The patient refuses to cooperate. What can you do? What *should* you do?

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The real estate business embraces the concept of *ownership* using the term "bundle of rights." Real estate agents view full, unaffected ownership of a real property as complete (ie, undivided) and, when ownership is shared, talk about percentages of that bundle.

The same principle can be applied to *guardianship*. Because we are our own guardians, we own a full, undivided bundle of rights, including all our constitutional rights and the right to make decisions—even bad ones. Of course, an undivided bundle also means that we are fully responsible for the decisions we make.

When a patient requires representation

There may be a situation when we would give someone else the authority to represent us for a specific reason. In this case we would authorize this person to act on our behalf as we would do ourselves—yet we still retain 100% ownership of the "bundle," and therefore can revoke this authorization at any time. The person we hire (appoint) to represent us will become our power of attorney (POA), and because we appoint this person for a specific situation (handle certain medical affairs, manage some financial affairs, sign real estate documents, etc.), this kind or POA is called "specific" or "special." When we give someone the right to represent us in any or all of our affairs, this POA is called "general" or "durable."

It is important to mention that as long as we continue to have psychological capacity and are willing to continue to be our own guardians (own 100% of the bundle of rights), we can terminate any POA we have appointed previously or designate another person to represent us as a "special" or "general" POA. Because of this, if an older patient—who is legally competent but physically unable to live on his (her) own—refuses to enter a long-term care facility, he (she) cannot be sent there against his will, even if the POA insists on it. Because of this, if the patient's primary team strongly disagrees with this patient's decision, his (her) "decision-making capacity" should be assessed and, if necessary, a competency hearing will need to be conducted. The court will then decide if this person is able (or unable) to handle his own affairs, and if the court decides that the person cannot be responsible to provide himself with food, health care, housing, and other necessities, the guardian (relative, friend, public administrator, etc.) will be appointed to do so.

Evaluating decision-making capacity

Determining "decision-making capacity" should not be confused with the legal concept of "competence." We, physicians, often

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are called to evaluate a patient and give our opinion of the current level of this patient's functioning (including his [her] decision-making capacity), and we—ourselves and a requesting team—need to be clear that it is merely *our opinion* and should be used as such. We need to remember that even if a patient is judged to be legally incompetent to handle financial affairs, he (she) might retain sufficient ability to make decisions about treatments.

We also need to remember that *decision-making capacity can change*, depending on medical conditions (severe anxiety, delirium), successful treatments, substance intoxication, etc. Because of this, we need to communicate to the requesting team that "decision-making ability" is situation-specific and time-specific, and that failure to make a decision on one issue should not be generalized to other aspects of the patient's life.

Any physician can evaluate patient's decision-making ability, but traditionally the psychiatry team is called to do so. It usually happens because the primary medical team needs us to provide "a third-party validation," or because of the common misperception that only the psychiatric team can initiate a civil involuntary detention when necessary.

In any case, regardless of who evaluates the patient, specific points need to be addressed and the following questions need to be answered:

- Does the patient understand the nature of his (her) condition?
- Does the patient understand what treatment we are proposing or what he should do?
- Does the patient understand the consequences (good or bad) if he rejects our proposed action or treatment?

When information (discharge plan, treatment plan, etc.) is presented to patients, we should ask them to repeat it in their own words. We should not expect them to understand all of the technical aspects. We should consider patients' intelligence level and their ability to communicate; if they can clearly verbalize their understanding of information and be consistent in their wish to continue with their decision, we have to declare that they have decision-making capability and able to proceed with their chosen treatment.

More matters that need to be mentioned

Restrictions on the patient. We need to remember that, even if a patient is thought to be able to make his own decisions, there may be some situations when he can be held in the hospital against his will. These usually are the cases when the patient is psychiatrically or medically unstable (unable to care of himself), but also if the patient is at risk of harming himself or others, subject of elder abuse, or suspected of being an abuser.

Restrictions on the practitioner. Even if the patient is determined to be lacking decision-making capacity, we, physicians, cannot perform tests, procedures, or do the placements without the patient's agreement.

Informed consent doctrine is applicable in this case, and if performing a test or procedure is necessary (except life- or limb-saving emergencies, when doctrine of physician prerogative applies), or if there a disagreement in post-discharge placement, the emergency guardianship may need to be pursued.

Clinical Point

Even if a patient is judged to be legally incompetent to handle financial affairs, he might retain the ability to make treatment decisions

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