

HARVARD CME · MEDICAL PSYCHIATRY

Complex Capacity Exams

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HARVARD
MEDICAL SCHOOL



Disclosures



No relevant financial or non-financial disclosures.

No off-label uses are discussed. All cases are composites, de-identified to protect patient privacy.

Learning Objectives



Distinguish the concepts

01

Separate capacity from competency, and from cognition and function.



Apply the four abilities

02

Elicit communicating a choice, understanding, appreciation, and reasoning at the bedside.



Calibrate to risk

03

Use a sliding-scale threshold and know when a screen is — and isn't — enough.



Resolve hard cases

04

Work through values-vs-illness, hidden illness, and depression using evidence-based strategies.

Does this patient have capacity?



“Mr. R,” 68, admitted with a painful, life-threatening infection. The team recommends treatment he keeps refusing — due to his religious beliefs. He is calm, articulate, quotes scripture fluently, and shows no obvious psychosis. The primary team is ready to state that the patient has capacity and let him go, but the risk is too high...

Unusual belief — or hidden illness? **We'll come back to Mr. R at the end.**

When should the team call us?

Most patients have capacity, and we're usually right to assume so. The skill is helping non-psychiatrists spot when it isn't straightforward, and for us to help the team understand our decision making.



Refusing recommended, potentially life-saving care



An abrupt change in mental status or new confusion



A choice that seems inconsistent with stated values



Can't explain the decision back in their own words



Waxing and waning alertness, or possible delirium



High-stakes or irreversible decisions, or team conflict



The quiet bias: we almost only get called when a patient says **no**. A risky **yes** deserves the same scrutiny.

Where we're headed

I



Foundations

Consent, and what capacity is — and isn't

II



The four abilities

The framework, and where capacity really breaks

III



The tools

Instruments, and the note that communicates it

IV



The hard cases

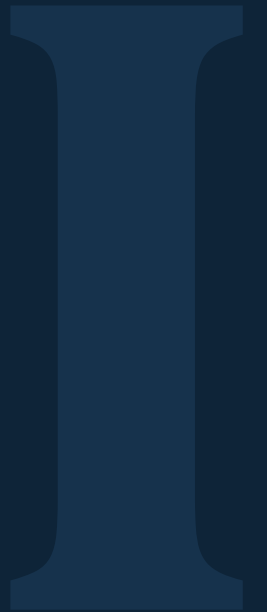
When values, illness, and ethics collide



PART I

Foundations & Consent

What capacity is — and just as importantly, what it is not.



Informed consent is a process, not a signature



Information

Adequate disclosure of the condition, the options, and their risks and benefits — in language the patient can use.



Voluntariness

A choice made freely, without coercion from illness, family, or the team.



Capacity

The ability to take in that information and make a choice. Without it, consent can't be real.



Bottom line: capacity is step one of consent. If the patient lacks it, a signature on the form doesn't make the consent valid.

Capacity vs. Competency

CAPACITY

Who decides A clinician, at the bedside

Scope Specific to one decision

Nature Clinical & fluid — can change by the hour

Example Can Mr. R refuse this antibiotic today?

COMPETENCY

A judge, in a courtroom

A global legal status

Categorical & durable

Guardianship (civil); competency to stand trial (criminal)

We assess capacity for a specific decision; only a court determines competency.

Capacity vs. Cognition & Function



Cognition & function

Broad descriptions of how the brain works and of the tasks of daily living (e.g., managing medications).

A general map of impairment — useful context, but not a verdict on any one decision.



Capacity

Cognition around **the specific question at hand** — not an overall score of impairment.

A person with real cognitive deficits can still have capacity for the decision in front of them.

A cognitive score is not a capacity test

MMSE and MoCA stratify risk — they don't decide capacity. Use them to raise your index of suspicion, then do the interview.

