

When a Patient Is at Foreseeable Risk of Losing Decisional and Functional Capacity

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The four-skills model of decisional capacity for providing informed consent for medical treatment developed by Appelbaum and Grisso is codified into most state statutes in articulating the legal criteria for establishing capacity. Decisional capacity is traditionally determined at a point in time based on a narrow clinical question; however, there are clinical scenarios in which patients may currently have decisional capacity but their recurrent nonadherence to care places them at foreseeable risk of being acutely incapacitated, both decisionally and functionally, in the near future. There is a gap in terms of how these four skills ought to be adapted when applied to a patient with recurrent altered mental status, especially delirium, because of nonadherence. To describe this clinical situation, we introduce a new risk factor, “foreseeable risk of losing decisional and functional capacity,” and discuss the clinical evaluation of a patient who currently has capacity but for whom this risk factor applies. We consider the implications of being at foreseeable risk of losing capacity and how foreseeable risk can be translated into a capacity determination in the present. We also describe interventions that can serve to protect the patient’s rights and safety.

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Capacity to provide informed consent for medical care involves four skills: the ability to communicate a consistent choice, to understand the risks and benefits of an intervention, to appreciate the situation, and to deliberate rationally.^{1,2} Although there have been some proposed alternatives,^{3,4} “four skills” has emerged as the dominant model for capacity assessment. A recent review of capacity legislation in the United States found that most statutes include some version of these four skills in the legal criteria for capacity.⁵ Capacity assessments based on these statutes may have close clinical correlates as well. For instance,

a study that compared the MacArthur Competence Assessment Tool for Treatment (MacCAT-T)⁶ with Ireland’s Assisted Decision-Making (Capacity) Act 2015⁷ (whose criteria include the ability to understand and retain information, to use that information to reason, and to communicate a decision) concluded that the results of mental capacity assessment are closely correlated between legal and clinical criteria.⁸

Although many medical and mental health conditions may impair a person’s decisional capacity, effectively no diagnosis wherein consciousness is retained necessarily determines a person’s ability to provide informed consent, even though there is a higher risk of incapacity associated with certain conditions, such as neurocognitive disorders⁹ and other dynamic impairments in which individuals can fluctuate between periods of capacity and incapacity.^{10,11} Moreover, the stringency of the capacity assessment is often proportional to the potential consequences of the patient’s decisions.¹²

Whereas the evaluation of decisional capacity may be thought of in terms of a cross-sectional assessment,

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Table 1 Example Conditions in Which Capacity Can Fluctuate Because of Treatment Nonadherence

| Condition | Treatment Being Declined | At-Risk Mental State |
|---|---|---|
| Conditions Leading to Delirium-Spectrum States | | |
| Hypertensive urgency or emergency | Antihypertensive, typically parenteral | Hypertensive encephalopathy with or without posterior reversible encephalopathy syndrome |
| Severe infection, especially sepsis | Antibiotics, typically parenteral | Septic encephalopathy |
| Acute or decompensated kidney failure | Renal replacement therapy | Uremic encephalopathy |
| Acute or decompensated liver failure | Lactulose, rifaximin, et al. | Hepatic encephalopathy |
| Brain metastases | Corticosteroids | Increased intracranial pressure presenting with delirium, seizures, or brain herniation |
| Severe chronic obstructive pulmonary disease | Home oxygen | Hypoxic encephalopathy |
| Insulin-dependent diabetes (“brittle diabetes”) | Insulin, dietary discretion | Diabetic ketoacidosis or hyperosmolar hyperglycemic syndrome, either presenting with seizures or delirium |
| Congestive heart failure | Diuretics, fluid discretion | Delirium because of several different electrolyte disturbances |
| Active substance use disorder | A range of potential offerings (e.g., rehabilitation) | Intoxication or withdrawal, either of which could present with delirium |
| Primary Psychiatric Conditions | | |
| Schizophrenia with thought disorganization | Antipsychotic medications | Thought disorganization |
| Psychiatric disorder presenting with catatonia | Lorazepam | Catatonia |

an evolving process over time, or in terms of its potential remediability, it is seldom considered in terms of when the decision to forego a clinical recommendation is, itself, likely to place the patient at elevated risk of future decisional and functional incapacity. This could occur, for example, in the case of an oxygen-dependent patient demanding discharge despite unavailability of oxygen in the community, thus creating the risk of acute delirium. In a medicolegal context, foreseeability pertains to how likely a reasonable person might anticipate the possible risks or actual consequences of a decision or action,^{13–15} and there are many conditions in which declining treatment interventions can foreseeably result in diminished capacity in the near future, even imminently so (Table 1).

Considering that decisional capacity can become impaired abruptly and that such impairment is often foreseeable, we consider this a necessary application of the four-skills model. These clinical situations present a challenge because evaluating decisional capacity in the moment should include an assessment of not only the current mental status but also of patients’ awareness and appreciation of a foreseeable event, namely their risk of acute incapacity based on their current decision (Fig.1). In many of the clinical scenarios in Table 1, near-imminent incapacity may be expected, rather than simply foreseeable.

