Rivers in Practice: Clinicians' Assessments of Patients' Decision-Making Capacity

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Since the Rivers v. Katz decision in 1986, clinicians in New York State have been required to assess patient decision-making capacity before judicial review of petitions to administer involuntary medication. The authors examined 42 capacity assessments made by psychiatrists at a large state hospital in New York City. Although the capacity assessments were often incomplete and rarely addressed the treatment decision, most clinicians judged patients as lacking capacity to make treatment decisions. The findings suggest that psychiatrists may view capacity assessments as irrelevant because of the manifestly grave nature of patients' illnesses or may not differentiate the capacity assessment from the mental status examination. The capacity assessment may nonetheless be a useful tool because it encourages clinicians to discuss the proposed treatment with patients and to present information more effectively in court.

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The growing emphasis on patients' right to self-determination has resulted in litigation in several states that has changed the way clinicians practice psychiatry (1). Even when the exercise of this right results in the rejection of medical intervention normally considered beneficial (2), self-determination has been supported in recent court decisions that provide for either administrative or judicial review of petitions to involuntarily medicate a patient. *Rennie v. Klein* (3) gave final authority to clinicians and administrators. This decision effectively granted patients the right to a second opinion (1). *Rogers v. Commissioner* (4) and *Rivers v. Katz* (5) were more protective of an actual right to refuse treatment because they emphasized capacity and required judicial input into determination of the right to refuse.

In *Rivers,* the New York Court of Appeals ruled that "in situations where the State's police power is not implicated, and the patient refuses to consent to the administration of antipsychotic drugs, there must be a judicial determination of whether the patient has the capacity to make a reasoned decision with respect to proposed treatment before the drugs may be administered pursuant to the State's *parens patriae* power." Clinicians were then faced with how to apply this decision. This paper examines how clinicians in a large state hospital in New York assessed the capacity of patients selected for judicial review for involuntary treatment after the *Rivers v. Katz* decision.

Decision-making capacity

Capacity is the ability to reach a treatment decision. It is sometimes referred to as functional competency. Clinical evidence suggests that despite alterations in thinking and mood, psychiatric patients are not automatically less capable than others of making health care decisions. For example, schizophrenic inpatients did not differ substantially from medical inpatients in their knowledge of their medication (6,7). In addition, hospitalized psychiatric patients and medical patients evaluated the risks and benefits of proposed research projects in a similar manner (8). Medical patients fail to comply with treatment as often as psychiatric patients, and their reasons for doing so include many irrational elements (9,10). Furthermore, incapacity may relate to factors other than psychiatric illness (11,12), including the nature of the interactions between the patient and the treatment system (9,10).

To assess capacity, it is essential to focus on the specific cognitive abilities the patient uses in the actual decision-making situation and to demonstrate how the patient's symptoms and behavioral disturbances interfere with passing commonly used tests of capacity. Authors in the legal and psychiatric literature have focused on five tests of capacity—evidencing a choice, factual under-

standing, rational reasoning, appreciation of the nature of the situation, and reasonable outcome of choice (13–18). The first four tests have been proposed as a hierarchy (16,18), with each level providing a stricter definition of decision-making capacity. Reasonable outcome of choice is not part of the hierarchy because it does not depend on the patient's reasoning but on the evaluator's judgment of what a reasonable person would do.

The *Rivers* decision and subsequent New York State Office of Mental Health regulations require each of two evaluating psychiatrists—the treating physician and the clinical director or designee—to interview the patient for whom a court order for involuntary treatment is sought and to formally evaluate capacity. While *Rivers* mandated assessment of capacity, it did not specify how capacity is to be assessed. State hospital policy requires psychiatrists to complete a psychiatric summary, outline the proposed course of treatment, complete a capacity evaluation form, and certify that the patient has received the necessary information about the proposed treatment. Judges are then asked to determine whether the patient lacks capacity and, if so, whether the proposed treatment is appropriate and in the patient's best interest. When both conditions are met, judges grant approval of involuntary treatment for periods usually ranging from 30 days to six months (19).

The capacity section of the application for involuntary medication assumes that patients who are refusing voluntary treatment have passed one standard—evidencing a choice. The State Office of Mental Health outlines three standards that should be applied by clinicians in determining a patient's capacity. They are factual understanding of the proposed treatment and of its risks, benefits, and alternatives; rational use of information to reach a conclusion about treatment; and appreciation of the consequences of refusing treatment, the ability to anticipate the future and to cognitively and affectively appreciate the impact refusing treatment would have on the course of the illness, ability to function, and quality of life. In the state system, standards are not applied hierarchically. Furthermore, the evaluator's judgment of what a reasonable person would do was not included as a standard because it is biased in favor of the physician's opinion that the patient needs treatment.

