TRANSCRIPT OF EPISODE 12 OF BREAKING DOWN MENTAL HEALTH
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Syma Khan:

Hello, and welcome to our podcast, Breaking Down Mental Health, with myself, social worker Syma Khan, child and adolescent psychiatrist Dr. Heidi Burns, and nurse practitioner Dr. Christina Cwynar. We are excited to be joined by Dr. Ben Biermann to discuss capacity assessments. Thank you so much for joining us today, Dr. Biermann.

Dr. Bernard Biermann:

I'm happy to be here. Thank you.

Dr. Heidi Burns:

Dr. Biermann is a child and adolescent psychiatrist on faculty at the University of Michigan. His clinical work focuses mainly on hospital-based care, psychiatric emergency services, psychiatric inpatient, consult liaison and ECT treatments. He served as the medical director of the child and adolescent inpatient service for nine years until 2017, before devoting most of his clinical time to the psychiatric emergency services. Dr. Biermann's clinical and scholarly focus has been on adolescence with mood disorders and disruptive behaviors, treatment-resistant depression, and youth in crisis. He also has an interest in substance use disorders and dual diagnosis. None of our speakers today have any conflicts of interest or financial disclosures to share.

Dr. Biermann, can we just start with a definition? What's a capacity assessment?

Dr. Bernard Biermann:

A capacity assessment is basically a determination of decision-making capacity. It tends to come up in medical situations when a treatment is proposed and a patient is refusing to get that treatment, and it seems that there's an obvious benefit from the treatment and that the patient is saying that they don't want it. Or in another situation where a patient too-readily agrees to a treatment that might be invasive or have a long-term consequence, and there really doesn't seem to be much of a discussion around it, and it raises a red flag in the minds of the providers.

Dr. Christina Cwynar:

When thinking about doing a capacity assessment, what types of things need to be included in that capacity assessment?

Dr. Bernard Biermann:

Well, first of all, let me just say that capacity is almost assumed for most patients. It's a very intuitive sense. When we go about our daily business of treating patients, we just generally accept that they understand what we're talking about. We have their best interest at heart, and they have their best interest at heart. When a situation arises where a treatment is proposed, or suddenly the patient is acting differently or talking differently or making a decision that doesn't seem to make sense to the treatment providers, the question of their capacity comes into play. At that point we begin a discussion of whether the patient has what we call capacity. Would you like me to go into some of the elements of how we-

Dr. Christina Cwynar:

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Yeah, I think that would be great.

Dr. Bernard Biermann:

Sure. There are some fundamental questions that we ask ourselves, and generally there are four things that we need to determine. One is whether the patient has an understanding of the benefits, the risks, the alternatives to treatment, including absence of treatment. So, what happens if you get the treatment, what happens if you don't get the treatment? That understanding is fundamental, and that involves communication and so on.

The second is does the patient really appreciate those risks and benefits and alternatives? Do they seem to understand and grasp it and be able to talk about it in a reasonable manner? The third thing is that the patient has to have reasoning capacity. They have to be able to have a sense of what goes into their decision-making: What do I want from this treatment, what are some of the downsides of the treatment and so on, and be able to demonstrate that through discussion that they can do that. And fourth, they need to have the ability to communicate those choices. They need to be able to tell us and describe what it is that goes into their decision-making.

Those are the four main elements that are generally accepted in various states, actually around the world, in determining capacity.

Dr. Christina Cwynar:

Now, Dr. Biermann, you and I and Dr. Burns, and even Syma, we've been involved in a lot of different cases that we get consulted as a psychiatry team to complete a capacity assessment. One of the scenarios that comes up frequently is a question to leave against medical advice. For example, we see a lot of young adults with eating disorders. If we could maybe walk through a case scenario: We have a 19-year-old female who has anorexia nervosa who came in for refeeding, who has a BMI of 16 and is asking to leave against medical advice. What are some of the specific questions that you would maybe ask when talking and determining capacity for that kiddo?

Dr. Bernard Biermann:

That's an excellent scenario, and actually a very common one. One of the factors that goes into reasoning capacity, for example, is whether or not there is a condition that can be treated, or a temporary condition. For example, a person with severe depression might feel that they don't deserve a treatment or they're not worthy of it, and we know that we can treat that depression and change that temporary state of incapacity to one where the patient might make a reasoned decision.

