Competency assessment of medical and psychiatric patients under Maryland's Health Care Decisions Act

Jeffrey S. Janofsky, M.D.

Dr. Janofsky is director of the psychiatry and law program at The Johns Hopkins University School of Medicine.

ABSTRACT: *The Health Care Decisions Act provides considerable flexibility and autonomy for patients regarding advance directives and surrogate decision making and clarifies how patients can tell their physicians and the world in general what they would like to have happen if they become incapable of making their own health care decisions. The law, however, is complex. This article provides help for physicians in interpreting some of the Act's clinical and legal ramifications.*

The Health Care Decisions Act,[1] which became law in Maryland in October 1993, clarifies what physicians should do if, on the basis of clinical assessment, they judge a patient to be clinically incompetent. Under the Act, patients are considered incompetent if they are "incapable of making an informed decision about their own health care." Although technically *competency* is a legal term and only a judge can declare a patient legally incompetent, physicians frequently assess patients' capacity to make informed decisions about their health care. This capacity is often termed *clinical competency* or *medical capacity*. In the present discussion, the terms *competence* and *competency* are used to refer to clinical capacity as assessed by physicians, rather than to a legal status pronounced by a judge.

Assessing competency

All adult patients are presumed competent to make medical treatment decisions for themselves. Many patients who initially disagree with their physician's advice have appropriate concerns about the proposed treatment. Time spent by the physician with the patient and family often results in agreement among the parties about what is best. Questions about competence usually arise in the clinical setting when the patient, physician, and family cannot agree on the best course of action. In this situation, the

Reprints: Jeffrey S. Janofsky, M.D., 30 E. Padonia Rd., Suite 206, Timonium, MD 21093

physician's first responsibility is to clarify the nature of the problem, for it may not be one of competency at all.

In the process of clarification, the physician should think clinically before thinking legally. Clinical thinking often reveals that what appears to be a problem in competency is actually a problem in communication (e.g., the patient or family does not understand the proposed treatment; the physician does not understand the patient's fears) or a problem in relationships (e.g., the physician has slighted the patient, whose response is to frustrate the physician's efforts; a disagreement between the patient and family has more to do with preexisting quarrels than with the patient's current medical situation). In most cases, members of the treatment team are able to recognize and address such issues; if resolution of the problem proves difficult, a consultation from the psychiatry service may be helpful.

Even when it is clear that the patient's competence to make medical decisions is impaired, physicians should still think clinically before thinking legally. This is important because the first question to be answered in the assessment of competence is, Competent to do what? The patient may well have the capacity to understand and decide about a straightforward, safe, minor treatment, but not a complex, risky, major one. Judgments about competence are therefore made in a context that includes not only the patient's mental state, but also the nature of the decision to be made.

Once the assessment of competence is undertaken, a thorough history and examination of the patient's mental state are required. The goal is to document phenomena (e.g., coma, delusions, hallucinations, dementia) that might affect the patient's capacity to make the decision in question. A quantitative test of cognitive functioning (e.g., the Mini-Mental State Examination[2]) should be part of the evaluation. Assessment of whether the patient has a factual understanding of the proposed treatment, including its benefits, risks, and alternatives, is also important. If the clinical judgment is that the patient truly lacks the capacity to make informed health care decisions, the physician has four choices.

Options in the absence of competence

Guardian or health care agent. First, if the patient has a previously appointed guardian or health care agent under an advance directive, the physician should read the guardianship or advance directive document to see if it allows the guardian or health care agent to consent in place of the incompetent patient. Consultation with an attorney is useful when the document is ambiguous.

Wait until competency returns. Second, if the patient does not have a guardian or health care agent, the physician could choose to take no action until the patient returns to competency. This approach is indicated when the proposed treatment is not urgent and the patient is suffering from a disorder (e.g., intoxication, delirium) that is expected to resolve.

Intervention without informed consent. Third, in certain circumstances, the physician can intervene without informed consent. The Health Care Decisions Act authorizes treatment without consent in a medical emergency if the attending physician determines that "there is a substantial risk of death or immediate serious harm to the patient and, within a reasonable degree of medical certainty, the life or health of the patient would be affected adversely by delaying treatment to obtain consent." This determination should be documented in the patient's chart using the language of the preceding sentence.

Surrogate. Finally, a surrogate can be appointed for a patient who is clinically judged incapable of making an informed decision. Before using a surrogate decision maker, the attending physician and a second physician, "one of whom shall have examined the patient within two hours of making certification, shall certify in writing that the patient is incapable of making an informed decision regarding the treatment." Although the two-hour limit applies to only one physician, the other also must have personally examined the patient.

Surrogate decision makers

The following individuals or groups, in order of priority, may make surrogate decisions for a patient:

- a guardian, if one has been appointed;
- the spouse;
- an adult child;
- a parent;
- an adult sibling; or
- another relative or friend who meets specific requirements (the Health Care Decisions Act requires that an affidavit be executed and in such circumstances, an attorney should be consulted).

Individuals in a particular surrogate class may be consulted only if all individuals in the next higher class are unavailable. Although surrogate decision making *cannot* be used for sterilization or treatment of a psychiatric disorder, it can be used if a psychiatric disorder causes the patient to be incapable of making an informed decision about the treatment of nonpsychiatric disorders. If surrogate decision makers disagree about the best course of action, or if the physician believes a surrogate is not acting responsibly, the case should be referred to either the legal office or the psychiatric consultation service for further help.

