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Decision Making and the Patient of Questionable Mental Capacity

Dentists confront many dental, medical, ethical and legal questions when dealing with mentally incapacitated patients and those with questionable mental capacity. Health care decisions are valid only when patients have the capacity to comprehend and consent to treatment – and patient capacity can be difficult to assess. As the number of older Americans continues to grow, this issue will affect greater numbers of dentists and patients.

There are no hard-and-fast rules to assure a dentist that the patient possesses or lacks capacity to consent to treatment. However, some capacity issues facing dentists are clear. Comatose patients are obviously not capable of giving informed consent. These patients are considered "generally incapacitated," meaning that they are incapable of making any life-determining decisions. A proxy decision maker with the requisite authority must make the consent decisions for such a patient.

In addition, emergency procedures may be completed regardless of the capacity issue in life-or-death situations, provided that the urgent need for intervention is clearly determined and documented. What may seem to be a "dental" emergency from the perspective of the dentist, patient, or patient's care giver, such as the extraction of a mobile and painful tooth, might not be deemed a true "life or death" emergency that would vitiate the requirement to obtain the consent to treatment from someone of capacity. Thus, dentists involved in questionable capacity situations must be cautions about decision making and treatment until all capacity issues have been resolved.

There are several basic tenets that a dentist should consider when capacity is at issue:

1. All adult patients are assumed to be capable of consent unless proven otherwise.

2. Only a court can officially designate someone as legally incapacitated.

3. Evidence of a good faith effort by the dentist to determine capacity will assist a dentist if the capacity issue arises after initiation of treatment.

4. There is no standard procedure that a dentist can utilize to evaluate and unequivocally prove capacity.

However, there is information that can assist the dentist. A 1982 report issued by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research included a three-part test for decision making ability. According to this study, to be considered to have the requisite capacity, the patient must:

- Possess a set of values and goals

- Be able to communicate and understand information

- Have the ability to reason and deliberate about choices

The following questions could assist a dentist is determining and documenting a patient's capacity to understand and consent to treatment.

Does the patient possess a set of values and goals?

- Question the patient about his or her daily routine. Ask why the patient does certain things (eating meals, taking medication, reading, watching television, discussing information with a caretaker).
- Ask the patient to list the five most important things he or she does every day.
- Ask the patient to describe his or her most pressing personal issue.
- Ask the patient to describe the most pressing issue for the country.

Is the patient able to communicate and understand information?

- Ask the patient to describe the reason for the visit to your office.
- Give the patient a simple explanation of treatment needs, and ask the patient to repeat the information to you.
- Ask the patient for the following information:
    - Date of birth
    - Age
    - Current address (the patient may not know the street address, but may know the location, e.g. "my daughter's house," or "All Care Nursing Home")
    - The name of his or her closest relative
    - The name of the person that should be contacted in an emergency

Does the patient have the ability to reason and deliberate about choices?

- Before you suggest any treatment, ask the patient if they have any suggestions about the treatment needed. Evaluate the sensibility of that information.
- Ask the patient to describe one or two problems that may arise if treatment is not completed.
- Ask the patient to list one or two positive benefits of the treatment you have recommended.

Legal Status of Proxies

Traditionally, patients' family members were relied on to make treatment decisions for incapacitated patients. The family was considered the proxy, even without formal designation. This view was endorsed in the 1976 New Jersey Supreme Court decision, *In the Matter of Karen Quinlan*, in which Karen Ann Quinlan's father was allowed to serve as his comatose daughter's surrogate decision maker.

Consequently, several states enacted statutes dealing with proxy designation through the appointment of a durable power of attorney for health care decision making. These statutes permit adults with the requisite capacity to appoint a proxy authorized to give or withhold consent for health care treatment if

the designator becomes incapacitated. Dentists were legally bound to recognize the surrogate's authority unless the appointment was overturned in court.