In the situation of something like an eating disorder, by virtue of the fact that it's a disorder, the criteria for that is there's a distortion in terms of thinking, in terms of body image. So, calling in a psychiatrist or a mental health professional would be to make a determination whether the eating disorder is affecting the person's reasoning to the extent that they can't make a sound decision. And it's not always clear-cut. For example, you may have a patient with an eating disorder who actually has a healthy BMI. What we know about eating disorders, for example, we used to be very strict about weight criteria, and the thinking on that has changed over the years, so that somebody might be at a healthy BMI and might not be an immediate threat of dying when they leave the hospital. They may have some reserve, be able to... So, that reasoning capacity is sometimes questionable. It's a judgment call.

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If somebody has a BMI of 16, like you said, or their electrolytes are dangerously impacted, they're at risk of cardiac arrest because they have low potassium or something like that, it's a pretty clear-cut decision. We would say that this individual because of their illness does not have capacity to make that decision. Oftentimes a psychiatrist might be called in to assess the role of the eating disorder in capacity. That's a common scenario that we see.

Syma Khan:

I really appreciate your reflection, Dr. Biermann, on the important questions that need to be asked within a capacity assessment. What are some of the situations that health care providers may find themselves in when they're having to get support to explore capacity? I think that's an important question to ask as well. What does it mean to lack capacity?

Dr. Bernard Biermann:

Going back to those four criteria, let me talk about some of the questions that we might ask, because I didn't specifically go into that with your previous question. But some examples might be just a very open-ended, "What is your understanding of your condition? Why is it that you're in the hospital? What is it that we're treating? What are the options for your situation? What do you understand that your treatment providers have told you about your situation, and what are your options here? What is the importance of nutrition in your life and your health? Can you talk about that? What is it that would happen if you continued to not get adequate nutrition? Can you explain that to me?" So, some very general questions to get at the person's, number one, understanding of the risks, and also looking at their decision-making capacity.

I might ask a patient, "I understand that you're insisting on leaving and you don't like being in the hospital. Tell me what the risks are if you leave. What might happen to you tomorrow or the next day? What is it that would happen if you stayed? Is there something we could do to help you feel more comfortable, or to help you make the decision that we're advising you to make?" You might even ask, "What criteria do you use when you make decisions about your health? I'm curious about that, because I'm worried about you and I worry that if you leave the hospital you're putting yourself in medical danger. Tell me how you've come to this decision that you want to leave the hospital."

So, just some general questions like that can give us a sense of how the person communicates. Do they really understand what's going on? Is there something like anxiety that we can manage or treat? Or is this really driven by their eating disorder, that they are panicking at the thought of gaining weight or getting nutrition? So, those general open-ended questions.

The other thing is to assess their understanding. I might say, "Tell me back what I just told you in your words. Sometimes doctors throw out medical jargon or something you might not understand. So, tell me back in your words what you think I just told you." At some point it might become obvious that the patient is really lacking capacity, because they can't articulate their reasons and it's just based on emotion.

Dr. Christina Cwynar:

I think we've been in scenarios when working with patients that they truly don't know what the risks are of not having a treatment, or maybe even getting a treatment. Going back to the case scenario that we've been talking about, I've met with eating disorder patients who can very clearly articulate, "If I leave the hospital and don't continue to get the nutrition that I need, I'm at risk for cardiac arrest, I'm at

risk for arrhythmias, I'm at risk for X, Y and Z." And in those cases where they have full capacity, an understanding of this poor decision, they still have the right to poor judgment, which I think is really hard for care providers to understand and appreciate, that insight is different than judgment. Do you have any thoughts about that, Dr. Biermann?

Dr. Bernard Biermann:

Yeah. The patient doesn't have to agree with us in order to have capacity. A patient might determine that they don't want a treatment. A good example that we see in society right now is the decision about getting COVID vaccine. As we all know, an issue like COVID, there are political implications and beliefs about health and beliefs about autonomy, and as a society we have not dragged people in and made them get vaccinated. So, we might not agree with someone's decision, but we respect it and we believe that they have capacity.

When somebody has a mental illness, there is an interplay with capacity and mental health law. As a psychiatrist I can mandate that somebody get an evaluation or even get treatment if there's an immediate threat to their life and well-being. The classic example is somebody who's suicidal. A patient who makes the decision, "I want to kill myself," as a psychiatrist, I have an obligation to protect that person. If somebody is going to harm somebody else, or if somebody is psychotic.