Guardianship is the traditional method for legally appointing a surrogate decision maker. When the above-noted surrogate process cannot be used (usually because no surrogate is available), guardianship is the only remaining option. The guardianship process requires a formal judicial hearing during which the patient has the right to be present, have counsel, present evidence, and cross-examine witnesses. A judge determines whether the patient meets the legal definition of incompetency and, therefore, whether a guardian should be appointed.

The guardianship process is complex and expensive, but it can be expedited. Most hospitals have policies and procedures for initiating a guardianship proceeding. A psychiatric consultation can be helpful in the clinical assessment of a patient for whom guardianship is being requested.

Psychiatric hospitalization

Admission of patients to a psychiatric hospital is even more complicated. For the past 30 years, psychiatrists have attempted to maximize voluntary admission to psychiatric hospitals and minimize involuntary admission, which in part has been accomplished by persuasion. In other cases, however, patients who may not have been fully capable of making an informed decision about voluntary admission and who gave no indication that they were unwilling to be a patient in the hospital were allowed to become voluntary patients. That is, psychiatrists have allowed patients to *assent* to be voluntary patients when they may not have been competent to give fully informed *consent* to hospitalization as voluntary patients.

A recent Supreme Court case now calls this practice into question.[3] David Burch, later diagnosed as paranoid schizophrenic, was found wandering along a Florida highway, bruised, bloody, and disoriented. He was taken to a community mental health center, where he was found to be hallucinated and confused; he thought he was "in heaven." He signed in voluntarily to a local hospital and three days later signed in voluntarily to a state hospital. No inquiry as to Burch's competence was made at either facility (Florida law requires that a voluntary patient must make application by "expressed and informed consent"). Burch remained hospitalized for five months without a review of his voluntary status. He later sued, claiming that he was not competent to sign in voluntarily to the hospital. His suit was dismissed at the trial court level. Burch appealed and his case was subsequently heard by the U.S. Supreme Court, which decided the case on a technical legal issue unrelated to the issue of voluntary psychiatric hospitalization. In its discussion, however, the court commented that the manner of Burch's confinement "clearly infringed on his liberty interests."

Like Florida, Maryland currently requires a voluntary patient to be competent. To be admitted voluntarily to a psychiatric hospital in Maryland, a patient must

- have a treatable mental disorder;
- understand the nature of the request for admission;
- be able to *give continuous assent to retention by the facility*; and
- be able to *ask for release* [emphasis added].[4]

Thus, it can be argued that to be voluntarily admitted to a psychiatric hospital in Maryland, a patient's competency to give informed consent for admission must be assessed.

The Health Care Decisions Act addresses part of this difficulty. In Maryland, advance directives can be either in formal written legal language or in oral form from a discussion with the treating physician that is subsequently documented in the patient's medical record. The advance directive can be broadly or narrowly drafted and can include authority to appoint a health care agent. The advance directive could give the health care agent the authority to admit the patient to a psychiatric hospital if the patient becomes incompetent at some point in the future.

The foregoing means, in effect, that unless a patient has an advance directive specifying that his or her health care agent can admit the patient voluntarily to a psychiatric hospital, a patient who is not competent to understand the voluntary admission process may not be voluntarily admitted to a psychiatric hospital. Guardians are forbidden by statute from signing a patient voluntarily into a psychiatric hospital.[5] Surrogate decision makers under the surrogate decision-making statute are also forbidden. Thus, without a previously written advance directive, there does not appear to be a method for providing psychiatric hospitalization for an incompetent, non-dangerous, non-objecting patient.

Until this situation is changed, psychiatrists can minimize future risk to their patients by encouraging them to formulate an advance directive. An oral advance directive can be fashioned from a discussion between patient and physician by indicating in the patient's medical record that

- at the time of the discussion, the patient was competent to make informed decisions regarding his or her health care;
- the patient wishes to be voluntarily admitted to the hospital if he or she becomes incompetent and requires psychiatric hospitalization; and
- the patient appoints a health care agent.

The physician should review these notations in the presence of the patient and one witness. The physician and the witness should then sign the medical record entry. If the patient subsequently seeks voluntary psychiatric admission and is not competent to do so, the health care agent could then sign the voluntary admission form.

Table 1 and **Figures 1-7** may help physicians appropriately apply this area of law. Several aspects of the Health Care Decisions Act, however, are open to interpretation (see annotations to the figures). Physicians who are unclear about legal (rather than clinical) aspects of the Act are advised to seek legal counsel.

Table 1. Admissions decisions for medical and psychiatric patients thought to be not clinically competent

	Voluntary psychiatric admissions	Medical treatment *without* risk of a substantial harm to life	Medical treatment *with* risk of a substantial harm to life	Psychiatric treatment (not voluntary admission) *without* risk of a substantial harm to life	Psychiatric treatment (not voluntary admission) *with* risk of substantial harm to life
Guardian of the person	no	maybe*	maybe,* with the court's authorization	maybe*	maybe,* with the court's authorization
Surrogate decision making	no	yes	yes	no	no
Durable power of attorney for health care executed prior to Health Care Decisions Act (10/1/93)	maybe*	maybe*	maybe*	maybe*	maybe*
Advance directive under the Health Care Decisions Act	maybe*	maybe*	maybe*	maybe*	maybe*

** Read document to see if it specifically allows the class of treatment being considered. If uncertain, obtain a legal consultation.*

Figure 1.