We sought to determine whether clinicians presented comprehensive treatment information to patients before assessing their capacity and to identify which capacity standards clinicians used most frequently and which standards patients were judged to have passed and failed. A case example will be presented to illustrate how clinical and legal concerns can both be served by using the capacity assessment properly.

Methods

This study retrospectively examined how clinicians evaluated capacity at a large state hospital in New York City for the one-year period immediately after implementation of the *Rivers* decision—August 8, 1986, to August 7, 1987.

Data were obtained from forms completed by clinicians, including the capacity evaluation form and checklist of information given to patients, from patients' charts, and from the New York State Office of Mental Health computerized patient information system.

For the one-year period, 21 patients (1 percent of the total number of beds) were judicially reviewed for involuntary medication. Because each patient was evaluated by two clinicians, 42 capacity assessments were reviewed.

A sole rater scored the capacity assessments. For each standard, the rater determined whether the capacity standard was addressed and, if so, whether the clinician focused specifically on the patient's capacity to make a treatment decision, rather than giving a description of the patient's general reasoning abilities and dysfunctions. The rater also judged whether the patient passed or failed the standard.

Patients were considered capable of factual understanding if they demonstrated adequate comprehension of the purpose of the prescribed medication and its potential effects. On the standard addressing rational use of information, patients were judged to be capable if they displayed relevant reasoning with respect to the treatment decision. Patients who acknowledged their mental illness and the potential effects of their treatment decision on their mental health were considered capable on the third standard, appreciation of the consequences of refusing treatment.

Results

The patients in the sample were representative of the hospital population. Of the 21 patients who appeared in court, four were women, 17 were men, 13 were black, four were Hispanic, three were white, and one was Asian. Fourteen of the patients had at least a high school diploma. At the time of the court proceedings, 14 patients had clinical chart diagnoses of schizophrenia, four had schizoaffective disorder, two had organic brain syndrome, and one had affective disorder.

The mean ± SD age of the women was 58 ± 13.9, and of the men, 39 ± 12.5. Females were somewhat underrepresented relative to the total hospital population, but the age skew was consistent. The mean ± SD number of previous psychiatric hospitalizations was 6.4 ± 6.2. Patients had been in the hospital for a mean ± SD of 11 ± 20.6 months at the time of the first evaluation for involuntary treatment. The mean ± SD time from the first evaluation to the court decision was 5.8 ± 2.3 weeks.

Treatment explained to patients. A majority of clinicians reported explaining all treatment-related issues to patients. Thirty-nine of the 42 evaluators stated that they explained the patient's condition, the proposed treatment, the anticipated benefits of treatment, and the risk of adverse effects of treatment. Thirty-five clinicians reported explaining the availability of other treatments and comparing their benefits and risks with those of the proposed treatment.

Table 1
Clinicians' use of standards in evaluating patients' decision-making capacity

Clinician response (N=42)	Standard: Factual understanding N	%	Rational use of information N	%	Appreciation N	%
Did not address	34	81.0	11	26.2	6	14.3
Could not evaluate	3	7.1	4	9.5	0	0.0
General comments	2	4.8	26	61.9	33	78.6
Treatment-specific comments	3	7.1	1	2.4	3	7.1

Standards of capacity. Only five assessments were performed using all three standards, 23 were made using two standards, and 14 using one standard. Factual understanding was addressed by eight evaluators, rational use of information by 31, and appreciation of the consequences of refusing treatment by 36.

None of the 42 evaluators assessed only factual understanding, three assessed only rational use of information, and 11 assessed only appreciation. The most frequently applied combination of standards was rational use and appreciation, which were used together by 20 clinicians.

Evaluations. A mean±SD of 1.8±.1 clinician comments per patient were about general patient dysfunction, while only .14±.5 per patient were specific to treatment. As Table 1 shows, the rest of clinicians' comments expressed their inability to make adequate evaluations of certain standards because patients were uncooperative with the interview. Seven of the 126 possible assessments were specific to treatment. The clinicians who made treatment-specific evaluations addressed all three standards of capacity.

The 42 evaluators gave patients passing marks on only three assessments—two on factual understanding and one on rational use of information. Five patients failed on one standard, 14 failed on two standards, and two failed on all three standards.

Case example

The following case exemplifies a complete and treatment-specific capacity evaluation.

Mr. S, a 41-year-old black male, had four prior psychiatric admissions. He was committed due to auditory command hallucinations to kill others. At the time of the initial evaluation for involuntary treatment, he had been in the hospital for four and a half months, and his diagnosis was chronic paranoid schizophrenia. He was at that time described as belligerent, hostile and potentially violent, combative, and threatening to staff and other patients. On at least one occasion, he was placed in seclusion. His reported symptoms were thought disorder and command hallucinations. His speech, which was pressured at times, was tangential with neologisms. He had abused cocaine and marijuana. His primary objection to medication concerned the adverse side effects he anticipated.