Applying the four traditional skills of capacity in the case of a patient who demonstrates recurrent altered mental status because of nonadherence introduces clinical and ethics challenges. Consider, for instance,

a patient with congestive heart failure who recurrently presents to the emergency department with heart failure exacerbation and delirium because of fluid overload. This patient may appear to be otherwise capacitated after initial diuresis, but once the delirium clears, the patient reliably refuses diuretics. The patient’s nonadherence may be a result of poor insight or limited health care literacy, financial considerations, reasons rooted in cognitive or emotional biases, or reasons that otherwise appear irrational.¹⁶ The process of determining decisional capacity in such a challenging case may compromise patient safety or delay care,¹⁷ particularly when the patient recurrently declines a time-sensitive medical intervention that may otherwise prevent a foreseeable and significant decompensation. We present an adaptation of the traditional skills model that extends the four skills in time as required in such situations. We further demonstrate how consideration of foreseeable risk can be translated into a capacity determination in the present.

Foreseeable Risk of Future Incapacity

Considering nonadherent patients who recurrently present with altered mental status, including delirium or other markedly altered states of mentation, and who are at ongoing risk of persistent nonadherence, we introduce the risk factor “foreseeable risk of losing decisional and functional capacity.” In addition to the standard term “decisional capacity,” we use the term “functional capacity” to describe the

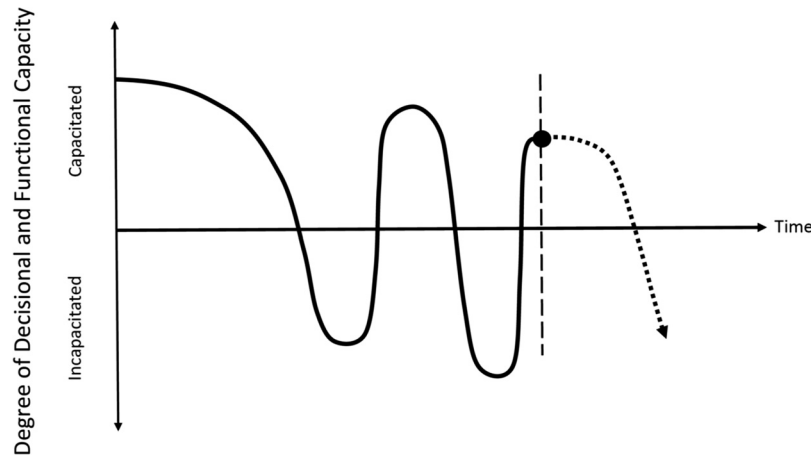


Figure 1. Capacity in a patient who has decisional capacity but is at foreseeable risk of losing decisional and functional capacity. A patient with a known diagnosis that is associated with fluctuating capacity because of treatment nonadherence can alternate between periods of capacity and incapacity over time (solid line). At the time of a capacity evaluation (dashed line), a patient may be capacitated. Whether a patient has a period of brief stability, its duration, and the acuity of decline in capacity (dotted line) will vary based on the nature of the patient’s condition and the effect of nonadherence, either partial or full.

ability to care for and protect oneself. Patients at foreseeable risk of losing decisional and functional capacity are at risk of developing acute, and often imminent, incapacity because their decisions could lead to abrupt functional decline or global neurocognitive impairment. This decompensation could result in a patient being either unaware of any risk at the time or unable to seek care even if awareness of personal risk were intact.

We propose four elements to this risk factor: foreseeability based on knowledge of the disease process and the consequences of certain recurrent behaviors; risk of an acute, potentially imminent negative outcome in the near future (i.e., within hours to days); the potential future outcome involves a state that would render the patient incapable of self care or protection; and the patient’s current decision to forego care directly entails this risk. The nature of this risk could be characterized based on each of these elements: its degree of foreseeability; the temporal course, including imminence; the scope and severity of incapacity; and the logical series of events linking the decision to the outcome of incapacity. The degree of acuity and severity anticipated affect the clinical urgency with which a medical or legal intervention might be warranted to ensure the patient’s safety.

Decisional capacity is context dependent and varies based on the clinical question, timing, and mental state. Evaluating decisional capacity for a patient who is at foreseeable risk of losing decisional and functional capacity involves the application of the traditional four skills to this risk factor. Table 2 depicts how the

traditional skills of capacity map onto the elements of this risk factor. Given that the risk is in the future and involves a state of decisional and functional incapacity, one important element of current decisional capacity, which should be evaluated explicitly, is the person’s metacognition regarding oneself. That is, persons should be able to demonstrate an appreciation that the risk is not only real but that it pertains to their future selves. This is likely to require education from the clinician regarding the nature and scope of these risks and the anticipated outcomes. For patients in this scenario to be determined to have capacity for the decision in question, they should satisfy all four skills in relation to the different elements of this risk factor.

Clinical Evaluation of Foreseeable Risk

When applying the foreseeable risk factor to clinical care, a clinician would first evaluate for the elements of risk as we have outlined (Table 2). Next, the clinician would review with the patient the available information and any anticipated risks, soliciting the patient’s degree of understanding. We also note that the accuracy of clinical predictions depends on the clinical data available and how well the patient’s conditions correlate with other similar situations that have been described (e.g., Table 1).