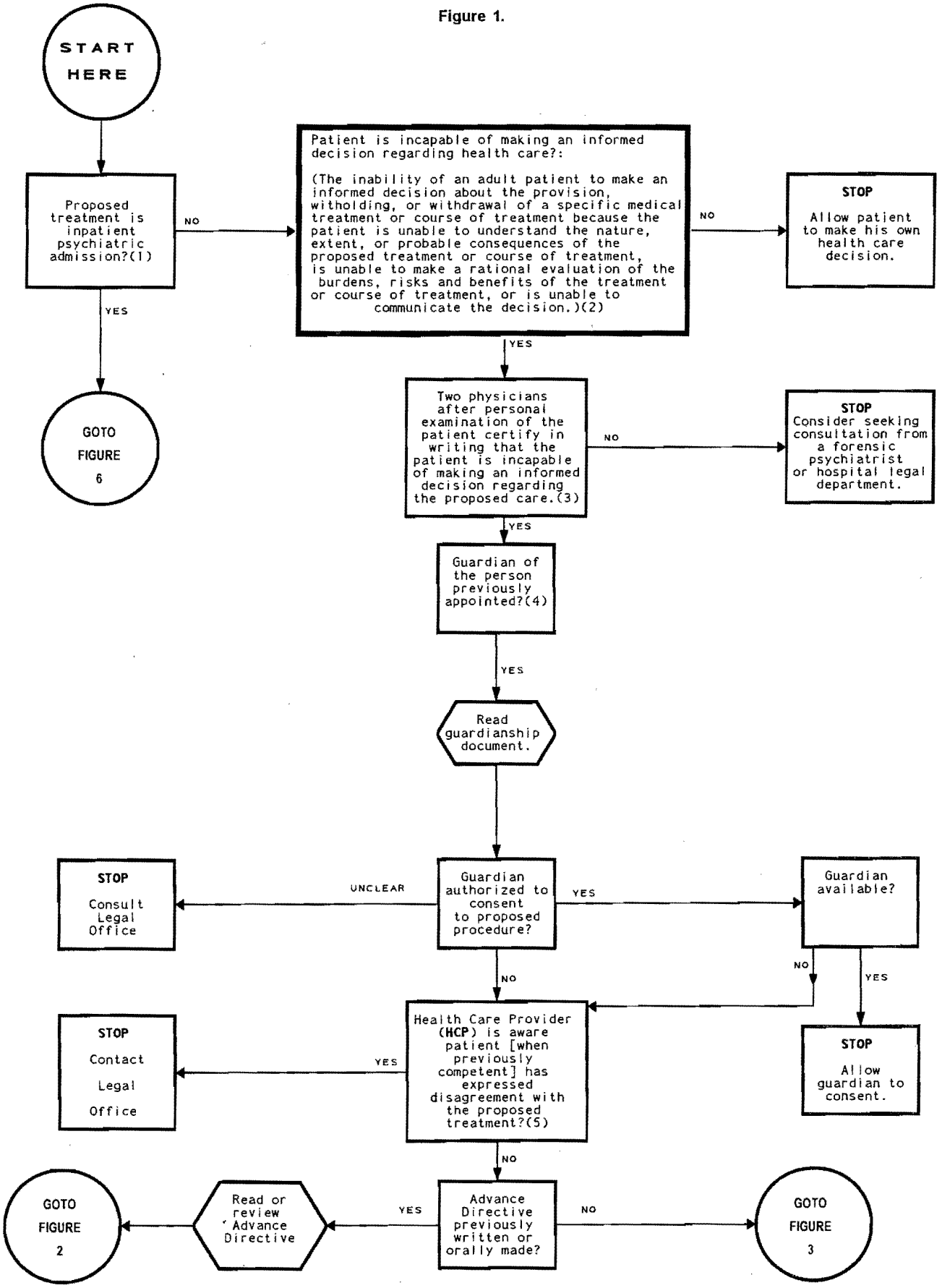
START HERE
Proposed treatment is inpatient psychiatric admission?(1)
NO
YES
GOTO FIGURE 6
Patient is incapable of making an informed decision regarding health care?:
(The inability of an adult patient to make an informed decision about the provision, witholding, or withdrawal of a specific medical treatment or course of treatment because the patient is unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment, is unable to make a rational evaluation of the burdens, risks and benefits of the treatment or course of treatment, or is unable to communicate the decision.)(2)
NO
STOP
Allow patient to make his own health care decision.
YES
Two physicians after personal examination of the patient certify in writing that the patient is incapable of making an informed decision regarding the proposed care.(3)
NO
STOP
Consider seeking consultation from a forensic psychiatrist or hospital legal department.
YES
Guardian of the person previously appointed?(4)
YES
Read guardianship document.
Guardian authorized to consent to proposed procedure?
UNCLEAR
STOP
Consult Legal Office
YES
Guardian available?
NO
YES
NO
Health Care Provider (HCP) is aware patient [when previously competent] has expressed disagreement with the proposed treatment?(5)
YES
STOP
Contact Legal Office
STOP
Allow guardian to consent.
NO
Advance Directive previously written or orally made?
YES
Read or review Advance Directive
GOTO FIGURE 2
NO
GOTO FIGURE 3

Figure 2.