With an eating disorder, it's a rare circumstance where somebody is in immediate threat of death. If we really think they are and we're exercising good medical judgment, then we can file a commitment petition and hold the person in the hospital against their will based on their mental illness. In the area of eating disorders, there is still some gray area because it's not the same as somebody, for example, who has an obvious psychotic disorder: somebody with schizophrenia, somebody with obvious delusions. Somebody with an eating disorder may be very bright, have good reasoning capacity, but still be impaired. And in that instance, we would have to turn to the mental health system in order to mandate their treatment.

Another example that we encounter is with substance abuse or addiction. We may have a person who is in the hospital because they just had an overdose and they were in the emergency room, they were resuscitated, they were given Narcan, and we know that they're at high risk of going back out and continuing to use drugs that are putting them at risk. We want them to get treatment and to abstain from substances, but they believe that they can be safe outside of the hospital. That's another area sometimes where we're at odds with true safety and the person's decision-making, and what the mental health code allows us to do and not to do. I think that's where some of our primary care physicians or emergency room physicians will call in psychiatry to make some of those distinctions about where does the person's illness leave off and their personhood or their actual decision-making capacity come into play.

Dr. Heidi Burns:

I think that's a good spot to ask a question about who is actually able to do a capacity evaluation, because you alluded to the fact that there are some situations where you might want a specialist's care or a specialist provider to come in and take a look at that situation and help make that decision. But who else is able to do that?

Dr. Bernard Biermann:

Well, actually, any medical provider can determine capacity. Capacity is a judgment call at any point in time around a specific decision, and it's a lot different than competence, which is a legal decision. A physician treating a patient who is proposing a treatment that a patient is refusing can make a determination about this person's ability to make that decision. For example, a patient might be delirious and confused and disoriented, and they need IV antibiotics because they're developing sepsis, and they might be just thrashing around and saying, "I don't like needles." A competent physician can insist that they get an IV, start the antibiotic in that situation.

When psychiatrists are called in, it's typically when a primary care provider, or any provider really, feels that they're not capable of making the determination. They might have a question or might not know that they're somebody who can make that determination. For example, if there's a patient who is schizophrenic and in the hospital needing to get IV antibiotics, and says, "I believe that I'm being poisoned. I don't think that there's antibiotic in that IV bag; I think you're trying to poison me, and I'm hearing a voice saying you're trying to poison me." A primary care doctor might call in a psychiatrist to determine that the person indeed does have psychosis, that they have schizophrenia, and as such through decision making capacity is impaired.

That's a long-winded answer to say that really any medical provider can determine capacity. Specialists are sometimes called in if there's a specific question that the primary care doctor feels that they are unable to answer, or if they want a second opinion. We can always in health care request a second opinion if we question our own judgment or don't have a clear answer.

Syma Khan:

Dr. Biermann, adding on our understanding of what is a capacity assessment, what does it mean when someone lacks capacity, what are the next steps if someone does lack capacity? What does that mean the medical team can do?

Dr. Bernard Biermann:

If an individual lacks capacity and we feel that a treatment is necessary, typically there's a couple of steps that they'll employ. One would be to turn to a family member or somebody who knows the patient well, and in most states they actually have a hierarchy of decision-making capacity. So, somebody who is married, we would typically turn to their spouse and ask them to make that decision for the patient, or a child of a patient, or a sibling, a close friend, somebody who knows the patient well, can make a decision on their behalf. Or any physician can always act in good faith. If a physician believes in an emergency situation that a treatment is required to save a person's life, then they can intervene, and the vast majority of instances would be protected under the law. So, lacking capacity means that we think this person is not capable of making a decision; somebody else now has to step in and make the decision for that person.

Dr. Christina Cwynar:

Dr. Biermann, you mentioned something a little bit earlier in the conversation that capacity assessment is a particular point in time for a particular question. So, somebody may have capacity for one decision but not the next, depending on their understanding of something. But how does that differ from competency?

Dr. Bernard Biermann:

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Competency is a legal determination that has to be made by a judge in court. Competency is a much more broad, constant, unchanging determination. For example, somebody with an intellectual disability, somebody who has an IQ of 40 and doesn't understand really what's going on without somebody else making that decision for them. A court can make the determination of competency in a situation or lack thereof, and that's a lot different than an individual with an average IQ, good reasoning capacity, who in a situation is impaired by an illness, by intoxication, by delirium, by a psychiatric condition. It's more static and global.