There are several elements that constitute a patient’s “appreciation of risk.” The risk *per se* is losing decisional and functional capacity, which could result in injury to self, injury to others, and being unable to care for oneself, including the risk of death. The reason for

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Table 2 Applying the Traditional Skills of Decisional Capacity to a Patient Who Is at Foreseeable Risk of Losing Decisional and Functional Capacity

| Skills of Capacity | Applying to a Patient at Foreseeable Risk of Losing Decisional and Functional Capacity | | | |
|--|--|--|--|---|
| | Foreseeability | Risk Acuity | Nature of Incapacity | Decisional Relevance |
| Communicate a consistent choice | Communicate a consistent choice | Communicate a consistent choice | Communicate a consistent choice | Communicate a consistent choice |
| Understand the risks and benefits of an intervention | Understand the predicted high degree of likelihood (foreseeability) of the future incapacity | Understand that the acuity of risk could be imminent, precluding in-the-moment attempts to seek care or assistance of others | Understand the consequences of such a mental state, which could include death or irreversible injury | Understand that alternative decisions could mitigate, if not eliminate, this risk |
| Appreciate the situation (insight) | Appreciate future likelihood (or past history) of decisional and functional incapacity because of the clinical condition in question | Appreciate that incapacity could occur suddenly, within minutes to hours, and very likely without warning | Appreciate that the anticipated state of incapacity would entail lack of awareness of the risk or inability to care for or protect self (appreciation should entail meaningful problem solving and attempts on the part of the patient to mitigate risk) | Appreciate that the decision in question directly creates risk |
| Deliberate rationally | Demonstrate rational prediction (including realistic, evidence-based appraisal based on any available evidence, such as evidence of prior such incapacity) regarding potential for future incapacity | Demonstrate rational problem solving based on potential acuity of risk | Demonstrate rational planning in response to anticipated incapacity | Demonstrate metacognition (including entertaining hypothetical scenarios) about future self |

the risk is nonadherence in the setting of a clinical condition that requires consistent adherence to a specific therapy. The risk is proximally attributable to the patient's decision. Moreover, the risk is foreseeable based on the patient's own prior and current circumstances, if known; it is also potentially imminent and directly attributable to the decision being made. The patient's ability to appreciate foreseeability is predicated on the patient's ability to metacognate, that is, the ability to conceive of one's future self, including the extent of possible consequences of decisions for one's future self.¹⁸ Appreciation of risk also requires patients to comparatively weigh potential outcomes that might result from their decision.

A clinician should attempt to review prior event(s) in which a patient exhibited altered mental status along with these events' outcomes to answer such questions as: Was the patient contacted or reminded to seek care? Did the patient attempt or was the patient able to seek care voluntarily? Did someone find the patient and either bring the patient to care or alert emergency services? Moreover, the clinician should consider the likelihood that someone would find the patient again if a similar situation were to

reoccur. If a patient living alone and without friends or family to check on the patient were to develop severe delirium, it may be unlikely that the patient would be found before grave harm occurred.

The nature of care nonadherence is also important. For instance, nonadherence might be recent, sporadic, or persistent. From a public health perspective, there are several trajectories of nonadherence across clinical conditions, including consistent adherence, initial nonadherence followed by increasing adherence, early or late declining adherence, and consistent nonadherence.¹⁹ Mapping a patient's adherence trajectory may aid in identifying the onset of nonadherence and an associated instigator of nonadherence that could be targeted for intervention.

As part of anticipating outcomes, a patient should demonstrate attempts to mitigate negative consequences, such as using a pill organizer to improve medication adherence, coordinating transportation to treatment, completing an advance directive, or identifying a surrogate decision maker (discussed below). Given that recurrent altered mental states may arise because of any number of patient-specific, economic, social, and cultural factors, the clinical task of reducing risk

of future incapacity should include addressing relevant modifiable factors, assessing the resources available to the patient to address these factors, and determining whether the patient has utilized these resources.²⁰ It may be necessary to discuss the patient's situation with collateral sources to make this determination.

Assessing what constitutes a rational thought process in this context also includes several elements, regardless of whether a patient accepts or declines treatment. Rational thinking includes the ability to manipulate true and false propositions with logical rules to reason from assumptions to conclusions. Rationality also requires a generally accurate appraisal of reality, recognizing some interpersonal variability. Patients who demonstrate rational thought would be able to provide recognizable reasons for their decisions that are relevant to the circumstance and proportionate to the consequences of the choice. In considering the sufficiency of the reason, the clinician would consider whether the stated reason aligns with the person's previously expressed values and goals and whether the person arrived at that reason via sound reasoning.^{21,22}

To illustrate these principles, consider the case of a woman with end-stage chronic obstructive pulmonary disease (COPD) who experiences recurrent hospitalizations secondary to nonadherence to prescribed home oxygen. In discussion with the patient and family, the patient is adherent to her prescribed medications except for oxygen, as she smokes cigarettes throughout the day, and she knows that she cannot smoke while on oxygen. She is precontemplative regarding smoking cessation, stating that she enjoys smoking and has no interest in stopping. She is aware that ongoing smoking worsens her COPD and places her at risk for ongoing hospitalization and possible death. The patient has identified her adult child as her surrogate decision-maker. In this circumstance, the patient is at foreseeable risk of losing decisional and functional capacity based on nonadherence to oxygen in the setting of end-stage COPD and ongoing smoking, but she retains decisional capacity to decline home oxygen.