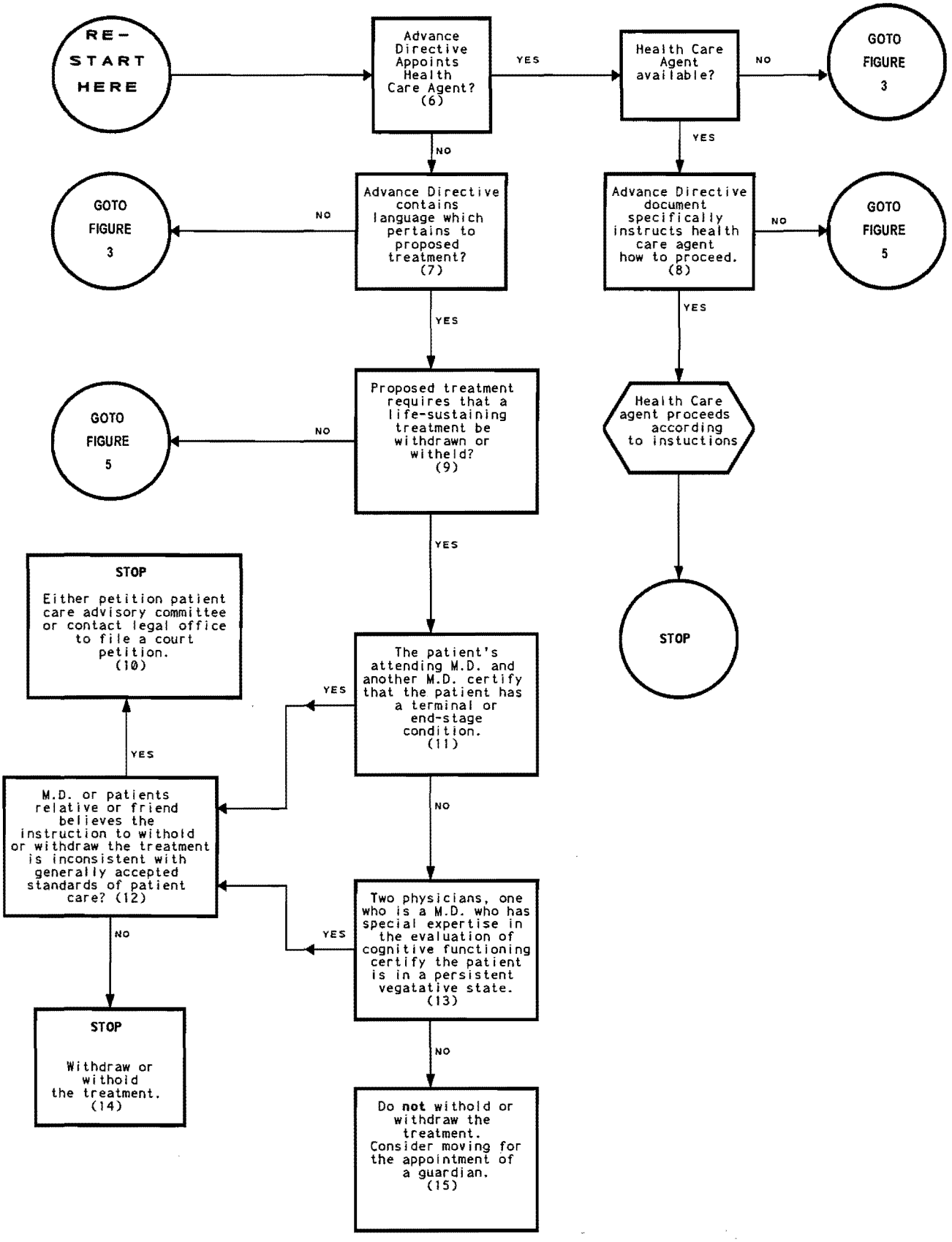
RE-START HERE
Advance Directive Appoints Health Care Agent? (6)
YES
Health Care Agent available?
NO
GOTO FIGURE 3
YES
NO
Advance Directive contains language which pertains to proposed treatment? (7)
NO
GOTO FIGURE 3
Advance Directive document specifically instructs health care agent how to proceed. (8)
NO
GOTO FIGURE 5
YES
YES
Proposed treatment requires that a life-sustaining treatment be withdrawn or witheld? (9)
NO
GOTO FIGURE 5
Health Care agent proceeds according to instuctions
YES
STOP
STOP
Either petition patient care advisory committee or contact legal office to file a court petition. (10)
The patient's attending M.D. and another M.D. certify that the patient has a terminal or end-stage condition. (11)
YES
YES
M.D. or patients relative or friend believes the instruction to withold or withdraw the treatment is inconsistent with generally accepted standards of patient care? (12)
NO
NO
Two physicians, one who is a M.D. who has special expertise in the evaluation of cognitive functioning certify the patient is in a persistent vegatative state. (13)
YES
NO
STOP
Withdraw or withold the treatment. (14)
Do not withold or withdraw the treatment. Consider moving for the appointment of a guardian. (15)

Figure 3.

