Capacity in Pregnancy

Brandon Hage, MD

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How to use this material:

- Review slides individually or as a self study group.
- For questions, go to normal view and read the notes.

Learning Objectives:

- Understand the basic concepts and 4 core components of capacity
- Determine which clinical scenarios require different levels of capacity
- Understand ways in which capacity can be restored
- Determine surrogate decision maker in scenarios in which capacity cannot be restored

Outline:

- Capacity: Core Concepts
- Sample Clinical Case
- Capacity: 4 Components
- Capacity: Decisions requiring different levels of capacity
- Practice Scenario #1: Does patient have capacity?
- Practice Scenario #2: Does patient have capacity?
- Ways to to restore capacity
- How to determine surrogate decision maker

Introduction to Capacity: Core Concepts

- 4-factor model of capacity is considered standard of care
- Specific for one medical decision, clinical assessment by physician
  - Decision to accept a recommended treatment and refuse a recommended treatment are two separate decisions
  - Capacity vs. Competency: competency is a more global concept, legal determination by judge (though state-to-state variability in terminology)
    - *Clinical* vs. *Legal* Capacity
- Restricted to current moment of time
  - Capacity to make a medical decision should be reassessed if patient, surrogate, or even treatment team wishes to change the treatment plan
- All patients are assumed to have capacity unless proven otherwise
  - Includes patients with a history of serious mental illness

OPM feedback: this is a little tricky to follow – might want to break this into a few different slides. What are the 4 factors? (are you planning to introduce them here and expand on them later? can they be clearly numbered 1-4? remember, those giving this talk will NOT be experts in this field necessarily). Details on capacity v competency should be elaborated upon in a separate slide. Similarly, what is the difference in clinical and legal capacity (even if it's a one-liner or hyperlink to more information that would be helpful)

Patient BW, Scenario #1

BW

- 23-year-old G0P0→ new patient evaluation for evaluation of potential pregnancy
- Past psychiatric history
  - Diagnosis of schizoaffective disorder, bipolar type
  - Multiple psychiatric hospitalizations for erratic and dangerous behaviors and florid religious-themed hallucinations and delusions
  - Last discharged from a inpatient psychiatric hospital stay 4 months ago
    - Clinically stable, no active psychotic symptoms
    - Prescribed risperidone 4mg QHS at discharge
  - No fill history in 3 months
  - Several missed appointments with outpatient psychiatry

Patient BW, Scenario #1

- Screening appointment
  - No period in 2 months and 2 positive home urine pregnancy tests last week
  - Office urine pregnancy test positive
  - 8 weeks gestation based on LMP
  - Unplanned and is unsure who the father is
  - Not sure if she wants to continue with her pregnancy but is willing to undergo routine prenatal screening at this time and follow-up for her 12-week appointment
- **What additional psychosocial information is important to gather at this time?**

LH: good, very clear

Patient BW, Scenario #1

1. Any additional medical issues (HTN, diabetes)
2. Insight into psychiatric condition/medication adherence
3. Lethality history and current symptoms
4. Substance use (past and recent)
5. Support network and barriers to care (e.g., transportation, finances, housing instability)

- Past medical history: denies
- Past psychiatric history
  - Multiple inpatient hospitalizations for "family issues" and "misunderstandings"
  - Prescribed risperidone but stopped taking because she "did not like how it made her feel"
  - Denies any suicidal or homicidal thoughts, plans, or previous attempts
  - Endorses daily cannabis use to "calm her nerves", denies any other substance use
- Social history: lives with her mother, close with sisters, not currently in a relationship, completed high school,is not working, collects social security disability, no access to guns or weapons

Patient BW, Scenario #1

About two weeks after this initial appointment, BW called the clinic and expressed her desire to terminate her pregnancy. She was offered an earlier appointment to discuss her options, but she declined, stating that she did not have transportation earlier, and felt comfortable following up in two weeks to discuss her options then.

BW returns to her 12-week appointment and states that after thinking about her situation for the past month, desires termination of her pregnancy.

- **How do we determine if BW has capacity to terminate pregnancy at this time?**

Capacity: 4 Components (Applebaum Criteria)

1. **Communicating** a clear, consistent choice
2. **Understanding** the relevant information or current condition
   - What is the potential treatment?
   - What are the benefits/risks/alternatives of this treatment?
3. **Appreciating** the situation and its consequences
   - What do you believe is wrong with your health right now?
   - What is this treatment likely to do for you?
   - What will happen if you are not treated at this time?
4. **Reasoning** about treatment options/manipulation of information given
   - How did you come to accept or reject this current treatment?

*Each successive step requires a more complex answer and is theoretically more difficult to achieve

LH: good

Capacity: “Sliding scale” of risk/benefit ratio

- High risk/low benefit
  - e.g., signing out AMA: requires HIGHEST level of capacity to make decision
- High risk/high benefit
  - e.g., consenting to a C-section
- Low risk/low benefit
  - e.g., accepting Tylenol for a headache
- Low risk/high benefit
  - e.g., signing voluntary commitment: requires LOWEST level of capacity to make decision

Patient BW, Scenario #1

- At her 12 week appointment, BW reiterates again that she would like to pursue an elective medical abortion at this time. She expresses understanding of the dilation and curettage procedure as well as the risks involved. She understands that this procedure means that she will no longer be pregnant and that this is not reversible. She states that she has thought about the alternatives such as foster care or adoption but decided that these are not always good options for a newborn. She says that she came to this decision because she did not feel she would be a good mother at this time because she does not feel she is emotionally capable of caring for a young child, especially without knowing who the father is, and she does not want to put this burden on her mother.