Consider another case of a woman with end-stage renal disease (ESRD) who is consistently nonadherent to outpatient dialysis because she believes that if she requires emergent dialysis and hospitalization then she will receive a renal transplant sooner. The patient disagrees with repeated counseling that her belief is incorrect, explaining that she knows the

transplant listing system better than clinicians. She is provided with medical transport to outpatient dialysis but refuses to go. She refuses to complete an advance directive or identify a surrogate decision-maker because she does not trust others to fulfill her wishes. In this circumstance, the patient is at foreseeable risk of losing decisional and functional capacity based on nonadherence to dialysis in the setting of ESRD, and she does not have decisional capacity to decline dialysis. Clinicians might consider pursuing dialysis over objection for patient safety.

Another example would be a man with schizophrenia who recurrently presents to the emergency department with psychotic decompensation and malnutrition because of antipsychotic medication nonadherence. In the past, this patient has received involuntary medications in the hospital and been discharged with either oral or long-acting injectable medication; however, he has never voluntarily established outpatient care. The patient has consistently declined outpatient treatment interventions offered through community mental health and assertive community treatment. His psychosis has led to aggressive behavior resulting in incarceration and to malnutrition requiring inpatient medical management. In this instance, after the patient has received involuntary antipsychotics to the extent that he is no longer acutely disorganized, he declines antipsychotic medication. The patient adamantly maintains that he is managing schizophrenia by fasting to cleanse the taraxein from his body. He refuses to complete an advance directive. As in prior circumstances with this patient, he is at foreseeable risk of losing decisional and functional capacity when he is no longer adherent to antipsychotic medications. He has no appreciation that nonadherence has reliably caused him and others harm. His delusions, including a delusional lack of insight, render him incapacitated regarding his decision not to take an antipsychotic. Clinicians might pursue long-term options to ensure that the patient receives antipsychotic medication over his objection to ensure his safety and the safety of others. In a related scenario, although patients with recurrent delirium because of ongoing nonadherence with medical care (e.g., lactulose for hepatic encephalopathy) are not delusional in a traditional sense, once the delirium clears, their refusal of care may be similarly adamant and not amenable to change in light of evidence and just as reliably results in foreseeable risk of incapacity.

In other situations, some patients can demonstrate a mentality akin to anosognosia or anosodiaphoria for the altered state. One wonders how a person can truly appreciate the risk of once again becoming altered if the person has no recollection of prior episodes. In an analogous legal situation, in many jurisdictions, voluntary intoxication and amnesia about it do not reduce responsibility for criminal acts committed while intoxicated.^{23,24} When applied to a medical decision-making context, this principle suggests that inability to recall being altered might not obviate the patient's need to appreciate the objective risks of that state. Put differently, ignorance of one's prior altered mental status, its impact on decision-making, or the associated inability to protect oneself in such a state is no excuse.

Some patient decisions can be especially challenging to override. For instance, a patient who is HIV positive with ESRD and who consistently presents in a delirious state, receives emergency dialysis, and then declines further dialysis. Or consider a patient with severe substance use disorder who repeatedly presents with sepsis secondary to infective endocarditis and consistently leaves against medical advice before the end of the recommended antibiotic course. In the first instance, overriding the patient's decision and mandating that the patient receive dialysis places health care workers at risk and constitutes potential harm to the patient (particularly if the patient must be restrained or sedated for the procedure) and very likely to clinical staff as they could be injured by the patient's combativeness in response to efforts to restrain the patient. In the second case, mandating that the patient remain in the hospital for several weeks of antibiotic therapy imposes a significant loss of autonomy and freedom and places the patient at risk of the not insignificant possibility that the health care facility may not adequately manage the comorbid substance use disorder.

These challenging situations underscore the fact that, like the four traditional skills of capacity, the stringency of this proposed risk factor is proportional to the potential consequences of the patient's decision and the clinical implications of determining that a person lacks the capacity to appreciate future incapacity. Although revoking a patient's autonomy in the face of imminent risk does fall within the purview of a clinician's duty to protect one's patient, detaining a patient entails legal scrutiny and must be balanced against the risk of unlawful detention. One should

always understand the statutes that apply in one's own jurisdiction and consider consulting institutional counsel or obtaining a second opinion if uncertain.

Interventions for Those at Foreseeable Risk

Mitigating the Risk

The cause of patient treatment nonadherence is often multifactorial. Patients at foreseeable risk of losing capacity should receive a comprehensive assessment, including medical, neurocognitive, social work, and case management evaluations. Ideally, this assessment should be performed when patients are at their baseline (nonaltered) mental state and should include collateral from family or friends as available. Following this assessment, a multidisciplinary medical team can propose to patients various inpatient and outpatient interventions aimed at reducing their risk of losing capacity.²⁵ In acute settings, a brief emergency hold may be necessary to ensure that the evaluation can be performed adequately.

If it is possible for a patient or the patient's social situation to change to reduce risk of incapacity and the patient declines or remains nonadherent, this strongly suggests impaired insight into the patient's condition. That is, the patient may no longer be "at foreseeable risk" of losing capacity but may currently lack decisional capacity. In such a case, if a surrogate decision-maker, such as a family member, is not available, then various legal interventions would be indicated to weigh alternative courses of action to balance the patient's wellbeing and right to self-determination.