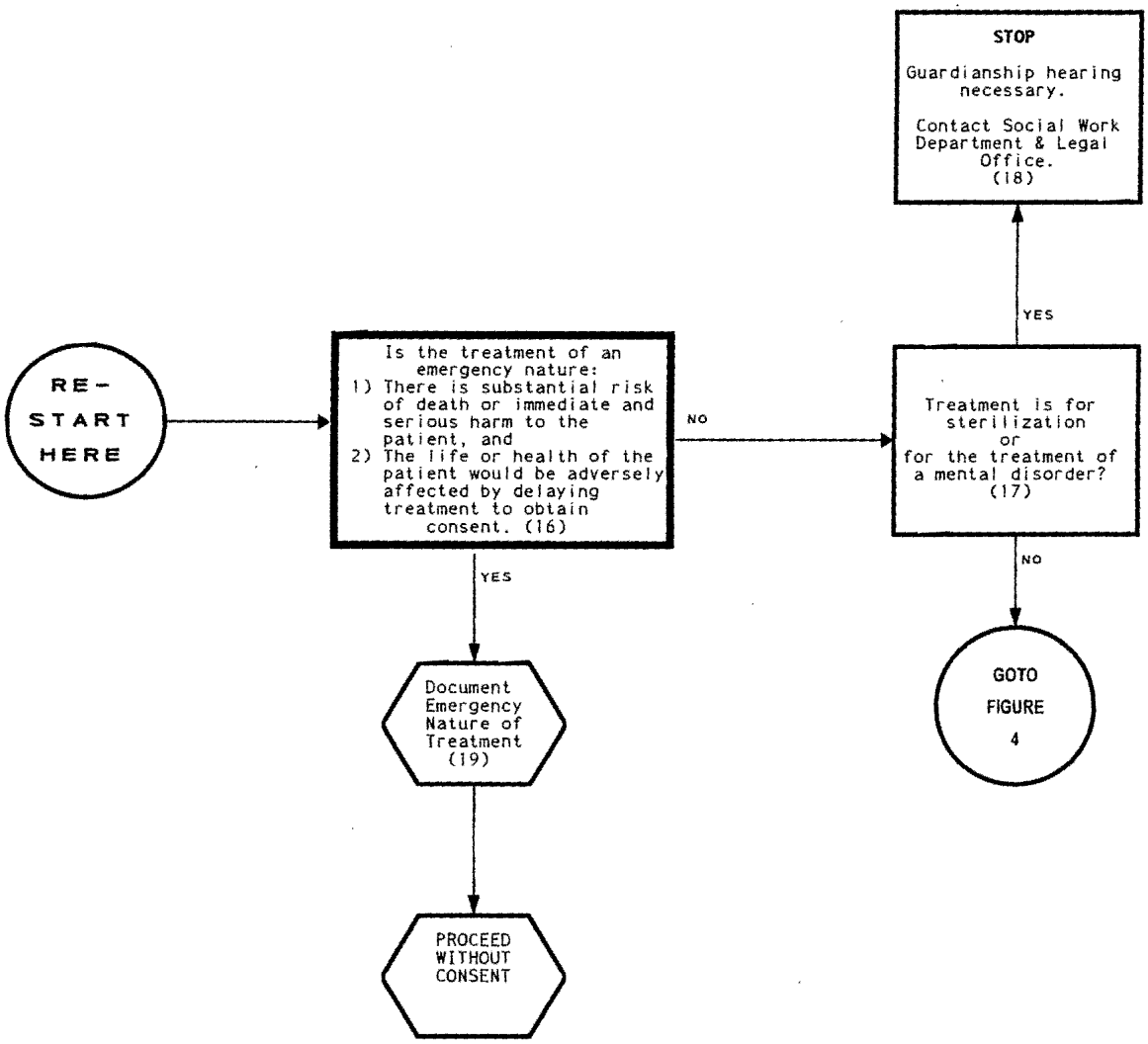
RE-
START
HERE
Is the treatment of an emergency nature:
1) There is substantial risk of death or immediate and serious harm to the patient, and
2) The life or health of the patient would be adversely affected by delaying treatment to obtain consent. (16)
NO
Treatment is for sterilization or for the treatment of a mental disorder? (17)
YES
STOP
Guardianship hearing necessary.
Contact Social Work Department & Legal Office. (18)
NO
GOTO FIGURE 4
YES
Document Emergency Nature of Treatment (19)
PROCEED WITHOUT CONSENT

Figure 4.

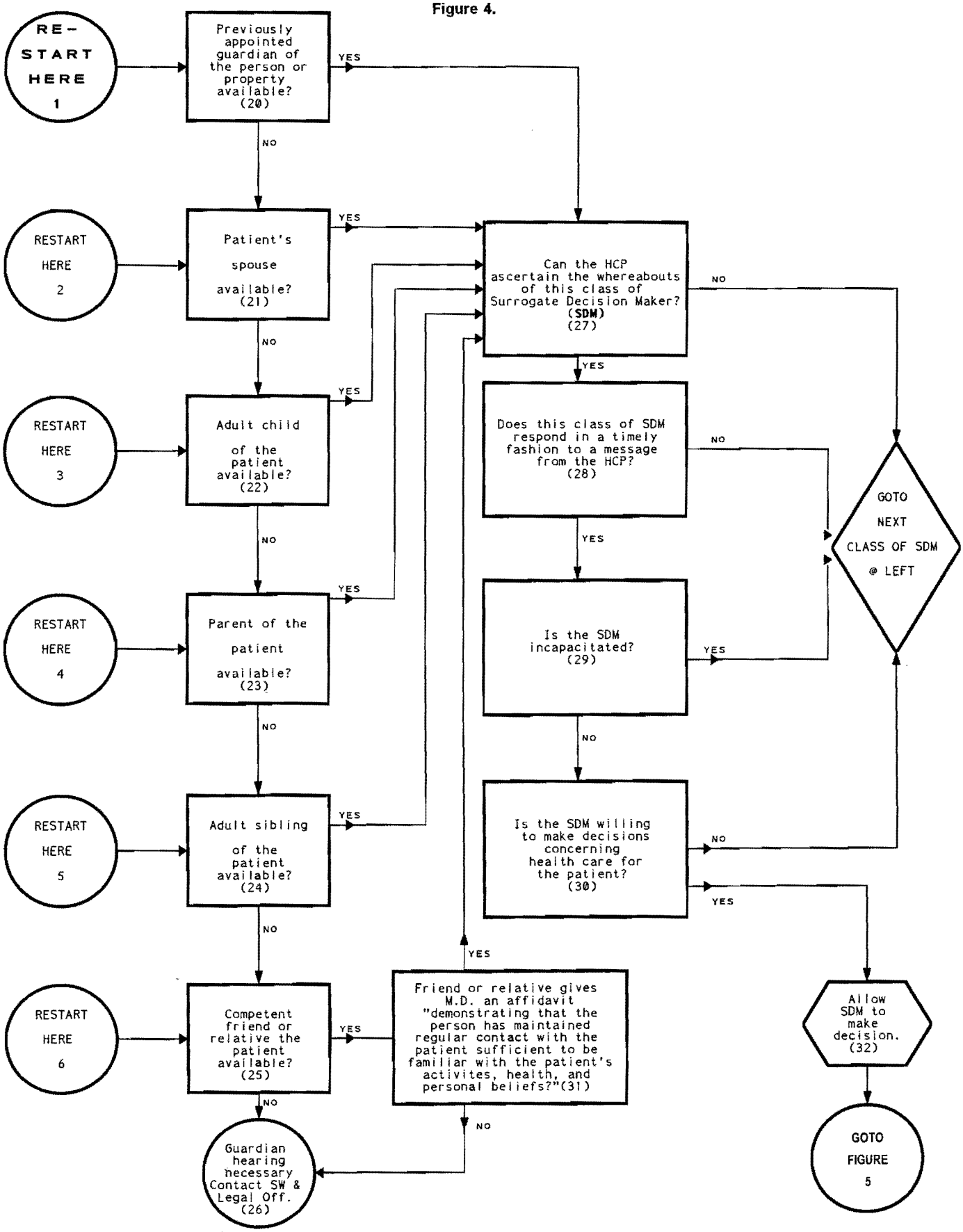
RE-START HERE 1
Previously appointed guardian of the person or property available? (20)
YES
NO
RESTART HERE 2
Patient's spouse available? (21)
YES
NO
RESTART HERE 3
Adult child of the patient available? (22)
YES
NO
RESTART HERE 4
Parent of the patient available? (23)
YES
NO
RESTART HERE 5
Adult sibling of the patient available? (24)
YES
NO
RESTART HERE 6
Competent friend or relative the patient available? (25)
YES
NO
Guardian hearing necessary Contact SW & Legal Off. (26)
Can the HCP ascertain the whereabouts of this class of Surrogate Decision Maker? (SDM) (27)
NO
YES
Does this class of SDM respond in a timely fashion to a message from the HCP? (28)
NO
YES
Is the SDM incapacitated? (29)
YES
NO
Is the SDM willing to make decisions concerning health care for the patient? (30)
NO
YES
Friend or relative gives M.D. an affidavit "demonstrating that the person has maintained regular contact with the patient sufficient to be familiar with the patient's activites, health, and personal beliefs?"(31)
YES
NO
GOTO NEXT CLASS OF SDM @ LEFT
Allow SDM to make decision. (32)
GOTO FIGURE 5