In 1990, however, the U.S. Supreme Court limited the authority of families to end life-sustaining treatment for incapacitated patients. The Court's decision in *Cruzan v. Director* opinion held that, while competent patients have the right to refuse unwanted treatment, states are not constitutionally prohibited from enacting laws mandating continued treatment to incapacitated patients when there is no "clear and convincing" evidence, such as a living will, to document that the patient would refuse it. Thus, states are not required to follow undocumented dictates from family members acting in the name of an incapacitated patient. In a 2001 decision, the California Supreme Court concluded that without clear and convincing evidence that a patient would have chosen to die, California law does not authorize a court-appointed conservator to approve withholding of life-sustaining nutrition to a conscious yet severely impaired individual who is not in a persistent vegetative state or terminally ill. While California law permits competent adults to determine how their health care will be handled should they lack capacity to consent to treatment, this case involved a court-appointed conservator rather than a living will or durable power of attorney for health care. *Wendland v. Wendland,* No. S087265, CA., 8/9/01.

The *Cruzan* decision and its progeny have encouraged patients to write advance directives. In addition, Congress responded by enacting the Omnibus Budget Reconciliation Act of 1990, which, in part, amended Chapter 18, Part C, of the Social Security Act. The amendments require, among other things, that hospitals and other health care institutions participating in Medicaid and Medicare programs provide patients with information upon admission about their rights under state law to execute advance directives and document in patients' medical records whether or not the patient has done so.

Encouraging Advance Directives

After *Cruzan*, one should no longer assume that undesignated family members may routinely serve as health care proxies. Although *Cruzan* does not address the issue of whether a state would be compelled to defer to the decision of a surrogate in the face of substantial evidence indicating that this would reflect the patient's wishes, the decision supports the view that incapacitated patients who have previously prepared a written document detailing their treatment choices and naming a health care decision maker are more likely to have their requests granted than those who lack such a document. (In some states, courts have accepted oral statements as compelling evidence of patient desires.)

It is in both the dentist's and the patient's interest to encourage the preparation of advance directives. While living wills and designated surrogates do not answer all of the ethical and legal questions raised by incapacitated patients, they extend a patient's self-determination, provide guidance for the dentist, and reduce potential conflict and stress.

Unfortunately, relatively few Americans – between 17 and 24 percent, according to recent studies – have prepared living wills or assigned durable power of attorney for health care decisions. Among the reasons so few patients have prepared advance directives:

- *Health care providers rarely mention them.* According to a 1991 study of California health care providers, only 19 percent of health care providers acknowledged that they introduced the topic of a durable power of attorney to their patients – often because they themselves were not well informed on the issue.

- *Practitioners do not or cannot always seek patient input about treatment decisions for institutionalized patients.* Dentists who provide care to an institutionalized patient are often unaware of, or unable to evaluate, the patient's mental capacities, and may make the wrong assumption regarding a patient's mental capacity. In addition, the dentist may be unaware of, or unable to determine, whether or not a patient has been adjudicated incompetent, and, if so, who has been assigned as legal guardian.

What Dentists Can Do

Early communication between patients, their families and their dentists is the key to minimizing informed consent problems if capacity later becomes an issue. Important decisions should be made and preferences discussed early in the relationship, long before the patient becomes incapacitated. When the treatment relationship begins subsequent to incapacity, contact the patient's previous treating dentist and/or physician to discuss any advance directive arrangements the patient may have implemented during previous treatment. Obtain copies of any documentation they have of those arrangements. Make notes of these discussions in your own patient records. In addition, the following tips can encourage discussion about advance directives.

- Understand federal and state statutes addressing advance directives. Be able to explain them to patients. Have written material and sample forms on hand for patients to review with family members and legal and financial advisers. Hospitals where you or your colleagues have staff privileges may also offer instructional documents and services.

- Talk about advance directives with patients before they're involved in a dental crisis. This will provide an atmosphere conducive to rational discussion, rather than in the context of a dental emergency. Actively encourage patients to write advance directives.

- Discuss with patients your own position on this issue to see if you're compatible and capable of coming to joint treatment conclusions. With this knowledge, you can avoid later conflicts caused by clashing ideas or ideals.