● **MMSE < 16**

HIGH RISK

Strongly correlated with impaired understanding & appreciation

● **MMSE 16–24**

DO THE INTERVIEW

Sensitivity & specificity are variable — a score can't decide it

● **MMSE > 24**

USUALLY RETAINED

Correlates with preserved decision-making ability



Same for the MoCA: a score ≤ 22 had ~90% sensitivity for detecting impaired consent capacity in one study — a good screen, still not a substitute

Diagnosis is not destiny

10–52%

Schizophrenia

impaired on ≥1 ability vs. 0–18% of controls — a wide range, not a rule

low

Depression

less impairing than assumed; most patients retain all four abilities

improves

TBI

impairment often recovers over 6–12 months — reassess, don't fix in time

common

Substance use

among the most frequent reasons capacity is questioned on the wards

A diagnostic label — AD, schizophrenia, depression — can never substitute for an assessment of the decision at hand.



PART II

The Four Abilities

Appelbaum & Grisso's framework — and where capacity actually breaks.



You may have heard of this paper

Vol. 319 No. 25 PATIENTS' CAPACITIES TO CONSENT TO TREATMENT — APPELBAUM AND GRISSE 1635

SPECIAL ARTICLE

ASSESSING PATIENTS' CAPACITIES TO CONSENT TO TREATMENT

PAUL S. APPELBAUM, M.D., AND THOMAS GRISSE, Ph.D.

Abstract The right of patients to accept or refuse recommended treatment requires careful reassessment when their decision-making capacities are called into question. Patients must be informed appropriately about treatment decisions and be given an opportunity to demonstrate their highest level of mental functioning. The legal standards for competence include the four related skills of communicating a choice, understanding relevant information, appreciating the current situation and its

consequences, and manipulating information rationally. Since competence is a legal concept and can be formally determined only in court, the clinical examiner's proper role is to gather relevant information and decide whether an adjudication of incompetence is required. Treatment for impairment of mental functioning can sometimes restore patients' capacities, making it unnecessary to deprive them of their decision-making powers. (N Engl J Med 1988; 319:1635-8.)

COMPETENT patients have the right to decide whether to accept or reject proposed medical care. Patients thought to be incompetent are denied this right, and others make their decisions for them. Competence is a legal concept; it can be formally determined only through legal proceedings. However, in practice physicians must make some assessment of their patients' decision-making capacity before accepting patients' decisions about medical care as valid, and they must raise the question of incompetence if substantial deficits in decision making are apparent.¹

Ordinarily, the assessment of a patient's decision-

we review current concepts of competence and approaches to its assessment.

CONCEPTS OF COMPETENCE

The legal standards for determining a person's competence to make decisions vary in wording from jurisdiction to jurisdiction. Scholars have found it convenient, therefore, to classify these standards according to categories. The majority of commentators suggest that the legal standards fall into one or more of four categories.^{1,6-11}

Communicating Choices

Paul Appelbaum and Thomas Grisse translated abstract legal ideas of competence into four concrete, clinical abilities you can actually elicit at the bedside.

Why it still anchors the field

- It protects autonomy while keeping care ethical — a shared language for clinicians, ethicists, and courts.
- For the widely-cited clinical update, see Appelbaum PS. N Engl J Med. 2007;357:1834-40.

Appelbaum PS, Grisse T. N Engl J Med. 1988;319:1635-8.

The four abilities



Communicate a choice

“So what would you like to do?”

A stable, consistent choice others can act on.



Understand

“Tell me, in your words, what's going on.”

Grasps the facts, options, risks & benefits — and can recall them.



Appreciate

“What does this mean for you?”

Applies it to their own situation — accepts it's really happening.



Reason

“How did you come to this decision?”

Compares options and reaches a logical, values-based conclusion.

Shaded = **the two that most often decide the case (next slide).**

Where capacity actually breaks

OFTEN PRESERVED

Communicating a choice

Understanding the facts

Retained even in severe dementia — a patient can state a choice and recite the facts and still lack capacity.