Figure 5.

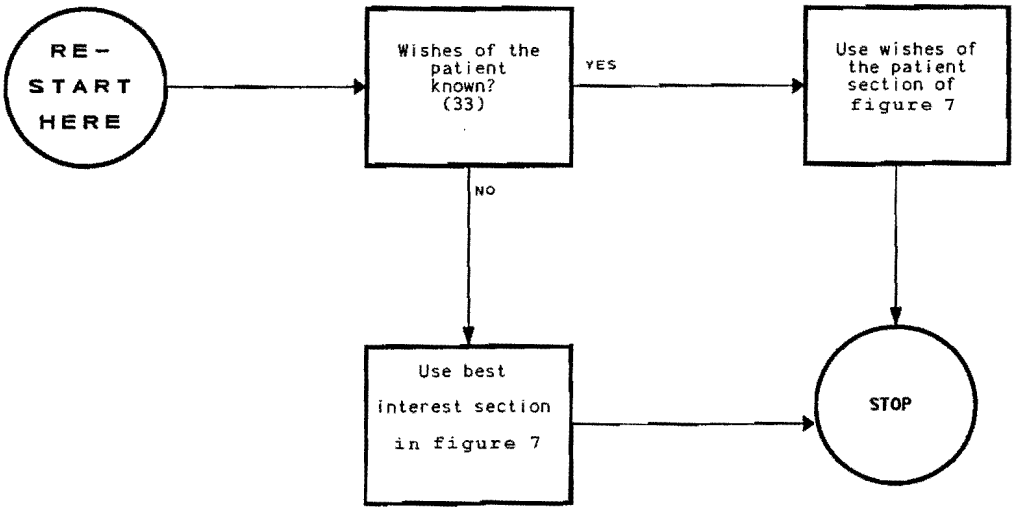
RE-
START
HERE
Wishes of the patient known? (33)
YES
Use wishes of the patient section of figure 7
NO
Use best interest section in figure 7
STOP

Figure 6.

