Mental Capacity Assessments - panel, 2011-3-7

Thank you for the introduction, David.

I trust all of you received a copy of this handout, titled “Comprehensive assessments of competence in the elderly”.

Are there questions about the handout?

What I want to do is to go through a couple of clinical examples to illustrate a couple of the points in the handout. Before doing so, I need your assurance that you will not discuss any information about these cases outside of this room. Even a casual discussion with a colleague in an elevator could be overheard and possibly provide enough information so that the people involved could be identified. So can I count on all of you to keep the discussion inside this room?

For these cases, I want you to imagine that you are the clinician doing the assessment. So I will introduce the case, then I want you to ask questions about what additional information you want to have in order to do your assessment.

Here’s the first case.

Cases for seminar on assessment of competence

1. An elderly man, widower, no children, retired businessman. Had written a will naming his late wife and a trust company as co-executors; also had given a mandate in case of incapacity naming his late wife and the same trust company as co-executors.

   I receive a request to certify that the man is competent to give a mandate in case of incapacity, naming his late wife’s niece and her husband as co-mandataries; also to change his will, naming as co-executors the same two people.

   Concerns are expressed that the trust company fees are exorbitant, and that they may not respect the client’s wishes re where his funds should be invested or in which nursing home he should live.

   Also, the will is somewhat unclear on exactly which charities are to receive certain sums. To overcome this, it is proposed that the notary set up a foundation so that the client, the late wife’s niece, and her husband could meet weekly to decide which charity would get funds.

   The notary wants a letter certifying global competence.

   My findings:

poor memory, confused about the need to make changes in his will or mandate, lack of knowledge about the size of his estate, lack of understanding of the purpose of a foundation or about the process of setting one up.

My recommendations:

- at the time of my assessment, I felt that the patient did not possess the capacity to give a mandate in case of incapacity or to change his will.
- because of fluctuations in cognition, I could not predict future capacity.
- Close monitoring is essential, because the patient is at risk of being unduly influenced.

Important issues:

- Who would benefit from a finding of competence (cf handout, finding of incompetence)?
- Warning flags: absence of involved blood relatives; notary asking for global competence; setting up a foundation involves being able to manage one's affairs, which has more stringent requirements than capacity to give a mandate or capacity to testate; the foundation issue only came out when I specifically asked what changes they anticipated in the will to deal with the problem of charities being imprecisely named.

Second case:

An elderly man is in a nursing home, primarily for medical problems. A daughter has been managing his finances with a power of attorney, including an inaptitude clause. The man owns a house together with his older brother, who had been living in it. The older brother has recently been institutionalized, and so the house which is currently unoccupied must be sold. The notary involved in the sale would need either the man to be declared competent so he could sign for the sale of the house, or declared incompetent so that a mandate in case of incapacity naming the daughter, can be homologated.

The man expresses awareness of his medical conditions, and asserts that he wants to retain control over medical decision-making, while expressing satisfaction with his daughter managing his affairs and continuing to do so. The mandate does not provide specifically for separating out decision-making as to person and to affairs.

On examination, the man has clear cognitive impairments that preclude his participation in managing his finances. Thus, some sort of regime de protection is necessary so that the house can be sold.

We considered various ways of dealing with this, including the possibility of naming the daughter as a private curator with respect to affairs, and as tutor with respect to person.

The issue is resolved when, on further questioning, the man expresses the desire to

return home to live, without being able to articulate why he had been placed in a nursing home, or what kind of help he would need in order to live at home. Thus, I had no difficulty assessing him as being inapt as to person and to goods, and given the nature of his illness (vascular dementia), permanent inaptitude. I also put down "total" because that appears to be necessary for homologation of a mandate.

widowed many years. Salesman.
at one point, seemed unaware of having a daughter. Thought his sister was managing his affairs. ie fluctuations in level of awareness.
daughter lives in another province.
blood pressures often low; can cause fluctuations in cognitive functioning.

However, the patient is protected, since
In Quebec, even people who have been declared incompetent have the legal right to refuse treatment, and that refusal must be respected if it is consistent and persistent.

In both of these cases, I felt that the conclusions I reached and the recommendations I made, were in the best interests of my patients. And normally that is how doctors should operate. But doctors and other health professionals are also called upon to act in ways which may be against the patient's interest. In the area of assessment of capacity, these issues are particularly troubling, and I personally struggle with them every time I am asked to make an assessment. I hope that this panel will provide me with some guidance.

In general, health clinicians do what is called "patient-centered care", but in psychiatry that is frequently not really true. When I worked at Douglas Hospital or at the Jewish, and covered the emergency room for psychiatry, patients would typically be brought to the ER by concerned family or friends, or by a landlord, or by the police. In the case of people who were a danger to themselves or to others, my responsibility was clear: I could commit these individuals to the hospital if necessary, and in this way be acting for the state, rather than for the individual. And when teaching these concepts, I would make a distinction between the customer and the client. For example, if I were a car mechanic, and someone brings their car to me for repairs, the car is not my customer, even though I do work on the car. Similarly, if a spouse brings their depressed and suicidal mate to the ER, or the police bring a manic, physically assaultive person to the ER, my customer is the person doing the bringing, even though I work with the client that has been brought in. And my efforts are directed to satisfying my customer's needs even when that may be in conflict with the wishes of my client, the patient. In those situations, I really have no difficulty seeing myself as an agent of the state, particularly since the state is also paying for my services, through medicare.

But it becomes complicated when I do assessments of capacity. Here is a quote from a recent article by Michel Silberfeld, a psychiatrist at the University of Toronto:

“In conducting mental capacity assessments, assessors are participating in law enforcement”.

Dr. Silberfeld goes on to say that the medical and the legal professions hold divergent views about the role of experts; one view emphasizes the adversarial nature of the process, with the assessor being retained to advocate the position of the lawyer. The other view holds that the assessor should be impartial.

In almost all of the capacity assessments that I have been asked to do privately, I was acting on behalf of the lawyer retained by the patient, and I was aware of my bias in emphasizing findings that supported the mutual wishes of the patient and his or her lawyer. And in general, I turn down requests for assessment made by lawyers who are not working in the interests of the individual who is to be assessed.

But having a bias does not mean covering up reality. For example, if a client and their lawyer are seeking to have competency in a particular sphere established, I may find that in fact the person does not possess that capacity, and that is the report that I will make.

This has created difficulties on occasion, when the client is unhappy with the finding, and refuses to pay my fee.

This gets is to the point where my thinking, and probably that of many lawyers, diverges from Dr. Silberfeld’s. Dr. Siberfeld believes that the assessment belongs to the lawyer for legal purposes and not to the client. If this is so, why is it that the lawyer expects the client to pay me for my services? I think that whoever pays the piper calls the tune, and ultimately if the patient is paying for my services, then the report belongs to him or her, even if it does not say what they would like to hear. If I were an oncologist, would I avoid telling patients that they have cancer simply because they don’t want to have cancer?

I would appreciate hearing other people’s points of view on this issue.