Does BW have capacity to choose an elective abortion?

- **Communicating**: **yes**- has clearly and consistently stated she wants an abortion
- **Understanding**: **yes**- understands procedure involved, risks, as well as alternatives
- **Appreciating**: **yes**- knows she will no longer be pregnant, and this cannot be reversed
- **Reasoning**: **yes**- came to this decision using logical, sound thought

Patient BW, Scenario #2

- At her 12 week appointment, BW reiterates again that she would like to pursue an elective medical abortion at this time. After the dilation and curettage procedure is explained to her, she responds “sure that’s fine, do whatever you have to do, just get this baby out of me.” She states that foster care or adoption are not feasible alternatives because “no one would want this devil baby.” She understands that this procedure means that she will no longer be pregnant and that this is not reversible. She says that a “demon impregnated her” and has heard the voice of the Archangel Michael telling her that “if she does not get rid of her unborn child, that it will become the Antichrist and destroy the world.”

Does BW have capacity to choose an elective abortion?

- **Communicating**: **yes**- has clearly and consistently stated she wants an abortion
- **Understanding**: **unclear**- would need to ask further for further details
- **Appreciating**: **yes**- knows she will no longer be pregnant, and this cannot be reversed
- **Reasoning**: **no**- clear psychotic decompensation

* Failure on even one factor means she does NOT have capacity to make this decision at this time

** BY itself, a *history* of severe psychiatric illness does NOT preclude a person to have capacity to make a specific medical decision, but *active, uncontrolled* mental illness *may* impact capacity at one specific point in time

Risk Factors for Diminished Capacity

- Inpatient hospitalization (medical or psychiatric)
- Learning disability
- Intellectual disability
- Intoxication
- Delirium
- Neurocognitive impairment
- Uncontrolled psychiatric illness

What do you do if you are concerned that your patient does not have capacity to make a specific medical decision?

- If high-risk decision, do not hesitate to consult psychiatry
  - Inpatient: Psychiatry Consultation-Liaison Service
  - Outpatient/ED: Consider involuntary commitment if patient's behavior puts her at imminent risk of harm to self or others, or if she shows a clear inability to care for self
- Attempt to restore capacity
  - Verbal interventions (RESPECT)
    - Rapport
    - Empathy
    - Support
    - Partnership
    - Explanations
    - Cultural Competence
    - Trust
  - Pharmacological
    - If lack of capacity is due to acute psychiatric illness (delirium, psychosis, mania, depression), capacity could potentially be restored with appropriate medication management OR psychiatric hospitalization if appropriate

Failure to Establish Capacity in Patient: Surrogate Decision Maker

- Other names: health care proxy, health care agent

- In the case where a patient does not have the capacity to make a medical decision, an appointed person makes this decision *in the manner in which they think the patient would decide if they had capacity*, NOT *how the surrogate would decide if they themselves were in that situation*.
  - Our case: if BW lacks capacity to have an abortion, but her surrogate decision maker (who is against abortion) believes that BW would want an abortion if she had the capacity, then the surrogate decision maker should make the decision to allow BW to have an abortion.

Determining Surrogate Decision Maker

1. Patient already deemed incompetent by court
   a. **Legal Guardian**

1. Patient, when capable, decides who their surrogate/proxy is if they were to become incapable
   b. **Healthcare power of attorney in Advanced Directive**
   c. **Designated representative of living will**

1. Patient, previously capable, becomes incapable without establishing healthcare POA or living will*:
   2. **Spouse**
   3. **Adult children**
   4. **Parents**: In BW's case, mother would be surrogate if capacity cannot be restored
   5. **Adult siblings**
   6. **Adult grandchildren**
   7. **Other adults with knowledge of patient's preferences/values**

   ***Different for each state, but this is general order

- If there is an emergent indication for an intervention/procedure, then they can bypass a surrogate and do the procedure, but all attempts to locate a surrogate still need to be made.
- If there is no surrogate whatsoever available, medical team can go to court to establish surrogate decision-making rights.

Ross NE, Webster TG, Tastenhoye CA,et al Reproductive Decision Making Capacity in Women with Psychiatric Illness:A Systemic Review : Journal of the Academy of Consultation Liason Psychiatry 2022:63;61-70

Key Clinical Points:

1. A patient's capacity is specific for one medical decision, restricted to one period in time, and can be assessed by ANY physician

1. The amount of capacity a patient needs to make a specific medical decision is based on the benefit/risk ratio of that decision

1. All patients are assumed to have capacity unless proven otherwise, including psychiatric patients

1. To have capacity to make a medical decision, a patient needs to **communicate** a clear, consistent choice, **understand** current condition and potential treatment options, **appreciate** the situation and its consequences, and give sound **reasoning** about making the decision
   a. Failure in ANY of these concepts means patient does NOT have capacity to make this decision

1. Consult psychiatry if needed and attempt to restore capacity if possible (verbally, pharmacologically)

1. Know your state's hierarchy of surrogate decision making if patient's capacity cannot be restored

ACOG- has a document to address Capacity
ACOG-Committee Opinion -

Key References for Capacity in Pregnancy

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Core References on Principles of Capacity

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Useful Resources/Links

AMA Code of Medical Ethics Opinions on Consent, Communication & Decision Making

Merck Manual (Professional Version): Medicolegal Issues

No single link to all 50 states surrogate decision maker list, but most are easy to find by googling "*insert state* surrogate decision maker"

LH: this is terrific! very clear and concise, right for an OB audience