WHERE IT USUALLY FAILS

Appreciation

Reasoning

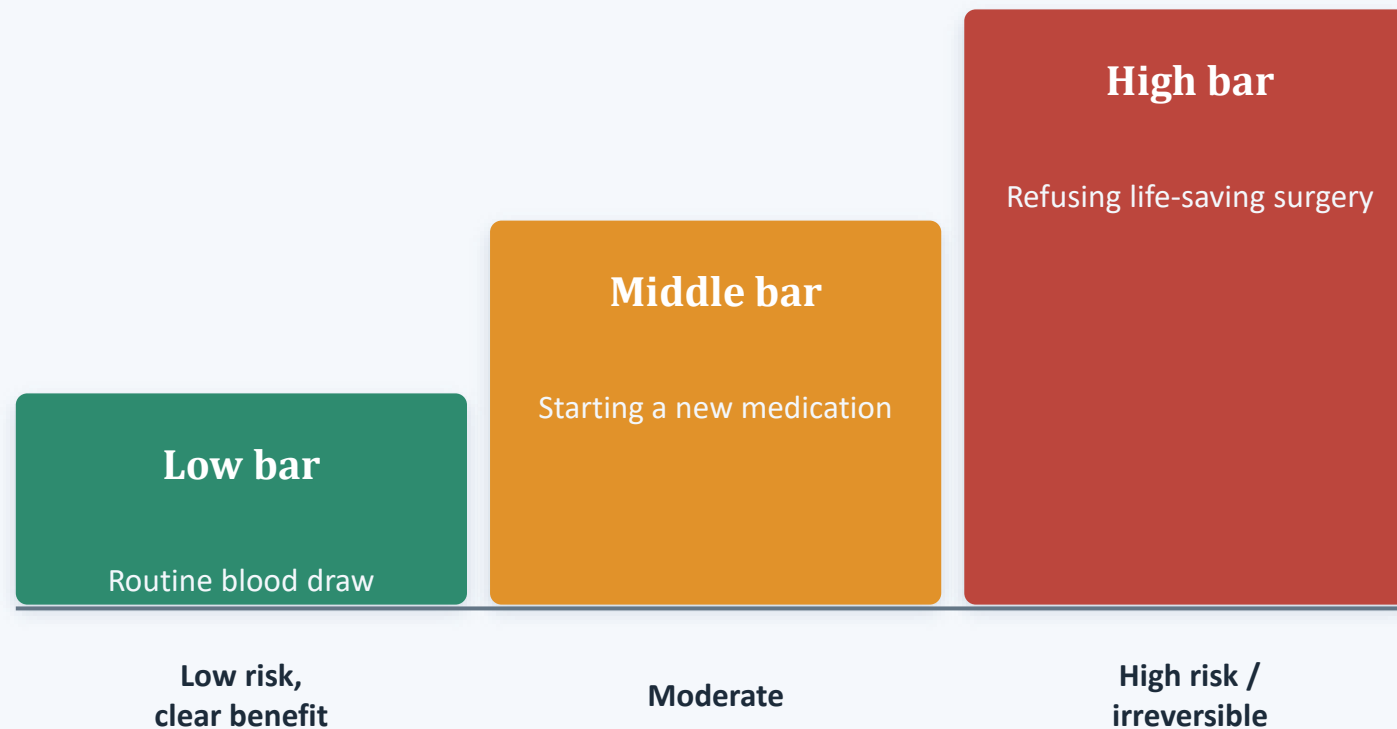
*"I understand the scan shows cancer — but I don't have cancer."
Facts intact; appreciation gone.*



So spend your time there. When a case is genuinely hard, the fight is almost always over appreciation or reasoning — not whether they can repeat the facts back.