Dr. Christina Cwynar:

Along that same vein, Dr. Biermann, in talking about competency, oftentimes we are looking at potentially pursuing guardianship of an individual. What types of situations would we consider pursuing guardianship, and how do we make this recommendation to a family of a young adult?

Dr. Bernard Biermann:

Guardianship, like competence, is a legal determination. A guardian is somebody who is appointed by the probate court to make decisions on behalf of an individual. In that case it's an individual of majority age, so somebody over 18, who is not competent to make decisions. A classic example may be a parent of a child who has an intellectual disability. Up until the person is 18, the parent is allowed to make the decision for any child really, but when that person turns 18 and they're the age of majority, a family member or a close friend, really anybody, can submit an application for guardianship. Or actually, most people don't realize an individual can submit an application for their own guardianship to have a guardian appointed to them if they meet certain criteria.

Where it comes into play oftentimes in health care is, let's say there's an individual who requires frequent health care, or is in the hospital a lot, and they're 17 and a half and the parents are making decisions for them, and we know that they're going to be turning 18 soon, we begin a discussion with families about submitting a petition for guardianship. Then there's a legal hearing and a proceeding, and the judge appoints a guardian for the patient.

Guardianship can be full in terms of making decisions about the person's finances, where they live, all their healthcare decisions, or it can be specific to a particular aspect of the person's life, such as health care. Basically, if a person lacks capacity to make a decision and they're not competent to make decisions about their life, somebody petitions for guardianship and the court appoints it.

Syma Khan:

Oftentimes in the hospital we have those situations where we feel like a young adult that we're working with doesn't have capacity, so we pursue emergency guardianship to help formalize a decision-maker to help that young adult in their care. It's really helpful to have that court process in place to be able to then access additional treatment and formally support that young adult even after they leave the hospital, because if they are a competent adult, they can make their own healthcare decisions, they can decide who's involved in their care, but if there is a temporary guardian while they're currently dealing with a pretty significant mental illness, that that person can be involved in their care and help support them ongoing as well.

Dr. Christina Cwynar:

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I think bouncing off of that, Syma, we often encourage or support families in going down the guardianship pathway or emergency guardianship when there is those maybe consistent capacity assessments or more global capacity assessment. They're like, "Ooh, this young adult is really struggling to make their health care decisions in general," and it's not just that one specific question that they're struggling with, it's more of that global concern from the health team.

Dr. Bernard Biermann:

Exactly. So, capacity to make a medical decision is basically informed consent, a snapshot in time about a particular decision. If it's going to be an ongoing, chronic situation about all of their health care decisions, a guardian is essentially a surrogate decision-maker for the person, and we encounter them often. For example, when I do ECT treatments, there are some patients that are chronically mentally ill, have conditions like schizophrenia or autism with a comorbid intellectual impairment. Oftentimes their parent is their guardian, or a spouse. So, when we have them sign their consent for treatment, the guardian signs the consent and we proceed with the care.

I would say probably the most common scenario where we do this is with patients with intellectual impairments. That population of patients happens to be more prone to health conditions, so they need a lot of assistance in terms of navigating that territory.

Syma Khan:

And as a health care provider, I think if you're in a setting and you have concerns about a young adult that you're treating that may have some... If you're treating a young adult with an intellectual disability and you're uncertain if they're able to really comprehend the medical information you're providing and it's impacting their health, maybe that is a point to also consult an ethics team and to explore further about whether potentially they need a health care guardian to help them make those decisions.

Dr. Bernard Biermann:

Hospitals have ethics teams for these types of scenarios. Most of the time it's clear-cut. We deal with well-meaning families who have family members who are very beloved but impaired. So, it's obvious that the parents should be the guardian, or another family member. In a situation where the parents are impaired or unable to make decisions, it can be contentious. Sometimes we would involve an ethics discussion, or there are also professional guardians, people who work for the court system and are willing to step into that role, are trusted individuals in the community that are able to make decisions for patients. I encountered that very thing the other day in the psychiatric emergency room. We have an individual who is in need of inpatient psychiatric care, is estranged from family members, and actually has a community member who's been appointed as a guardian for this individual to help them make decisions.

