s) of concern
- Assess whether the disease is considered communicable and how readily the disease could be contracted by others. This should include the route of disease spread (physical contact, airborne, etc.)
- Assess illness severity, should it be contracted by others. (e.g., the concern for contagion when considering a patient with a viral upper respiratory infection is significantly lower than the risk for a tuberculosis patient.)
- Consider availability and difficulty of disease treatment. What does the treatment entail? Can the patient be easily managed as an outpatient or would the intervention require inpatient management?
- Assess the population being placed at risk. Evaluate factors regarding potential disease spread (e.g., in our case, an immunocompromised group was being exposed to a readily communicable illness).
- Assessment of the at risk population should include consideration of the patient's employment; a job with limited human contact confers less risk than working directly with the public
- Practitioners should familiarize themselves with the laws regarding communicable disease reporting in the state in which they practice.
- When in doubt, obtain the opinion of an attorney or representative from the medicolegal department for further assistance in understanding practitioner responsibility to report.

Finally, when patients' decisions regarding their medical care could potentially impact public health, physicians should carefully explore their understanding as to how their choice could affect the health and well-being of those around them. Although the current criteria for assessing capacity does not include questioning regarding the impact a patient's decision has on public health, this must be considered in cases where repeated unfavorable decision-making provides doubt as to the patient's

understanding of the possible severity of the risk to others.

CONCLUSION

This case provides a platform to discuss the matter of stated versus demonstrated capacity, a topic on which the literature is essentially silent. Psychiatrists are often asked to comment on difficult capacity assessments, and even the most seasoned physicians may disagree over the state of someone's decision-making ability. Decisional capacity has routinely been observed solely from the patient's side, considering how the patient's decision will impact her as an individual. Examining decisional capacity while considering how a patient's choice impacts the public and society can be complicating. The process is presently ambiguous, raising concerns regarding the practitioner's responsibility in protecting the public from patients' unfavorable decisions. Physicians should review the laws in their state to better understand their legal responsibilities regarding the reporting of communicable diseases. Future discussion amongst healthcare providers as well as state and federal representatives could provide further transparency into the moral and legal standards expected of practitioners with regards to communicable disease reporting as well as public health protection.

*The authors were unable to obtain written or verbal informed consent from the patient for this case study as he refused to participate in conversation. Although the case presented was representative of an actual patient assessed by the psychiatry consult service, certain elements of the presentation were altered or withheld to respect the patient's privacy.

REFERENCES

1. Appelbaum, P. S. (2007). Clinical practice. Assessment of patients' competence to consent to treatment. *New England Journal of Medicine, 357*(18), 1834-1840. doi:10.1056/NEJMcp074045
2. Charland, L. (2011). Decision-Making Capacity. *Stanford Encyclopedia of Philosophy.* Retrieved from https://plato.stanford.edu/entries/decision-capacity/#EleCap
3. Chenneville, T. (2007). Tarasoff and HIV: some considerations for therapists. *Focus, 22*(5), 5-8.
4. Felthous, A. R. (2006). Warning a potential victim of a person's dangerousness: clinician's duty or victim's right? *Journal of the American Academy of Psychiatry and the Law, 34*(3), 338-348.
5. *HIV criminalization in the United States: A sourcebook on state and federal HIV criminal law and practice.* (2017). In (pp. 336-356). Retrieved from http://www.hivlawandpolicy.org/sites/default/files/HIV%20Criminalization%20in%20the%20U.S.%2

0A%20Sourcebook%20on%20State%20Fed%20HIV%20Criminal%20Law%20and%20Practice%209.5.18.pdf
6. Ohio Rev. Code. §3701.81
7. Ohio Rev Code § 3701.3
8. Sorrentino, R. (2014). Performing capacity evaluations: What's expected from your consult . *Current Psychiatry*, *13*(1), 41-44. Retrieved from http://www.mdedge.com/currentpsychiatry/article/79219/practice-management/performing-capacity-evaluations-whats-expected
9. Tarasoff vs Regents of University of California. 17 Cal.3d 425. (1976).

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