Match the bar to the stakes

The riskier and more irreversible the decision, the higher the bar for capacity. (Drane, 1984)



The asymmetry

It takes a **higher bar to refuse** a low-risk, high-benefit treatment than to accept it. A “yes” to something safe barely needs scrutiny; a “no” to something life-saving needs a lot.

CURBSIDE, mapped to the framework

Keep the mnemonic — but see how each letter lands on one of the four abilities.

	WHAT YOU'RE LISTENING FOR	MAPS TO
C	Communicate — get the choice across, any way they can	Communicate a choice
U	Understand — the risks and benefits, in plain language	Understanding
R / B	Risk–Benefit — actually weigh the upside and downside	Reasoning
S / I	Situation & Impact — connect it to their own life	Appreciation
D	Decide — land the plane on a consistent choice	Communicate + Reason
E	Explain — give coherent reasons for the choice	Reasoning

What a good capacity note looks like

The most persuasive note isn't your conclusion — it's the patient's own words under each ability.

CAPACITY ASSESSMENT — consent to IV antibiotics for endocarditis

Understanding: *“There's a bug growing on my heart valve and the antibiotics are supposed to kill it.”*

Appreciation: *“Yes, this is happening to me — if I don't treat it, it could kill me. I get that.”*

Reasoning: *“I'd rather take the drugs and keep the line than risk my heart giving out.”*

Choice: *Clear and consistent across two visits: “Start the antibiotics.”*

Assessment: Demonstrates all four abilities for this decision at this level of risk → **has capacity to consent.**

Pearl: name the specific decision and its risk level, quote verbatim for each ability, and note consistency over time.

When capacity is present — and when it isn't



Has capacity

Honor the choice — even one we disagree with. Autonomy is the default.



Lacks capacity

Turn to a surrogate, who decides as the patient would have — substituted judgment, not the surrogate's own preference.



Who is the surrogate?

1. **Health Care Proxy / DPOA-HC** — Someone the patient chose in advance
2. **Guardian** — Court-appointed when no proxy exists
3. **Next of kin** — Family, in a legally defined order

In Massachusetts: the Health Care Proxy — statutory form, two witnesses, no notary; revocable anytime the patient is of sound mind; travels to most states.

Why the exam is worth doing well



Surfaces values

A fuller picture of the patient's preferences and beliefs, so care fits them.



Deepens the conversation

Real discussion of risks and benefits — patients feel more in control.



Improves the record

Documented assessments strengthen communication and continuity of care.



Checks our bias

Structured assessment makes the judgment more objective and patient-centered.



Builds rapport

Open engagement lowers tension and strengthens the therapeutic alliance.

Instruments — and the one with the most evidence

Semi-structured tools

- ACED — everyday decisions (geriatric)
- CCTI — consent, esp. research
- California Scale of Appreciation
- Competency Assessment Interview
- Informed Consent Survey
- MMSE / MoCA — screens, not capacity tests



MacCAT-T

MacArthur Competence Assessment Tool for Treatment

Most empirical support of any instrument (Dunn et al., 2006).
15–20 min; covers all four abilities; individualized to the patient's own treatment.

Gives a structured score to communicate across the team.



But: needs training, isn't stand-alone, and has **no magic cutoff score**. It guides judgment — it doesn't replace it.



PART IV

The Hard Cases

When the tools run out and judgment begins — Kane et al., 2022.

IV

The first study of how experts resolve hard cases

Difficult Capacity Cases—The Experience of Liaison Psychiatrists. An Interview Study Across Three Jurisdictions

Nuala B. Kane^{1*}, Alex Ruck Keene¹, Gareth S. Owen¹ and Scott Y. H. Kim²

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Background: Assessment of capacity for treatment and discharge decisions is common in the general hospital. Liaison psychiatrists are often asked to support the treating medical or surgical team in difficult capacity assessments. However, empirical research on identification and resolution of difficult capacity cases is limited. Some studies have identified certain patient, decisional, and interpersonal factors which cause difficulty, but no study has explored how these issues are resolved in practice. Our study therefore aimed to describe how experienced liaison psychiatrists identify and resolve difficult capacity cases in a general hospital setting.