Dr. Heidi Burns:

Thanks, Dr. Biermann. Could you explain how is capacity different between adolescents and adults?

Dr. Bernard Biermann:

That's a very interesting question, and it's one of those areas where there are no clear-cut answers in certain cases. If a person under 18 comes in and there's a question about their decision-making

capacity... First of all, I think we should back up and talk about the issue of the rights to health care for adolescents. That's something we often encounter. What sorts of services are minors, for example, able to have access to without parental consent? There are some circumscribed areas that are generally universally accepted. One area is reproductive health. A child, it's generally over the age of 14, can go to Planned Parenthood, for example, and seek birth control, get treatment for an STD, and just get assistance with reproductive decisions. Obviously, when it comes to sexual behaviors, most kids don't want to go to their parents and talk about these things, and they can get themselves in trouble and we want to help them make reasoned decisions. That's pretty carefully-protected by law.

In many states, a surgical procedure such as an abortion can't be performed without parental consent. That's one area. The other is seeking mental health care. There may be an individual under the age of 18 who wants to seek mental health care, and for whatever reason chooses not to discuss that with their parents. We may have a child coming from an abusive home, or a child coming from a situation where the parents don't believe in mental health care. We encounter that. Or a child who simply doesn't want to discuss their mental health issues with their parents. That individual can seek mental health care, and there are certain number of therapy sessions they're able to get depending on the state. The only thing that we can't do is hospitalize them without a parent consent, or prescribe medication without a parent consent. So, minors have certain rights under the law.

Another area that I didn't mention is substance abuse. Adolescents can seek substance abuse treatment. They can decide that they don't want their parents to see the results of a drug screen. There are certain protections under federal law that protect people who seek substance abuse treatment. So, those three areas for adolescents: reproductive health, mental health, and substance abuse treatment, are generally protected under the privacy laws in most states.

What happens in a situation where an adolescent is saying they don't want a treatment, and there really isn't a responsible parent to make that decision? So, an angry adolescent that doesn't want to take their insulin in the hospital. We would go through that same determination of capacity with that adolescent. Do they really understand? Do they have reasoning capacity? Are they able to communicate that, and so on. So, the same principles of determining capacity would be undertaken in that individual.

Syma Khan:

In those situations, would you often also engage the family? And how does a family, or more than a family, a parent's decision, also play a role in the adolescent's treatment?

Dr. Bernard Biermann:

A parent is legally allowed to make a decision. But for example, as mental health professionals, we very commonly treat kids in the hospital who don't want to take medication. We believe it would be helpful for them, their parents believe it would be helpful for them, and the parents are willing to give consent, but the adolescent decides they don't want to take the medication. In that situation, we would really spend time reasoning with them, trying to get them to come around, use therapeutic approaches, try to engage the family, try to engage a trusted individual such as a pastor, a member of the clergy, a school counselor, somebody that might have a relationship with the child or adolescent, and try to get them to really examine their thought process and make a determination. Am I just being stubborn because I'm an adolescent and I want autonomy? Or do I really believe I don't want to take this medication because of side effects, or I'd like a different treatment approach?

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So, generally we like to have what's called assent. A parent can give consent, but a child or an adolescent can give assent, which means they are in agreement, even if they don't legally consent for it. Going back to the example of ECT, we have kids that we treat with treatment-resistant depression, very severe depression that would benefit from ECT treatments, and in that case it involves a general anesthetic and it's a little bit more complicated than starting a medication. We would be very unlikely to do that procedure if we had a teenager just insisting that they didn't want to do it. We would get the consent from the parents and the assent from the adolescent.

I know of two cases in my career where it was felt to be an immediate life-threatening situation where we actually went to court and got a court order to do ECT in teenagers, but that would be a very rare exception. So, just as you mentioned, Syma, we typically try to involve others, spend some time discussing with the child, bring in parents or other trusted adults, before we would do something like go to the court system to overrule a child's decision.

Syma Khan:

It really seems like adolescents have a lot of autonomy in their care as well, unless it's life-threatening, where they're refusing a medication that may cause death. I think... the example of a child that needs insulin for Type 1 diabetes. But otherwise that adolescents can really choose aspects of their medical care, even if their parents are recommending it or their medical care teams are recommending it.