Practical steps to maximize the likelihood that the patient's state of incapacity will be identified promptly, should it occur, are key to treatment planning. This can include arranging for family or friends to provide supervision for patients or to check in on them regularly (e.g., calling at scheduled times and, if the person fails to answer or respond in a set amount of time, going to visit in person). Daily home visits by nurses or community workers can provide additional support in the community, as can prearranging wellness checks or mobile crisis visits, where available.

Alternate Decision-Making

To safeguard the patient's autonomy, the preferred intervention for patients at foreseeable risk of losing capacity is to have the patient sign an advance directive at a time when the patient has capacity to do so.²⁶ This directive can include identifying a

surrogate (proxy) decision-maker who would be legally empowered to make substituted judgment decisions and consent on behalf of the patient should the patient become incapacitated. If the patient does not have a surrogate, then case management or legal counsel might assist in identifying one.²⁷ When patients decline to identify a surrogate, then they can sign an advance directive that specifies what they do or do not want done if they become incapacitated. In this case, the advance directive would functionally serve as a prospective consent document, like a Physician Orders for Life-Sustaining Treatment (POLST) or Medical Orders for Life-Sustaining Treatment (MOLST) form.²⁸

Although advance directives are traditionally associated with end-of-life care, there are situations in which patients may develop advance directives when they are known to have a condition that can impair decisional capacity. This is evident in the example of advance directives for mental health treatment (also called “self-binding directives” or “Ulysses agreements”), which can communicate patients’ wishes for treatment when they experience symptom exacerbation or incapacity secondary to a mental health disorder.^{29,30} There is significant variance as to the components and legally binding nature of an advance directive,³¹ and there are challenges to utilization of a single advance directive for providing care by a potentially heterogeneous group of clinicians and organizations.³² Completion of advance directives for these patients may require health care system-level support to facilitate their completion.³³ States may differ regarding whether this advance directive for foreseeable risk of losing decisional and functional capacity would be regulated by laws defining medical advance directives, psychiatric advance directives, or both.

If the patient declines to sign an advance directive, then the patient’s clinician should review the relevant state laws regarding default surrogate decision-makers if the patient were to become incapacitated.³⁴ Furthermore, the patient’s clinician should identify who that surrogate decision-maker would be and document that person’s name and contact information in the patient’s medical record so that it will be readily accessible to clinicians for future care when the patient is incapacitated.

Appointing a Health Care Power of Attorney

If a patient does not have an advance directive or surrogate decision-maker, then health care clinicians

may need to seek other parties who can make decisions on behalf of the patient. The health care power of attorney (HPOA), or the durable power of attorney for health care, is an agent who is legally empowered to make health care decisions (and only health care decisions) on behalf of the patient in the event the patient becomes incapacitated. Typically, the HPOA will make decisions based on the patient’s previously expressed wishes and values and in the patient’s best interests if those wishes and values are unknown.³⁵ If the patient does not identify an HPOA prior to being incapacitated, many jurisdictions have statutes that define health care representatives as well as a hierarchy of designated surrogates (spouse, adult children, etc.). Otherwise, an HPOA can be appointed by the probate court.

Imposing Guardianship

Imposing guardianship of person for incapacity prioritizes patient safety over autonomy. Often, incapacitated patients require guardians to consent to disposition decisions or medical interventions, although the timing of this requirement is often urgent or emergent to the extent that a disposition decision might be performed while a patient is awaiting the appointment of a guardian.³⁶

In guardianship, a probate court appoints a third party who may or may not be known to the incapacitated person to make decisions for the protected person. Standards and processes for appointing guardians vary according to state.³⁷ Depending on the circumstances, the court may appoint the guardian to make decisions regarding the person (guardianship of person, which typically includes medical decision-making), guardian of property (responsible for financial decisions), or as a general guardian empowered to make all legal decisions about the person. Conservatorship is typically limited to control of another’s finances and property. The legal process for establishing general guardianship or conservatorship is often lengthy, and at the same time, there have been concerns about limited due process afforded to the would-be protected person³⁸ and financial exploitation by the court-appointed guardian.³⁹

State and federal courts may offer an abbreviated process to appoint a *guardian ad litem*, which grants guardianship over a protected person limited to an individual lawsuit. What constitutes a “proper” appointment of a *guardian ad litem* is not clearly settled, particularly regarding whether the conservatorship

or criminal competency standard should be utilized. Moreover, the *guardian ad litem's* decision-making is governed by the standards of best interest and substituted judgment.⁴⁰

Implications

We have proposed an adaptation of the four skills for decisional capacity that involves the evaluation of decisional capacity for patients at foreseeable risk of losing decisional and functional capacity. This approach is a novel extension of the traditional criteria in time: consideration of foreseeability and the anticipation of how the patient's decision will likely affect the patient's decisional and functional capacity in the near future.

This adaptation requires that patients demonstrate insight about not only the current situation but a future state in which they would no longer have decisional or functional capacity. This scenario requires that patients have insight into their present state, can entertain hypothetical scenarios of their future state, and exercise metacognition regarding their future state. Further, they should understand how their future state may foreseeably be affected by present decisions and, as a key source of evidence that they have insight into the situation, attempt to participate in mitigating any foreseeable risks. Whereas assessment of the above skills represents an evaluation of the patient at a single point in time, the fact that the assessment extends into the future may affect the extent to which a patient's capacity must be reevaluated if the clinical situation changes significantly.