Methods: We carried out semi-structured interviews with 26 liaison psychiatrists from England, Scotland, and New Zealand, on their most difficult capacity cases. Thematic analysis was used to examine types of difficulty and how these were resolved

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26 experienced C-L psychiatrists · England, Scotland, New Zealand · semi-structured interviews about their hardest cases.

Four kinds of difficulty



Values or illness?



A hidden / high-functioning mask



Applying ethical principles



Procedural difficulties

Is it an unusual decision — or a hidden delusion?



The case: Mr. R — refusing life-saving treatment on religious grounds, calm and articulate. Is this genuine faith, or a delusion dressed in the language of faith? A hunger strike that looked political turned out, after collateral, to be a persecutory delusional disorder.

How the experts resolved it



Get collateral

Family, longitudinal records, prior baseline



Learn the history

Has this belief been lifelong, or is it new?



Bring in context

A religious or cultural leader can distinguish faith from pathology

The “high-functioning” mask



The case: A woman with severe alcohol use — falls, head injuries, decline — but polished and socially graceful in the exam room. The family quietly reports daily drinking, DUIs, and that they've already taken over her finances. Good verbal skills; no follow-through in real life.

How the experts resolved it



Gather hard evidence

Medical records, financial & legal history



Interview collateral

What does day-to-day functioning actually look like?



Compare to premorbid

Common in alcohol-related & subcortical dementias with executive/impulse deficits

Depression — or an understandable resignation?



The tension: “Is he depressed, or is he just making a decision that all of us might make if we had such a terminal, serious illness?” Refusing dialysis, or treatment near the end of life — is a psychiatric illness devaluing the future, or is this a reasonable response to real suffering?

How the experts resolved it



Treat the depression

When present, treat it — then reassess the decision



Build rapport over time

Serial visits and supportive psychotherapy clarify more than any one exam



Watch appreciation

Hopelessness that colors the future is the red flag, not the refusal itself

When ethics and logistics get in the way

Ethical principles in tension



Protection of welfare

Barefoot in the snow; the stove left on



Autonomy

The right to make an unwise choice



Justice

Fair access — e.g., capacity lost before transplant



Non-discrimination

Mental illness ≠ incapacity



Procedural difficulties

Lack of engagement · facts you can't verify · interpersonal conflict between patient and team. *We get creative, and we learn to cope with limited information.*

Strategies that resolve hard cases



Assess over time

When risk is high, examine across several moments to test consistency.



Repeat & build rapport

Return visits make sure basic concerns are heard and addressed.



Negotiate & mediate

In patient–team conflict, advocate for flexible, individualized treatment.



Widen the circle

Bring in the ethics committee and the office of general counsel.

And the golden rule: take your time, over time, be self-aware, and **never worry alone.**

Your intuition is a tool — and a bias



Each of us carries beliefs about what makes a life meaningful — and those values quietly shape how we judge a patient's choices, especially in high-stakes cases.

Intuition grounded in experience is valuable — but it has to be balanced with objectivity. Name your biases, and your assessments get fairer, more accurate, and more respectful of autonomy.

Self-awareness isn't a soft skill — it's part of the method.

Back to Mr. R — and three things to keep



Mr. R: collateral and a careful history revealed the “religious” refusal was a persecutory delusion in disguise. Treated, his appreciation returned — and so did his capacity. The verdict flipped once we dug past the surface.

1



The four abilities

Communicate, understand, appreciate, reason — weighted to the stakes.

2



Reach for tools when stuck

Semi-structured instruments exist for the hardest cases.

3



Never worry alone

We bring ourselves into these. Take your time, over time; stay self-aware.

References & further reading

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Thank you

Please bring your questions to the panel discussion.

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