- Include advance directives and related material in the patient's chart. Don't search for the directive after the emergency arises – the patient may not be able to help you at that point. Send a copy of the advance directive to any hospital or nursing home that admits the patient. This should be done at each admission.

- Document your discussions with family members as well as patients. Have the patient co-sign the documented discussion in the clinical record.

- Refer especially difficult cases to your dental association's ethics committee. Encourage your dental society or association to form an ethics committee to be available to assist members with difficult decision making. These committees may include a cross section of dental and other health care providers, lay people and religious leaders.

A Sample Case

The following fictitious case illustrates some of the complex issues in dental decision making for physically or mentally incapacitated patients.

> *Barbara Parker presents to the office of Jack Michaels, D.D.S., for evaluation and treatment of acute periodontitis in teeth seven, eight and nine. The 79 year-old Mrs. Parker has been mentally disoriented for several years, necessitating a live-in home care companion to assist her with her daily activities. Mrs. Parker's only daughter comes to see her weekly and actively participates in day-to-day decision making for her. However, Mrs. Parker is her own legal guardian, and has never been adjudicated incompetent by a court. Her daughter brings her to the dentist's office.*
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> *According to her daughter, Mrs. Parker suffered a stroke several years before, which has left her with impaired mobility and facial muscle weakness. She also has partially controlled hypertension, adult onset diabetes and Crohn's Disease. The daughter states that her mother, when lucid, says that she is very concerned about her appearance.*

Mrs. Parker has a full complement of teeth, all of which exhibit moderate to severe periodontal disease. Dr. Michaels determines that the most appropriate emergency treatment would be the removal of the three upper anterior teeth and an abscessed lower second molar. Based on the condition of the remaining upper teeth, neither fixed nor removable replacement of the upper anteriors would be advisable. It is clear from his examination that full mouth extractions would be the treatment of choice in the near future. However, it would be difficult to fabricate a clinically acceptable full set of dentures for Mrs. Parker, and her lack of facial muscle tone and control would make any removable prosthesis difficult for Mrs. Parker to use.

The daughter is very unhappy with these treatment options, as they will significantly compromise her mother's appearance. She is adamant that Dr. Michaels find an option that could retain or replace teeth seven, eight and nine. She refuses to acknowledge the potential need for full mouth extractions. Against his better judgment, Dr. Michaels begins to discuss other treatment options with Mrs. Parker's daughter.

While they are conferring, the receptionist receives a call from one of Mrs. Parker's sons, who had been at odds with his siblings for many years over the care of his mother. He is the sole co-signer on her checking account, and he pays all of her bills. He wants to comply with what he believes are his mother's wishes to conserve her assets, and asks Dr. Michaels to perform the least expensive appropriate care. The son does not believe that his mother would be more concerned about her appearance than her finances. He is certain that she is in pain, and is worried that her diabetes will complicate her condition if it is not dealt with immediately.

Because the patient is unable to comprehend her options and consent to treatment, her wishes relating to dental care cannot be determined. There is no document which memorializes her desires concerning her oral care, her appearance or her financial matters. Since she does not have a legal guardian to make her decisions, she is the only one who is legally authorized to make these decisions.

Dr. Michaels knows she must receive care soon. In order to provide this care, he must contend with opposing instructions given by quarreling siblings. Without the son's cooperation, it is doubtful Dr. Michaels would receive payment for any services rendered to Mrs. Parker. Without the daughter's cooperation, it is unlikely that Dr. Michaels will be able to perform any treatment for Mrs. Parker. He is uncertain whether or not either of the children actually has the legal right to give him consent to treat Mrs. Parker. It seems that no matter what he does, someone will be very upset, informed consent standards may be breached, and the health of the patient may be compromised.

This fictitious example shows that, in the absence of an advance directive documenting a patient's treatment desires, or without the appointment of a durable power of attorney for health care or dental care decision making, clinical decision making can become exceedingly problematic for both incapacitated patients and their dentists.