Limitations

The traditional four skills have been codified into most United States statutes for decisional capacity; however, we would not envision that this proposed application of these skills needs similar codification. Rather, these considerations are proposed as an application of these four skills and deserve further development through legal theory, case law, and medicolegal precedent. Additionally, the application should be evaluated for whether it affects the medicolegal standard for patients' ability to understand and reason, given that this heightened scrutiny could lower the threshold for determining clinical incapacity or legal incompetence.⁴¹⁻⁴³

In some jurisdictions, a surrogate's decision cannot override a patient's previously stated treatment

decision.⁴⁴ For instance, if a capacitated patient declines a treatment intervention (e.g., dialysis) and then subsequently becomes incapacitated, the patient's surrogate may lack the authority to override the patient's prior decision.⁴⁵ In such an instance, the patient might experience long-term incapacity or death as a result of never receiving the treatment that could restore the patient's capacity. Such a case highlights the importance of the proposed assessment, especially the need for patients to demonstrate their appreciation of the risk of foreseeable loss of capacity as a feature of determining present capacity.

Some current statutes allow for medical treatment either with or without a guardian or conservator.⁴⁶ At the same time, these statutes might have gaps that do not account for a clinical scenario wherein a patient who otherwise has capacity at the time of the evaluation may yet lack any awareness or appreciation of the possibility of foreseeable, imminent physical and cognitive compromise by declining medical interventions.

This application requires further development to ensure adequate interrater reliability between clinicians performing the capacity assessment. Although clinical judgment is required for capacity assessment, there can be very poor interrater reliability for traditional capacity assessments.⁴⁷ Interrater reliability can be improved by training clinicians to use uniform criteria for capacity assessment consistently,^{48,49} although this does not eliminate the need for clinicians to be aware of possible biases.⁵⁰

Finally, while this application undergoes further legal development and evidence-based adjustment, a clinician utilizing this proposed approach may consider obtaining an ethics consultation or consulting another clinician. If another clinician, such as a psychiatrist, is being consulted to conduct the capacity assessment, the primary clinician should alert the consulting clinician to the patient's history of treatment nonadherence and the associated concern of foreseeable medical decompensation.

Future Directions

Research is needed to clarify the types of clinical scenarios to which this risk factor applies and their prevalence. Consensus is needed to standardize the components and structure of an advance directive for these patients and which party would be responsible for distributing the advance directive to clinicians and organizations who currently care for the patient and for those who will in the future. Research could

also develop how this risk factor changes standards for involuntary inpatient treatment, including medical incapacity holds,⁵¹ assisted outpatient treatment, or the appointment of an HPOA or guardian. Moreover, research can identify what inpatient and outpatient interventions are most effective in reducing a patient's foreseeable risk of losing capacity.

Establishing interrater reliability will be key to ensuring the validity of this risk factor. Future research should seek to limit false-positive and false-negative results of this kind of capacity assessment. Actuarial risk assessment instruments may be created, such as those used to evaluate recidivism risk, although such predictive algorithms can have significant limitations in accuracy and fairness.⁵² Recidivism may also be an imperfect analogy, as foreseeability of recidivism is at least partly related to predicting what an individual's freely chosen behavior might be at some future time. Whereas future behavior is challenging to predict,⁵³ the clinical scenarios we are considering involve an established decision to decline a medical intervention with foreseeability being linked to that decision. That is, this application involves predicting the risk of a medical sequela, not the risk of a behavior. Medical sequelae of treatment nonadherence are more predictable than behavior.^{54,55}

Finally, considering that a patient's foreseeable risks place a liability on the patient's clinicians,⁵⁶ the responsibility of clinicians to obtain or enforce advance directives for patients with this risk factor requires further consideration. Developing tailored statutes may provide legal protection for clinicians and some paternalistic oversight for patients. There is also some legal precedent that clinicians performing and acting upon capacity assessments are protected from medicolegal liability provided that they act in the patient's best interest and in accordance with a "reasonable belief" that the patient did or did not have capacity per a criteria-based capacity assessment and provided that the clinician does not act negligently or contrary to the wishes of the surrogate decision-maker (if one is available).⁵⁷ Similar to other challenging medicolegal scenarios, it is crucial for clinicians performing capacity assessments to document the evidence and reasons for their decision.⁵⁸⁻⁶⁰

Conclusion

We adapt the traditional skills of decisional capacity to the circumstance of a patient who demonstrates recurrent altered mental status because of nonadherence. In doing so, we propose the risk factor of

foreseeable risk of losing decisional and functional capacity to describe this circumstance. We further describe how to apply the skills of decisional capacity to patients at foreseeable risk of losing decisional and functional capacity to make capacity determinations. This development of the decisional capacity skills aims to protect the safety and autonomy of vulnerable individuals regarding both their decisional and functional capacity.