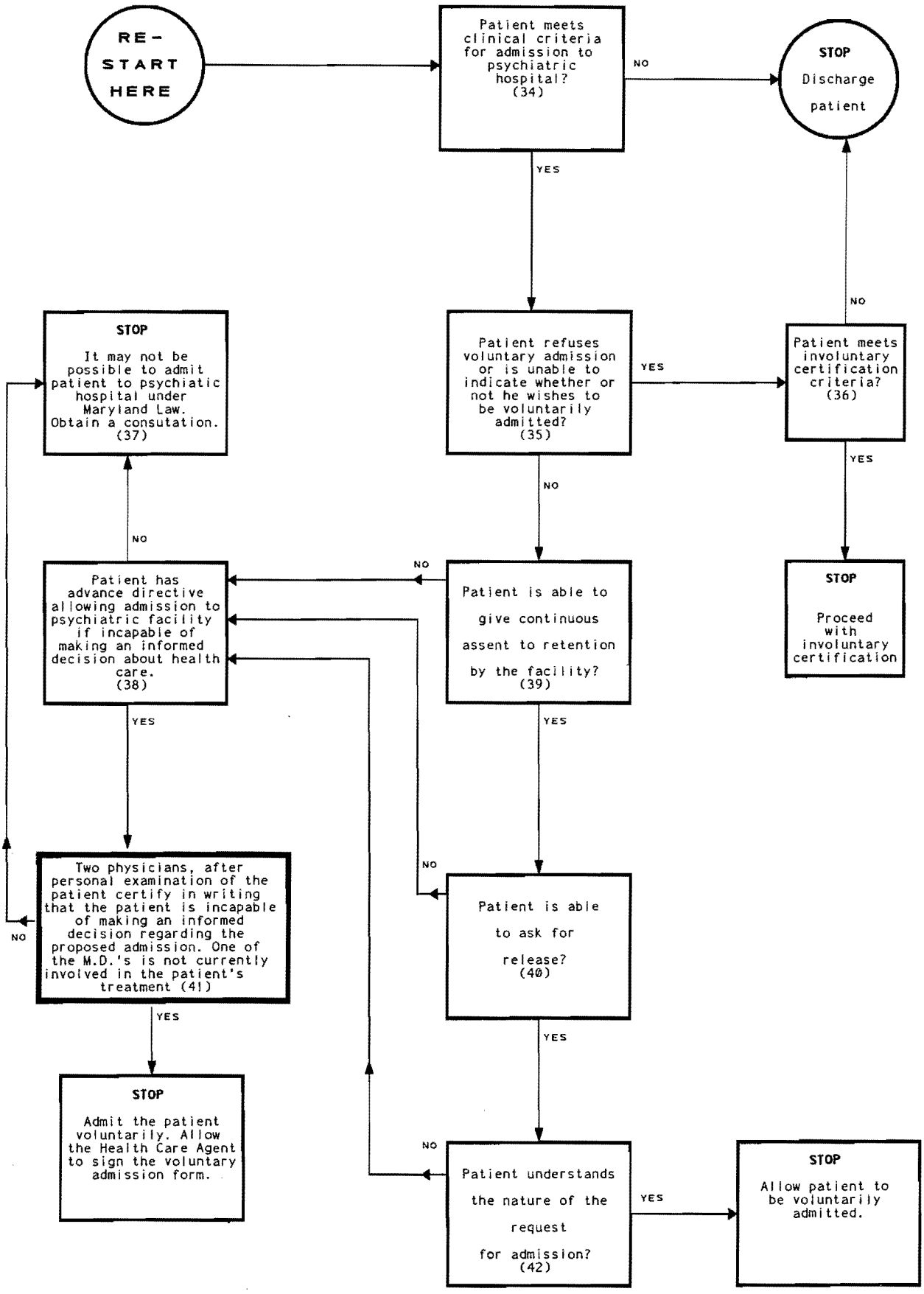
RE-START HERE
Patient meets clinical criteria for admission to psychiatric hospital? (34)
NO
STOP Discharge patient
YES
NO
STOP It may not be possible to admit patient to psychiatic hospital under Maryland Law. Obtain a consutation. (37)
Patient refuses voluntary admission or is unable to indicate whether or not he wishes to be voluntarily admitted? (35)
YES
Patient meets involuntary certification criteria? (36)
NO
YES
NO
NO
Patient has advance directive allowing admission to psychiatric facility if incapable of making an informed decision about health care. (38)
Patient is able to give continuous assent to retention by the facility? (39)
STOP Proceed with involuntary certification
YES
YES
NO
Two physicians, after personal examination of the patient certify in writing that the patient is incapable of making an informed decision regarding the proposed admission. One of the M.D.'s is not currently involved in the patient's treatment (41)
Patient is able to ask for release? (40)
NO
YES
YES
STOP Admit the patient voluntarily. Allow the Health Care Agent to sign the voluntary admission form.
NO
Patient understands the nature of the request for admission? (42)
YES
STOP Allow patient to be voluntarily admitted.

Figure 7.

✣ Wishes of the patient

In determining the wishes of the patient the health care agent or surrogate decision maker should take the following into account:

- current diagnosis and prognosis with and without the treatment at issue; and
- expressed preferences regarding the provision of, or the withholding or withdrawal of, the specific treatment at issue or of similar treatment; and
- relevant religious and moral beliefs and personal values; and
- behavior, attitudes, and past conduct with respect to the treatment at issue and medical treatment generally;
- reactions to the provision of, or the withholding or withdrawal of, a similar treatment for another individual; and
- expressed concerns about the effect on the family or intimate friends of the patient if a treatment were provided, withheld, or withdrawn.
- *Not* based on either a patient's preexisting, long-term mental or physical disability or the patient's economic disadvantage.[43]

✣ Best interest of the patient

In determining the best interest of the patient, the health care agent or surrogate decision maker should determine if the benefit to the individual resulting from a treatment outweighs the burdens to the individual resulting from the treatment, taking into account:

- the effect of the treatment on the physical, emotional, and cognitive functions of the individual; and
- the degree of physical pain or discomfort caused to the individual by the treatment, or the withholding or withdrawal of the treatment; and
- the degree to which the individual's medical condition, the treatment, or the withholding or withdrawal of treatment results in a severe and continuing impairment of the dignity of the individual by subjecting the individual to a condition of extreme humiliation and despondency; and
- the effect of the treatment on the life expectancy of the individual; and
- the prognosis of the individual for recovery, with and without the treatment; and
- the risks, side effects, and benefits of the treatment or the withholding or withdrawal of the treatment; and
- the religious beliefs and basic values of the individual receiving treatment, to the extent these may assist the decision maker in determining best interest.[44]

References

1. Md. Ann. Code, Health-General §5–601 to §5–618.
2. Folstein MF, Folstein SE, McHugh PR. Mini-mental state: a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res* 1975;12:189–198.
3. *Zinermon v. Burch* 494 S. Ct. 975, 1990.
4. Md. Ann. Code, Health-General §10–609.
5. Md. Ann. Code, Estates and Trusts §13–706(a) and §13–708(b)(2).