Dr. Bernard Biermann:

The other situation that sometimes happens is if we feel a treatment is necessary and the parent won't consent to it. Many families are nervous about mental health treatments, for example. We may encounter a child who comes in and had a suicide attempt, and we determine that the best course of action is an inpatient psychiatric hospitalization, and the parents aren't willing to allow that to happen. So, there are situations where we have to involve the legal system. We might contact social services and make a claim of medical neglect, and we might involve the court system. So, we do encounter those situations.

We like for adolescents to have autonomy and to make sound decisions about their mental health care, and adolescence is a very challenging time in our lives, and it's a very challenging population for health care practitioners to deal with. There's a reason why child and adolescent psychiatry is a subspecialty, and there's a reason why adolescent medicine is a subspecialty of pediatric care, because having the skills to deal with young adults and adolescents in that age group can be challenging.

I think it's important to consider where people are developmentally as well. What we know about the adolescent brain is that the reward centers, so the pleasure centers and peer influence and so on, the affiliative parts of our brain and the reward parts of our brain, are much more powerful than the cognitive higher-order thinking skills. So a kid, an adolescent, might insist on being discharged because they have a party to go to that they've been looking forward to, but they really need three more days of chemo or they need three more days of antibiotics. In that case, we would have to recognize this is an individual who lacks capacity. They're not exercising good judgment about their care by virtue of where they are developmentally, so we would have to step in and override that decision-making or involve the parents.

Syma Khan:

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I really appreciate the addition of developmental concerns, because recognizing that adolescence is a time when your brain is developing even as a young adult, we've talked about that in some previous podcasts, that our brains are still changing at that time. So, it can be hard to make well-reasoned decisions and include the multiple factors. I think this talk has really showed us that there are so many layers to medical decision-making and it's not really straightforward, and to utilize those supports as well, and to not feel like you have to make some of these decisions all by yourself if you feel like there's a sticky situation and you're uncertain about the ability of a young adult to consent, to maybe get those other teams involved.

Dr. Bernard Biermann:

Absolutely.

Dr. Heidi Burns:

I think the thing that strikes me when I think about capacity evaluations and the experiences that I have had doing them in the inpatient world is, a lot of times we end up not actually having to go forward with a capacity evaluation if someone will take a little bit of extra time to go in and discuss the procedure or discuss the fears around it, and just taking that little bit of time to spend with a patient before pulling the trigger on going for a capacity evaluation, which can be a contentious thing for a patient to go through. It's oftentimes clouded in miscommunications, and sometimes just spending a little bit of extra time with that patient and helping them, bringing them along with you and helping them understand why you might want them to do this and why you think it's good for them, is really worthwhile.

Dr. Bernard Biermann:

You make an excellent point. That whole idea of communication, understanding decision-making, is very nuanced. So, many of these decisions to refuse care are based on fear or heightened emotions. So, having somebody who is skilled at helping patients come down from a high emotional state to regulate their fears and just have a conversation, explore their understanding, would make a true capacity evaluation unnecessary. So, what starts out being a capacity evaluation can often turn into a half-hour therapeutic intervention where we acknowledge the patient's fears, we address the concerns that they have, look at their anger, their helplessness.

A good example of this is kids with chronic medical conditions, so a kid with cystic fibrosis who comes in the hospital every two months for antibiotics, and on a given day is just not wanting their breathing treatment. It's like, "I just don't want this. I'm angry. I don't care if I die. Go away from me." They may be having a bad day, and we can postpone the treatment for an hour and have a discussion, and do some therapeutic work with the patient to get them to come around and accept this unpleasant scenario, but it happens to be the reality of their life, and try to get them to use some perspective-taking and to make a different decision.

A couple other things that I didn't mention that I think are important here, one is communication skills or language barriers. Those sorts of things can come into play, so we want to make sure that the patient understands us, and think about the type of medical jargon that we use. That's where we're seeking clarification or using an interpreter if English is their second language, and there are some nuances that they might not understand.

The other area is cultural or religious beliefs. The classic example is the Jehovah's Witness who is refusing a blood transfusion, even if it might be life-sustaining. Most courts would determine that the

patient has a right to that autonomy, and we wouldn't be able to step in and do something against their will. That doesn't mean that they lack capacity. It means that a particular treatment or a particular intervention is contrary to their values as a human being, as a certain cultural or ethnic group, as a particular religion. So, sometimes we have to consider those things as well about our patients.