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References

1. Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. *N Engl J Med*. 1988 Dec; 319(25):1635-8
2. Grisso T, Appelbaum PS. *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals*. New York, NY: Oxford University Press; 1998
3. Drane JF. Competency to give an informed consent: A model for making clinical assessments. *JAMA*. 1984 Aug; 252(7):925-7
4. Appel JM. A values-based approach to capacity assessment. *J Legal Med*. 2022 Jan-Jun; 42(1-2):53-65
5. Appel JM. The statutory codification of decisional capacity standards. *J Am Acad Psychiatry Law*. 2023 Dec; 51(4):506-19
6. Grisso T, Appelbaum PS, Hill-Fotouhi C. The MacCAT-T: A clinical tool to assess patients' capacities to make treatment decisions. *Psychiatr Serv*. 1997 Nov; 48(11):1415-9
7. Irish Statute Book. Assisted Decision-Making (Capacity) Act 2015 [Internet]; 2015. Available from: <https://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/print>. Accessed June 3, 2024
8. Curley A, Murphy R, Plunkett R, *et al*. Concordance of mental capacity assessments based on legal and clinical criteria: A cross-sectional study of psychiatry inpatients. *Psychiatry Res*. 2019 Jun; 276:160-6
9. Kim SYH, Karlawish JH, Kim HM, Kelly BD. Preservation of the capacity to appoint a proxy decision maker: Implications for dementia research. *Arch Gen Psychiatry*. 2011 Feb; 68(2):214-20
10. Peterson A, Karlawish J, Largent E. Supported decision making with people at the margins of autonomy. *Am J Bioeth*. 2021 Nov; 21(11):4-18
11. Shulman KI, Hull IM, DeKoven S, *et al*. Cognitive fluctuations and the lucid interval in dementia: Implications for testamentary capacity. *J Am Acad Psychiatry Law*. 2015 Sep; 43(3):287-92
12. Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. *N Engl J Med*. 2007 Nov; 357(18):1834-40
13. Cornell Law School, Legal Information Institute. "Foreseeability" [Internet]; 2021. Available from: <https://www.law.cornell.edu/wex/foreseeability>. Accessed May 6, 2024
14. Owen DB. Figuring foreseeability. *Wake Forest L Rev*. 2009; 44:1277-308
15. Resnik DB. What are reasonably foreseeable risks? *Am J Bioeth*. 2013; 13(12):29-30
16. Brock DW, Wartman SA. When competent patients make irrational choices. *N Engl J Med*. 1990 May; 322(22):1595-9
17. Larkin GL, Marco CA, Abbott JT. Emergency determination of decision-making capacity: Balancing autonomy and beneficence in the emergency department. *Acad Emerg Med*. 2001 Mar; 8(3): 282-4

