

Capacity in Pregnancy

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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 core components of a capacity evaluation
- 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: Does this patient have capacity?
- Ways to restore capacity
- Surrogate decision making



Introduction to Capacity: Core Concepts

- Physicians are required by law and medical ethics to obtain *informed consent* before initiating treatment
- Valid informed consent involves “disclosure of appropriate information to a competent patient who is permitted to make a voluntary choice” (Appelbaum 2007)
- Physicians evaluate the *capacity of a patient to make a medical decision*
- In other words, does this patient have the capacity to make this *single medical decision*, at this *current point in time*?



Introduction to Capacity: Four factor model (Appelbaum 2007)

Does the patient:

- 1) **Communicate** a clear and consistent choice
- 2) **Understand** the relevant information or current condition
 - What is the potential treatment?
 - What are the benefits/risks/alternatives of this treatment?
- 3) **Appreciate** 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) **Reason** about treatment options/manipulation of information given
 - How did you come to accept or reject this current treatment?



Introduction to Capacity: Core Concepts

The **4-factor model** of capacity is considered the standard of care (Appelbaum 1998, 2007)

- *Each successive step requires a more complex answer and is theoretically more difficult to achieve
- *Must have all four; failure a single factor means the patient does not have capacity to make this decision at this time



Introduction to Capacity: Core Concepts

- Capacity is a clinical assessment that can be performed by ANY physician (not just psychiatry)
- Determination of capacity is specific for a single medical decision and is restricted to the current moment in time
- The decision to accept a recommended treatment and the decision to refuse a recommended treatment are two separate decisions
- *Capacity vs. Competency:*
 - Competency is a global, legal concept (although states differ in terminology)
- All patients are assumed to have capacity unless proven otherwise
 - Includes patients with a history of serious mental illness

Risk Factors for Diminished Capacity

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

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

Sample Clinical Case

- Patient BW, 23 years old, G0P0: New pt evaluation for evaluation of ?pregnancy
- Past psychiatric history:
 - Diagnosis: schizoaffective disorder
 - Multiple psychiatric admissions for erratic/dangerous behavior, most recently 4 months ago
 - History of florid hallucinations/delusions
 - Currently clinically stable, was prescribed risperidone upon discharge

But:

- No fill history in 3 months
- Several missed appointments with outpatient psychiatry



Sample Clinical Case

- 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

Sample Clinical Case

- Screening appointment
 - Has missed period for at least two months
 - Took two home urine pregnancy tests last week, both positive
 - Office urine pregnancy test: positive
 - Approximately eight weeks pregnant per LMP
 - Unplanned, partner not in the picture
 - Not sure if she wishes to keep the pregnancy
 - But willing to do routine prenatal care and return for her 12 week appt



Sample Clinical Case

- Two weeks after the appointment, BW calls the clinic and expresses her desire to terminate her pregnancy (she lives in a state where voluntary termination of pregnancy is legal)
- She is offered an earlier appointment to discuss her options, but she declined, stating that she did not have transportation, 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, desires termination of her pregnancy
- How do we determine if BW has capacity to terminate pregnancy at this time?



Sample Clinical Case: Scenario #1

- At her 12 week appointment, BW reiterates that she would like to pursue an elective termination.
- 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 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 does not feel she is emotionally capable of caring for a young child, and she does not want to put this burden on her mother.



Does BW have capacity to choose an elective termination?

- **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



Sample Clinical Case: Scenario #2

- At her 12 week appointment, BW reiterates that she would like to pursue an elective termination 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.”

Sample Clinical Case: Scenario #2

- 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 termination?

- **Communicating: yes**– has clearly stated she wishes to terminate
- **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**– psychotic decompensation



If the patient is found to lack capacity

Attempt to restore capacity:

- Remedy reversible medical conditions/delirium (due to fever, hypoxia, etc.)
- Address acute psychiatric conditions: psychopharmacologic treatment and psychoeducation, consult psychiatry if high risk or when needed
- Utilize verbal interventions (RESPECT)
 - Rapport
 - Empathy
 - Support
 - Partnership
 - Explanation
 - Cultural competence
 - Trust

Surrogate Decision Making

- If the patient lacks capacity to make a medical decision, an appointed person acts as a *surrogate decision maker* (also called a health care proxy or health care agent)
- The surrogate decision maker must make this decision in the manner in which they believe the *patient* would decide if they had capacity, *not* how the surrogate would decide it for themselves

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.



Who is the Surrogate Decision Maker?

Patient, when capable, decides who their surrogate/proxy is if they were to become incapable, *with* an advanced directive or living will:

Advanced directive: healthcare power of attorney

Living will: designated representative

Patient is previously capable and becomes incapable *without* an advanced directive/living will (order differs by state):

Spouse

Adult children

Parents

Adult siblings

Adult grandchildren

Other adults with knowledge of patient's preferences

If patient is already deemed incompetent by a court, then their legal guardian acts as their surrogate decision-maker

Who is the Surrogate Decision Maker?

- If there is an *emergent* indication for an intervention/procedure, physicians 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.

Key Clinical Points:

- A patient's capacity is specific for one medical decision, restricted to one period in time, and can be assessed by ANY physician
- The amount of capacity a patient needs to make a specific medical decision is based on the benefit/risk ratio of that decision
- All patients are assumed to have capacity unless proven otherwise, including psychiatric patients
- 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
- Attempt to restore capacity if possible (verbally, pharmacologically)
- Utilize surrogate decision making if patient's capacity cannot be restored



Key References for Capacity

- Babbitt, K. E., Bailey, K. J., Coverdale, J. H., Chervenak, F. A., & Mccullough, L. B. (2014). Professionally responsible intrapartum management of patients with major mental disorders. *American Journal of Obstetrics and Gynecology*, 210(1), 27–31.
- Committee Opinion No. 664 Summary: Refusal of Medically Recommended Treatment During Pregnancy. (2016). *Obstetrics & Gynecology*, 127(6), 1189–1190.
- Zalpuri, I., Byatt, N., Gramann, S. B., Dresner, N., & Brendel, R. (2015). Decisional Capacity in Pregnancy: A Complex Case of Pregnancy Termination. *Psychosomatics*, 56(3), 292–297.
- Appelbaum, P. Clinical practice. (2007). Assessment of patient's competence to consent to treatment. *New England Journal of Medicine*, 357(18), 1834–1840.



Core References on Principles of Capacity

- Ross, N., Tinsley, G., Webster, T., Tastenhoye, C., Hauspurg, A., Foust, J., Gopalan, P., & Friedman, S. (2022) Reproductive Decision Making Capacity in Women with Psychiatric Illness :A Systematic Review. *Journal of the Academy of Consultation-Liaison Psychiatry, 63*, 61-70.
- Barstow C., Shahan B., & Roberts M. (2018). Evaluating Medical Decision-Making Capacity in Practice. *American Family Physician, 98*(1), 40-46.
- Sessums, L., Zembrzuska, H., & Jackson, J. (2011) Does This Patient Have Medical Decision-Making Capacity? *Journal of The American Medical Association, 306*(4), 420-427.
- DeMartino, E. S., Dudzinski, D. M., Doyle, C. K., Sperry, B. P., Gregory, S. E., Siegler, M., Sulmasy, D. P., Mueller, P. S., & Kramer, D. B. (2017). Who Decides When a Patient Can't? Statutes on Alternate Decision Makers. *The New England Journal of Medicine, 376*(15), 1478-1482.



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”

