Competence and Health Law Issues in the Elderly

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Seniors Mental Health Team

R and C
Objectives

- To increase the appreciation of Nova Scotia Health Law legislation
- Promote understanding of the components of completing competency assessments
- To increase comfort level in participating in (capacity) competency assessments
Why Is This Important For You?

- *In NS, any physician* is qualified to give an opinion on competency:
  - Does **not** need to be a psychiatrist, geriatrician
  - The team can contribute greatly
- You have special knowledge related to discipline and training
- If 2 doctors opinions are needed, your input will be invaluable to them
Why is This Important For You?

- Unprecedented growth in the number of seniors, trend even bigger in NS
  - 700 people turn 65 in NS every month
- Health professionals will be increasingly involved in the care of geriatric patients
- All team members will need to contribute to the competency assessment of patients they know well or who are new to them
5 Key Messages:

1) EPOA and substitute decision makers are for everyone! (talk to patients)
2) Understanding & Appreciating are the key elements in competency assessment
3) An MMSE is usually NOT enough
4) Home visit is ideal- But always get collateral
5) Least restrictive alternatives (aka. Will they accept help?)
Clinical Highlights

- Review 3 common types of competence
- When should competency be addressed?
- Who assesses competency?
- How is competency addressed?
Case: Mr. Frale
Case: Mr. Frale

- 79 year old, widowed x8 years
- Known to the clinic you work in for 10 years
- Lives alone in small home
- Referral to your team from AP after neighbour called: concerns financial abuse by nephew. Not looking as neat in his appearance, and seems to be losing weight. Doesn’t seem like his normal self. Sort of mixed up.
Case: Mr. Frale

- WHAT SHOULD YOU DO?

- WHAT AREAS OF COMPETENCY NEED TO BE CONSIDERED?
Competence / Capacity

- financial
- personal care
- consent to treatment
- sign out AMA
- testamentary
- marry
- parent

- fitness to stand trial
- fitness to instruct council
- responsibility for a crime
- be a witness
- enter into a contract
- assign POA
Competency – The Definition

- Ability to make a decision
- Minimal cognitive capacity required to perform a recognized act
Concepts of Capacity
Necessary Components

- Ability to communicate choice
- **Understanding** the relevant information
- **Appreciating** the situation and its consequences
- Manipulating information rationally (Applebaum)
Competence / Capacity

- **financial**
  - administer estate
  - manage property
  - enter contract
  - make will
  - be corporate partner
  - act as trustee
  - assign POA

- **personal care**
  - take care of oneself
    - shelter
    - food
    - clothing
    - safe, secure environment
    - ADLs
    - medical treatment
Financial Assessment

- Assets, income, expenses, debt
- Corroboration by collateral
- History of management of finances in past
- Need for support in same

MacKay, MJ. C J Psychiatry 1989; 34:829-832
Financial assessment

- Implications if poor judgment used
- If fluctuating competence, should be safe during poorest level of function
- Delusions/hallucinations that would impair competency
- Patient’s preference for estate management

MacKay, MJ. C J Psychiatry 1989; 34:829-832
Personal Care Competence

- Health, nutrition, ADLs, hazards
- Appreciation of strengths and weaknesses
- Willing to make use of supports if necessary
- History of poor judgment resulting in harm to self or others

C J Psychiatry 1989; 34:829-832
Personal Care competence

- If fluctuating competence, should be safe during poorest level
- Delusions/hallucinations that would impair capacity

C J Psychiatry 1989; 34:829-832
Competency for Treatment Decisions

- Understand?
  - The condition for which treatment is proposed
  - The nature and purpose of the treatment
  - Risks in undergoing treatment
  - Risks in not undergoing the treatment

- Whether or not his (her) ability to consent is affected by the condition
Levels of assessment

- **Urgent**
  - e.g. life-threatening injury

- **Non-urgent, clear cut**
  - e.g. obvious dementia

- **Non-urgent, complex**
  - e.g. early dementia
  - relevant health care professionals’ assessments helpful
  - fewer consults; more time

Kline SA. Health Law in Canada 1992; 13:125-8
Functional Abilities in Decision Making

- Ability to *express* a choice
- Ability to *understand* information relevant to decision making
- Ability to *appreciate* the significance of that information (including consequences)
- Ability to *reason* with relevant information to weigh options
Ability to express a choice

■ Decreased ability:
  ▶ Expressive aphasia
    ◁ look for a consistent message
    ◁ try nonverbal techniques
  ▶ Poor memory - inability to make consistent choice
  ▶ Depression (ambivalence)
Ability to understand information

- Impaired comprehension:
  - Receptive aphasia
  - Poor attention span
  - Psychiatric
    - denial
    - delusions
Ability to appreciate consequences / reason

- Depression - delusions of punishment, hopelessness
- Frontal lobe damage
  - evaluating consequences
  - insight into significance of problem
  - mental flexibility to adapt to changes
  - memory problems not necessarily prominent
Law and Medicine

- Competence is a legal judgment
- Past view: competent or not competent
- Current view: concept of a continuum of competence
  - limited guardianship
  - segregation of competencies
  - least restrictive alternative
Competency-to assess or not to assess…

- Presumption of competence
- Cognitive deficits alone are not sufficient basis for incompetence
- Person is allowed to make a “poor” decision
When not to assess …

- Is formal assessment necessary?
  - 15% of referrals dismissed
    - motive not in best interest of patient
    - misunderstanding of legal consequences of potential assessment
    - another alternative available that would better serve the person's interest
  - Incompetent person willing to accept help may not need to be formally declared incompetent
Remember...