The clinician's assessment. The following statements are verbatim accounts from the clinician's report. The phrases in quotes are statements by the patient that were included in the clinician's report to substantiate the assessment.

Factual understanding of the proposed treatment. Mr. S is aware that neuroleptics act on the nervous system and that they "affect the brain" and may cause adverse effects such as "impotence and low blood pressure."

Rational use of information. The patient fears adverse effects of the medication and is skeptical of any benefits it may offer.

Appreciation of the consequences of refusing treatment. The patient has poor insight into his illness. He does not appreciate his deterioration over the past weeks with regard to his withdrawn, hostile, and violent behavior. He believes he is functioning as he always has without medication and that he can exercise self-restraint to prevent future violent behavior. He is not aware of his thought disorder and denies any emotional difficulties associated with it. He appears not to understand the difficulty he will have leaving a locked ward if he continues to refuse treatment.

The rater's conclusion. Mr. S, the only patient judged to have passed any capacity standard, passed two of the three standards—factual understanding and rational use of information—but failed the third standard because he was incapable of appreciating the consequences of refusing treatment. The clinician made treatment-specific comments to substantiate his opinion on all three standards.

Discussion

In this small sample, a majority of clinicians reported presenting comprehensive treatment information to patients undergoing review for involuntary treatment. However, the clinicians appeared to have difficulty applying capacity standards. Although too few capacity standards were used and the clinicians' comments were too generalized, most clinicians concluded that patients lacked the capacity to reach a treatment decision.

The few clinicians who attempted to assess the patients' factual understanding often found that patients refused to be interviewed. This finding is consistent with previous findings of greater hostility among patients who refuse psychiatric treatment (20).

There are other possible explanations for clinicians' neglect of the factual understanding assessment. Physicians may not value the patient's role in decision-making and ignore the patient's grasp of the facts. Some patients may not be able to convey adequate information (21). However, since some findings of adequate capacity at the level of factual understanding were observed, failing to assess patients on this standard

may cause clinicians to underestimate capacity. The failure to address factual understanding may also indicate that clinicians used the mental status exam to assess capacity without having a discussion focused on the patient's understanding of the treatment.

Clinicians assessed rational use of information and appreciation most often, perhaps because they were the most meaningful or understandable of the capacity standards. Whatever the rationale for emphasizing these standards, a majority of clinicians implicitly held patients to the strictest tests of capacity. Judges reinforced this practice, upholding the refusal of only one of the 21 patients (19).

Although clinicians were directed to use all three standards in evaluating capacity, only 12 percent did so. The clinicians who used all three standards also made at least one treatment-specific comment. This finding suggests that clinicians who have a better grasp of the tasks involved in the evaluation of capacity perform more complete assessments.

The tendency among clinicians to make only general comments and ignore the narrower question of whether the patient has the capacity to reach a treatment decision suggests that clinicians simply transfer information from the mental status examination to the capacity assessment. General statements such as, "patient is grossly psychotic," "patient has a profound thought disorder," "patient has poor insight and judgment," and "patient believes his food is poisoned" do not by themselves constitute statements about the patient's capacity to make a treatment decision.

What clinicians reported may not adequately reflect their interactions with patients. Nevertheless, only 6 percent of all evaluations concerned the patient's reasoning about the proposed treatment. This finding supports the observation that psychiatrists tend to assume there is a directly inverse relationship between the degree of psychopathology and the patient's capacity, even though empirical findings do not support this belief (18,22). Thus clinicians' focus may not appreciably shift to the assessment of capacity.

The lack of completeness and specificity of the capacity assessments suggests that psychiatrists may misunderstand the concept of capacity or consider it irrelevant because the patients selected are severely and chronically ill. Clinicians may fear prejudicing the judicial decision against treatment. While this study took place in a state hospital, the same tendency to ignore patient capacity has been noted in a variety of other inpatient and outpatient settings (23).

Furthermore, some authors suggest that judges, like psychiatrists, appear to be more focused on the need for treatment than on the patient's decision-making capacity (24). Yet the capacity assessment is a more useful tool than the mental status examination for addressing the problem of treatment refusal. As Brooks (1) notes, the value of emphasizing patient self-determination is largely heuristic. The capacity assessment explores the patient's own understanding and motivations regarding treatment, encourages psychiatrists to communicate more effectively with patients, provides physicians presenting their treatment opinions in court with a set of criteria recognizable to judges, and offers a theoretically sound perspective on the host of clinical and legal issues involved in treatment refusal.

Acknowledgment

This work was supported in part by grants MH41734 and MH41735 to Dr. Stanley from the National Institute of Mental Health.

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