Dr. Christina Cwynar:

I definitely appreciate you bringing in the cultural aspect to things. I think just a couple months ago we had a young lady who was practicing Ramadan but had an eating disorder, and calling on our colleagues in spiritual care to help us with those conversations and help her see what she was doing was detrimental despite her religious beliefs, but also partnering with those people outside of the medical community to have those conversations. And you made another good point, Dr. Biermann, is a lot of times patients make decisions out of fear. And if we can just pause and figure out how to address that fear, we can still get them the medical care that they need. Is it that breathing treatment doesn't need to happen at 6:00 AM? Can we just do it at 7:00 AM when I'm a little bit more awake, or whatever it may be, to help the patient continue their care, but in a comfortable way?

Dr. Bernard Biermann:

As providers who do consult liaison work, every patient is different. We do things like, let's cluster our care. So, 2:00 is a good time. Come in, get the vitals, do the blood draw, bring in the consult teams, meet them all at one time, because this is a good time of the day for this particular patient. Just meeting the patient where they are can sometimes make a capacity assessment unnecessary, or avoid triggering a patient into a state that they might willfully, angrily refuse to get a treatment based on emotion.

Dr. Christina Cwynar:

And it would foster that ongoing patient-centered care approach, that family-centered care approach, as opposed to creating that contention that may happen.

Dr. Bernard Biermann:

One question that we sometimes forget to ask in the literature that I looked at on capacity is to ask the patient, "Do you trust your health care providers? Do you believe they have the competence and ability to make good decisions about your care? Or have you had experiences where you've had negative side effects or something go wrong, so you have grown to not trust health care providers? And what can we do to help you gain trust, help us gain trust with you, and show that we really do have your best interests at heart? That indeed there was a poor decision made about your health care six months ago, but we know better now, we have more information, so we're better able now to make a decision that you would agree with and that you find favorable.

Syma Khan:

Thanks, Dr. Biermann, for mentioning personal histories and the impact of trust as well, as we know that for many populations, health care hasn't been a space that's been supportive of them. For the black community, there are many examples of discrimination, of mistreatment provided. We need to be aware of things that have happened in histories from both a historical perspective, an individual perspective, trauma that they may have experienced. All those things I think really need to be considered when we're thinking about someone's capacity to make a decision.

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Dr. Bernard Biermann:

Another area that is much more prevalent in our culture now than 50 years ago is gender. We have patients who identify as non-binary or transgender, and have had negative experiences by being misgendered or misunderstood. I'm thinking of this because just recently I had a situation where a patient was seeking psychiatric care, and had had some very negative experiences around their gender identity that impacted their willingness to seek treatment further. They didn't want to put themselves in certain situations where they might be misunderstood or misgendered, but they really needed treatment. So, it was a matter of really taking the time to listen, to validate, to understand, to thank them for educating us around how to ask questions, how to respect their autonomy, their identity, their sense of personhood, and cut through some of those barriers that were present and very obvious in this situation.

Syma Khan:

We've had a really rich discussion about capacity, medical decision-making, and ways as health care providers we can help support our patients and their families. Any other thoughts, Dr. Biermann, that you'd like to share with our audience?

Dr. Bernard Biermann:

Just one other thought that I think is important is, there are some actual assessment tools and some instruments out there if we really need to do a formal capacity assessment and want to have a clear outline of some questions to ask. There are some well-known instruments out there. One of them is called the Aid to Capacity Evaluation, or the ACE assessment. It's available online, and it just is a series of questions where we can say yes, no or uncertain. Then the other thing is to document in the record that we've assessed capacity, and where possible to include quotes from the patient, particularly if we are determining that there is not capacity. We always want to rule in favor of patient autonomy when we can and err on the side of the patient. So, if we're we're documenting that there is not capacity, we really need to document that in the record and justify our decision-making around that. I think that's an important point to leave the audience with.

Dr. Christina Cwynar:

Thank you, Dr. Biermann, for joining us today, and spending this time with us and sharing your expertise. We really appreciate it. And to nurses, social workers and physicians, you can claim CMEs and CEs at UofMHealth.org/breakingdownmentalhealth. You're able to do this anytime within three years of the initial air date. And thank you to our audience who tuned in with us today, and we hope to see you guys next time.