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18. Craigie J. Capacity, value neutrality and the ability to consider the future. *Int'l J L Context*. 2013 Mar; 9(1):4–19
19. Alhazami M, Pontinha VM, Patterson JA, Holdford DA. Medication adherence trajectories: A systematic literature review. *J Manag Care Spec Pharm*. 2020 Sep; 26(9):1138–52
20. Osterberg L, Blaschke T. Adherence to medication. *N Engl J Med*. 2005 Aug; 353(5):487–97
21. Banner NF. Unreasonable reasons: Normative judgements in the assessment of mental capacity. *J Eval Clin Pract*. 2012 Oct; 18(5):1038–44
22. Karel MJ, Gurrera RJ, Hicken B, Moye J. Reasoning in the capacity to make medical decisions: The consideration of values. *J Clin Ethics*. 2010; 21(1):58–71
23. MacIntyre MR, Darby WC, Sones AC, *et al*. Voluntary intoxication, homicide, and *mens rea*: Past, present, and future. *Behav Sci & L*. 2021 Mar/Apr; 39(2):150–69
24. Watterson RT. Just say no to the charges against you: Alcohol intoxication, mental capacity, and criminal responsibility. *Bull Am Acad Psychiatry Law*. 1991; 19(3):277–90
25. Schweikart SJ. Who makes decisions for incapacitated patients who have no surrogate or advance directive? *AMA J Ethics*. 2019 Jul; 21(7):E587–93
26. Moye J, Sabatino CP, Brendel RW. Evaluation of the capacity to appoint a healthcare proxy. *Am J Geriatr Psychiatry*. 2013 Apr; 21(4):326–36
27. Appel JM. Locating and identifying third-party decision-makers. *J Am Acad Psychiatry Law*. 2022 Mar; 50(1):84–96
28. Lee RY, Brumback LC, Sathitratanaheewin S, *et al*. Association of physician orders for life-sustaining treatment with ICU admission among patients hospitalized near the end of life. *JAMA*. 2020 Mar; 323(10):950–60
29. Srebnik DS, La Fond JQ. Advance directives for mental health treatment. *Psychiatr Serv*. 1999 Jul; 50(7):919–25
30. Series L. Relationships, autonomy and legal capacity: Mental capacity and support paradigms. *Int'l J L Psychiatry*. 2015 May-Jun; 40:80–91
31. Henderson C, Swanson JW, Szmukler G, *et al*. A typology of advance statements in mental health care. *Psychiatr Serv*. 2008 Jan; 59(1):63–71
32. Kemp K, Zelle H, Bonnie RJ. Embedding advance directives in routine care for persons with serious mental illness: Implementation challenges. *Psychiatr Serv*. 2015 Jan; 66(1):10–4
33. Swanson JW, Swartz MS, Elbogen EB, *et al*. Facilitated psychiatric advance directives: A randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness. *Am J Psychiatry*. 2006 Nov; 163(11):1943–51
34. DeMartino ES, Dudzinski DM, Doyle CK, *et al*. Who decides when a patient can't? Statutes on alternate decision makers. *N Engl J Med*. 2017 Apr; 376(15):1478–82
35. Swanson J, Swartz M, Ferron J, *et al*. Psychiatric advance directives among public mental health consumers in five U.S. cities: Prevalence, demand, and correlates. *J Am Acad Psychiatry Law*. 2006 Mar; 34(1):43–57
36. Bandy RJ, Helft PR, Bandy RW, Torke AM. Medical decision-making during the guardianship process for incapacitated, hospitalized adults: A descriptive cohort study. *J Gen Intern Med*. 2010 Oct; 25(10):1003–8
37. Zietlow K, Dubin L, Battles A, Vitale C. Guardianship: A medicolegal review for clinicians. *J Am Geriatr Soc*. 2022 Nov; 70(11):3070–9
38. Moye J, Naik AD. Preserving rights for individuals facing guardianship. *JAMA*. 2011 Mar; 305(9):936–7
39. Appelbaum PS. Preventing abuses in guardianship cases. *Psychiatr Serv*. 2023 Oct; 74(10):1108–11
40. Harkness DS. “Whenever justice requires”: Examining the elusive role of *guardian ad litem* for adults with diminished capacity. *Marq Elder's Advisor*. 2006; 8(1):1–29
41. Felthous AR. Competence to stand trial should require rational understanding. *J Am Acad Psychiatry Law*. 2011 Mar; 39(1):19–30
42. Marshall JR. Two standards of competency are better than one: Why some defendants who are not competent to stand trial should be permitted to plead guilty. *U Mich J L Reform*. 2004; 37(4):1181–225
43. Meisel A. The “exceptions” to the informed consent doctrine: Striking a balance between competing values in medical decisionmaking. *Wis L Rev*. 1979; 1979(2):413–88
44. Burke KM, Herb A, Swidler RN. Three stubborn misconceptions about the authority of health care agents. *NY St BA Health L J*. 2005; 10(3):63–70
45. Smith AK, Lo B, Sudore R. When previously expressed wishes conflict with best interests. *JAMA Intern Med*. 2013 Jul; 173(13):1241–5
46. California.Public.Law. CA Prob Code Section 3208 [Internet]; 2023. Available from: https://california.public.law/codes/ca_prob_code_section_3208. Accessed June 4, 2024
47. Marson DC, McInturff B, Hawkins L, *et al*. Consistency of physician judgments of capacity to consent in mild Alzheimer's disease. *J Am Geriatr Soc*. 1997 Apr; 45(4):453–7
48. Volicer L, Ganzini L. Health professionals' views on standards for decision-making capacity regarding refusal of medical treatment in mild Alzheimer's disease. *J Am Geriatr Soc*. 2003 Sep; 51(9):1270–4
49. Marson DC, Earnst KS, Jamil F, *et al*. Consistency of physicians' legal standard and personal judgments of competency in patients with Alzheimer's disease. *J Am Geriatr Soc*. 2000 Aug; 48(8):911–8
50. Braun M, Gurrera R, Karel M, *et al*. Are clinician's ever biased in their judgments of the capacity of older adult's [sic] to make medical decisions? *Generations*. 2009; 33(1):78–91
51. Cheung EH, Heldt J, Strouse T, Schneider P. The medical incapacity hold: A policy on the involuntary medical hospitalization of patients who lack decisional capacity. *Psychosomatics*. 2018 Mar-Apr; 59(2):169–76
52. Dressel J, Farid H. The accuracy, fairness, and limits of predicting recidivism. *Sci Adv*. 2018 Jan 17; 4(1):eaao5580
53. Szmukler G. Violence risk prediction in practice. *Br J Psychiatry*. 2001 Jan; 178(1):84–5
54. Higashi K, Medic G, Littlewood KJ, *et al*. Medication adherence in schizophrenia: Factors influencing adherence and consequences of nonadherence, a systematic literature review. *Ther Adv Psychopharmacol*. 2013 Aug; 3(4):200–18
55. Tohme F, Mor MK, Pena-Polanco J, *et al*. Predictors and outcomes of non-adherence in patients receiving maintenance hemodialysis. *Int Urol Nephrol*. 2017 Aug; 49(8):1471–9
56. Smith AR, Witte TK, Teale NE, *et al*. Revisiting impulsivity in suicide: Implications for civil liability of third parties. *Behav Sci & L*. 2008; 26(6):779–97
57. Nicholson TRJ, Cutter W, Hotopf M. Assessing mental capacity: The Mental Capacity Act. *BMJ*. 2008 Feb; 336(7639):322–5
58. Resnick P, Saxton A. Malpractice liability due to patient violence. *Focus*. 2019 Oct; 17(4):343–8
59. Kontos N, Taylor JB, Beach SR. The therapeutic discharge II: An approach to documentation in the setting of feigned suicidal ideation. *Gen Hosp Psychiatry*. 2018 Mar-Apr; 51:30–5
60. Trépanier G, Laguë G, Dorimain MV. A step-by-step approach to patients leaving against medical advice (AMA) in the emergency department. *Can J Emerg Med*. 2023 Jan; 25(1):31–42