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COMPREHENSIVE ASSESSMENTS OF COMPETENCE: A PSYCHIATRIST'S PERSPECTIVE

Henry Olders, M.D., F.R.C.P.C. *

From the point of view of a geriatric psychiatrist who does assessments of competence, there are a number of essential elements to consider, as well as some more nuanced issues.

Let's start with some core considerations: (1) competence is always presumed when the evidence is inconclusive; (2) competence is task- or decision-specific, such that assessments for each task or decision must be independent (for example, consent to treatment, refusal of treatment, choosing where to live, managing one's finances oneself, executing a power of attorney or a mandate in case of incapacity, or making a will); (3) the recommended intervention should be the least restrictive of autonomy, while adequately protecting the patient.

What Reports Include

A complete assessment of competence is typically multidisciplinary. A report from a social worker, addressing financial status, sources of income, type and number of expenses, availability of family or friends who can help, and risk for financial, physical, or emotional abuse is included. Additionally, an occupational therapist can also make a report, dealing with observed capacities in daily living activities such as paying bills, banking, preparing meals, or using transportation. Where indicated, a psychologist can provide an in-depth assessment of cognition and judgment.

Depending on individual circumstances – for example, if there is a history of being abused, unduly influenced, or of exercising poor judgment – the re-

* Geriatric Psychiatrist, Ste. Anne's Hospital, Ste-Anne-de-Bellevue, QC. Assistant Professor, Department of Psychiatry, McGill University.

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port should include information from relatives, friends, caregivers, and business or work associates. As a physician, I often make use of information from patient charts – whether hospital, nursing home, or CLSC home care. Along with medication lists, lab test results, and medical and psychiatric diagnoses, charts may include assessments by other psychiatrists, neurologists, occupational therapists, social workers, and psychologists. Particularly valuable are nursing observations regarding manifestations of anxiety, paranoia, losing or misplacing things (wallets, money), overtrusting behaviour (not locking doors, leaving valuables lying around, revealing financial information to strangers), episodes of wandering or fugue, and verbal or physical aggression. Signs and symptoms of depression, mania, psychosis, or delirium may also be reported by nursing staff.

Also essential from a physician's point of view is an accurate medical diagnosis. Some medical conditions can cause impairments of capacity that are temporary or perhaps partially reversible. A definitive opinion on competence should be deferred if the underlying problem has not been precisely determined, if the impairment can be treated, or if the patient's condition is likely to fluctuate.

Safety considerations are also crucial when assessing competence. This includes physical and emotional security, not only for the patient, but also for family members–spouses, children, and parents–who, like business partners or associates, may have financial interests that warrant protecting.

As for any medical intervention, a free and informed consent for the assessment to take place, given by either the patient or his/her legal representative, is a legal requirement. Even if declared incompetent, individuals have the right to refuse treatment, including assessment of capacity. In Québec, a consistent or persistent refusal can be overridden only with a court order.

Some Nuanced Issues

When conducting assessments, one should ask the question: who might benefit from a finding of incompetence? On occasion, a finding of competence may be requested when the patient appears incompetent. The question then becomes: who might benefit from a finding of competence?

This leads to the more general question: on whose behalf is the assessment being done? A physician assessor may feel under pressure to respond to the needs and wishes of several different parties with conflicting interests. The physician's first responsibility is to the patient, following the maxim "do no harm." However, psychiatrists in particular frequently act for the state (for example, to confine to hospitals individuals who present a danger to themselves

or others). Providing assessments which aid the judiciary in ruling on incapacity and appointing a legal representative can similarly be viewed as acting on behalf of the state or the community.

So the person who requests the assessment figures as a player. It may be a family member who is genuinely concerned with the patient's well-being, but it could also be someone who is hoping to benefit personally from a judicial declaration of incapacity.

The patient may be represented by a lawyer, as may the person requesting the assessment. What allegiance does the assessor owe to lawyers? The latter may exert pressure on the assessor to be part of an adversarial process, whereas the assessor, who has been consulted only to provide expertise, may view his or her role as impartial. But for Michel Silberfeld, a psychiatrist at the University of Toronto, assessors conducting mental capacity assessments "are participating in law enforcement."[1] Further, he argues that the assessment belongs to the lawyer for legal purposes and not to the client.

However, it is not the lawyer who pays for the assessment. In Canada, medically-necessary assessments are usually paid for by the publicly-funded health care system; however, there are many situations where the patient foots the bill, even when another person requested the assessment. Perhaps the question of whose interest should be put first, and to whom the report should be remitted, might follow the principle: "he who pays the piper calls the tune." Medical journals routinely require statements about potential conflicts of interest; assessment reports could include such statements as well.

In the Patient's Interest

Some reports should be "red-flagged"; examples include a one-page report with checkboxes; a non-specialist report for a complex medical problem; a report done during an acute care hospitalization, when the patient was likely in worse condition than when not in the hospital; a diagnosis of dementia based on a Mini-Mental Status Exam score; a report documenting the recent onset of cognitive impairment, fluctuations in performance, or the presence of depression; and a report done in the absence of involved family members (as friends or informal caregivers may attempt to take advantage of the patient), or when there is conflict between relatives.

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[1] Michel Silberfeld, "Overview of Mental Capacity Assessments" (2009) 12:9 Geriatrics & Aging 469.

My view is that the common good is best served when the physician puts the interests of his or her patient first and offers impartial expertise to the judicial system, much like a "friend of the court." Given that opinions can differ between assessors, I search for abilities, and not only for inabilities. I may look to the lawyer to help define what aspects of competence need to be assessed, and ultimately aim for a comprehensive report that will help move the process forward.