- Competency assessment places person's fundamental rights and freedoms at risk, particularly the right of liberty.
- It should focus on the needs of the patient and not others and should only be used as a last resort.
  - Incompetence route can be highly coercive way of advocating services and professionalizing care.
Competency Assessment Guidelines

- Standardized assessment and criteria is the goal
- One-shot assessments should be the rare exception
Overview of assessment - Who should assess?

- Family medicine, Psychiatry, Geriatric Medicine
- Neuropsychology
- Social work
- RN
- OT / PT
- Other team members
Principle:

- weigh the tenuous balance of person’s autonomy against the need to act in that person’s interest
Competency Assessment

- Is the referral specific?
- Talk to referral source / family
- Explain purpose to patient
Competency Assessment

- Mental status
  - orientation (to pay bills)
  - memory (keep track of financial transactions)
  - concentration
  - simple and complex calculations
  - delusions / hallucinations
  - insight
  - judgment
  - intellect
Cognitive Assessment

- The following tests are useful:
  - MMSE
    - Recall
    - Concentration
  - Clock drawing
  - “F” words / animals in 60 seconds
  - Similarities
  - Trails B
  - Frontal assessment battery
Interview: Financial Competence

- **Assets, income**
  - Unaware of $200,000 in savings, he thinks it may be $2000, Neighbor knows its Down to $100,000
  - Unaware of pensions, “I’m too old to get them”

- **Debts, expenses**
  - Nephew insists on “helping”
  - Thinks he pays $10 for electricity once or twice a year, unsure of phone cost
  - Unpaid bills
Mr. Frale : Finances

- Thinks he can manage his money
- Trusts Bruno
Mr. Frale: Financial competence

- Collateral, history of money management
- Does he accept need for support? - no
- Delusions or hallucinations that may impair decisions? - no
- Patient’s preference

CONCLUSION?
Mr. Frale:  
Personal Care Competence

- Health Deficits:
  - Parkinson’s disease - harder to walk, falls
  - COPD - stopped smoking
  - dementia - memory decline X 3 years, forgets pills
Personal Care Competence

- Functional deficits:
  - Lives alone
  - Mrs. Goodhart sometimes bakes
  - Cooks soup on wood stove, losing weight
  - Cleans?
  - Independent ADLs but poor hygiene
  - Drives to grocery store in mornings
  - ER - minor traumas
Personal Care - Interview

- Admits he needs help with his pills – it's hard to keep track
- Says he gets some meals on his own but appreciates neighbor’s cooking
- Admits to falls but says he always manages to get the help he needs or will get to ER
- Agrees to have someone in the home who would help him organize pills, clean
Personal Care Competence

- History of poor judgment resulting in harm - no
- Delusions that would impair capacity - no
- Appreciate his own strengths & weaknesses - yes
- Willing to use supports – yes

**CONCLUSION?**
Competency Assessment

- Consider extra data
  - Home visit
  - Collateral re: finances, personal care and function.
  - Neuropsychology
  - OT assessment of function

- Is condition permanent or temporary?
  - Re-evaluate if temporary
Presumption of Capacity

- In Nova Scotia, each person is presumed to have capacity to make his/her own decisions.
- This includes decisions for and against recommended medical treatment.
- Except in very limited circumstances, no one can make decisions for a competent individual.
Substitute Decision Makers

- **Medical decisions, hierarchy**
  - Person authorized under Medical Consent Act
  - Court appointed guardian
  - Spouse or common law partner, is cohabitating in conjugal relationship
  - Adult child
  - Parent
  - Adult sibling
  - Any other adult next of kin
  - Public Trustee

- **Financial decisions**
  - POA (enduring)
  - Not NOK
Substitute Decision Makers cont’d

- SDM shall make a decision in relation to a specific medical treatment
  - In accordance with the patient’s prior capable informed expressed wishes; OR
  - In the absence of a prior capable informed expressed wish, in accordance with what the SDM believes to be in the patient’s best interests
Power of Attorney Act 1988

- Authorizes person to act on your behalf
  - general
  - specific
- Duration
  - standard
  - enduring POA
Hospitals Act-Amended

- Psychiatrist must assess:
  - capacity to consent to treatment in psychiatric facility
  - financial competence when necessary in a psychiatric facility
  - no provision for personal care competence

- For the purpose of a person in a hospital the attending physician may now comment on capacity to consent to treatment and financial competency
Hospitals Act-Amended

- Incompetence without a judge
- Lasts for duration of hospitalization only
Incompetent Person’s Act

- “Insane person” or “lunatic”
- Requires medical evidence from one medical practitioner; often two obtained
- Judge must declare person incompetent, then appoint a guardian
- Guardian of estate and person
Adult Protection Act 1986

“In need of protection”

- Victim of abuse +/- mental cruelty incapable of protecting themselves by reason of physical disability or mental infirmity

  OR

- Not receiving adequate attention or incapable of caring adequately for themselves by reason of physical disability or mental infirmity

- ? Where they live, duration of 6 months
Summary

If we have a patient who is not competent and has no:

- Person authorized under the Medical Consent Act
- Court appointed guardian

We must rely on Next of Kin

- As outlined in the amended Act
5 Key Messages to Remember:

1) EPOA and substitute decision makers are for everyone! (talk to patients)
2) Understanding & Appreciating are the key elements in competency assessment
3) An MMSE is usually NOT enough
4) Home visit is ideal- *Always* get collateral
5) Hard vs soft approach to incompetency (aka. Will they accept help?)
REFERENCES