Annotations (Figures 1-7)*

1. H.G. § 10–601 to § 10–619
2. H.G. § 5–601(l)
3. H.G. § 5–606(a)
4. Estates and Trusts § 13–708(b)(8)
5. H.G. § 5–611(e)(2). The exact language reads: "Nothing in this subtitle authorizes any action with respect to medical treatment, if the health care provider is aware the patient for whom the health care is provided has expressed disagreement with the action." On first reading it appears that this language would not allow a health care provider to provide health care for a patient, who while not clinically competent, vocalizes a refusal of a treatment which a surrogate decision maker or a health care agent has authorized. However, this did not make ethical or clinical sense. An opinion was sought from the Johns Hopkins Ethics Committee, which replied:

   "We interpret [the Health Care Decisions Act] to mean the patient's expressed wish occurred PRIOR to the patient's present incapacitated state. If that is correct, the committee agrees that what the law states is what is ethically appropriate: that we have a moral obligation to respect the expressed wishes of patients when they were competent.

If, however [the Health Care Decisions Act] is legally interpreted to mean that the patient is PRESENTLY refusing treatment while not having the capacity to give informed consent or by inference informed refusal, then the committee feels obligated to advise you that your moral obligation should be to act in the patient's best interest, and if the best clinical judgment is that the patient's best interest includes treatment that the patient is presently refusing, that this treatment be given.

If [the language in the Health Care Decisions Act] is legally interpreted to be a PRESENT statement of refusal of treatment while not having the capacity to give informed consent, there is a logical inconsistency in the law which is as follows. A different standard of surrogacy is implied for ACCEPTANCE of treatment as opposed to REFUSAL of treatment under these circumstances ... We are aware of no moral or logical basis for stating that there is a difference between informed consent and informed refusal" (Peter B. Terry, M.D., Chairman, The Johns Hopkins Hospital Ethics Committee, personal communication).

The language "[when previously competent]" was therefore inserted in the flow chart. Clinicians might consider consulting their own ethics committees for help in interpretation.

6. H.G. § 5-602(b)(1); H.G. § 5-601(c)
7. H.G. § 5-603
8. H.G. § 5-602(h)
9. H.G. § 5-606(b); H.G. § 5-601(m)
10. H.G. § 5-612
11. H.G. § 5-601(i); H.G. § 5-601(q); H.G. § 5-606(b)(1)
12. H.G. § 5-612(a-b)
13. H.G. § 5-606(b)(2); H.G. § 5-601(o)
14. H.G. § 5-612
15. H.G. § 5-606(b)
16. H.G. § 5-607
17. H.G. § 5-605(d)
18. H.G. § 5-605(d)
19. H.G. § 5-607
20. H.G. § 5-605(a)(2)(i)
21. H.G. § 5-605(a)(2)(ii)
22. H.G. § 5-605(a)(2)(iii)
23. H.G. § 5-605(a)(2)(iv)
24. H.G. § 5-605(a)(2)(v)
25. H.G. § 5-605(a)(2)(vi)
26. Estates and Trusts §13-704
27. H.G. § 5-605(a)(ii)
28. H.G. § 5-605(a)(iii)
29. H.G. § 5-605(a)(iv)
30. H.G. § 5-605(a)(v)
31. H.G. § 5-605(a)(3)
32. H.G. § 5-605
33. H.G. § 5-605(c)
34. H.G. § 10-609(c)(1&2)
35. H.G. § 10-617(a)(4)
36. H.G. § 10-617(a)(1-5)
37. *Zinermon v. Burch* 494 S. Ct. 975,1990
38. H.G. § 5-603
39. H.G. § 10-609(c)(4)
40. H.G. § 10-609(c)(5)
41. H.G. § 5-601(l); H.G. § 5-606(a)
42. H.G. § 10-609(c)(3)
43. H.G. § 5-605(c)
44. H.G. § 5-605(c); H.G. § 5-601(e)

* H.G. = Annotated Code of Maryland, Health-General Article
Estates and Trusts = Annotated Code of Maryland, Estates and Trusts Article ■

STARK II

As of January 1, 1995, complex federal legislation known as Stark II went into effect. An extension of Stark I, it prohibits Medicare and Medicaid reimbursement for physician referrals of designated services to an entity with which the physician or a family member has a financial arrangement. Designated services are

- clinical laboratory services;
- physical therapy services;
- occupational therapy services;
- radiology, magnetic resonance imaging, computed axial tomography, and ultrasound services;
- durable medical equipment;
- parenteral and enteral nutrition, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices;
- home health services;
- outpatient drugs;
- inpatient and outpatient hospital services.

Financial arrangements include both ownership interests and compensation arrangements. There is no minimum investment criteria; any level of investment or ownership apparently may constitute a financial interest. In addition to traditional methods of compensation (e.g., salary, personal service agreements, recruitment incentives), the statute includes "any remuneration, directly or indirectly, overtly or covertly, in cash or in kind." Stark II contains numerous, often complex exceptions that may not be clarified until the Health Care Financing Administration issues the regulations implementing the new law. According to AMA sources, however, the regulations will not be issued for at least two months and may not be available until June. Nevertheless, compliance with the law is mandatory and will be enforced. Penalties include a civil monetary penalty of up to $15,000 for each violation and exclusion from participation in Medicare and Medicaid programs.