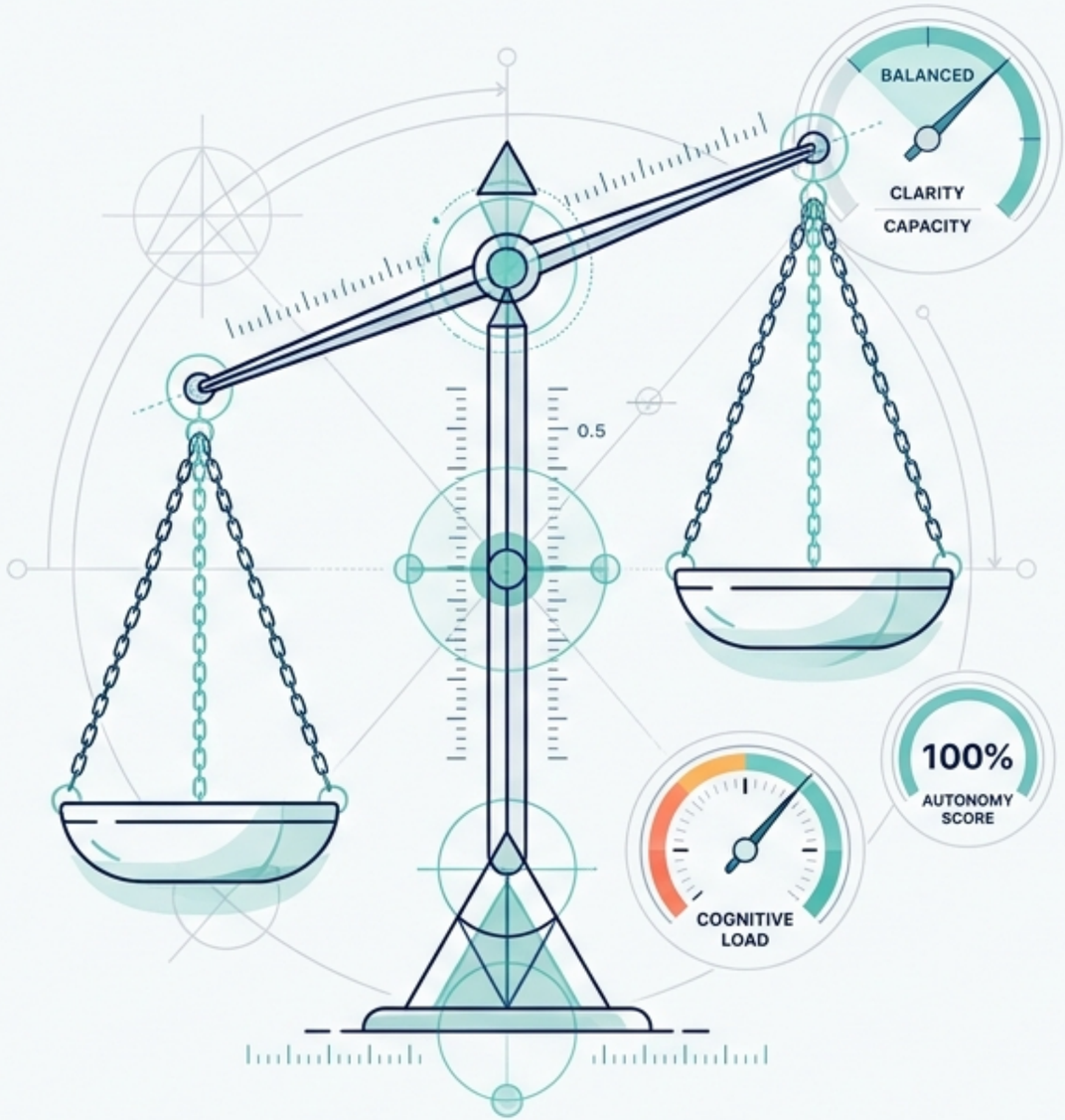
Navigating the Scales of Autonomy

A clinical framework for assessing decision-making capacity at the bedside.

Jerad Shoemaker, MD | Clinical Reference Framework



A Daily Clinical Reality

Impaired capacity is exceptionally common in inpatient settings. Correctly identifying it is a critical competency that directly impacts treatment authorization, advance directives, and the ethical obligations of every provider.

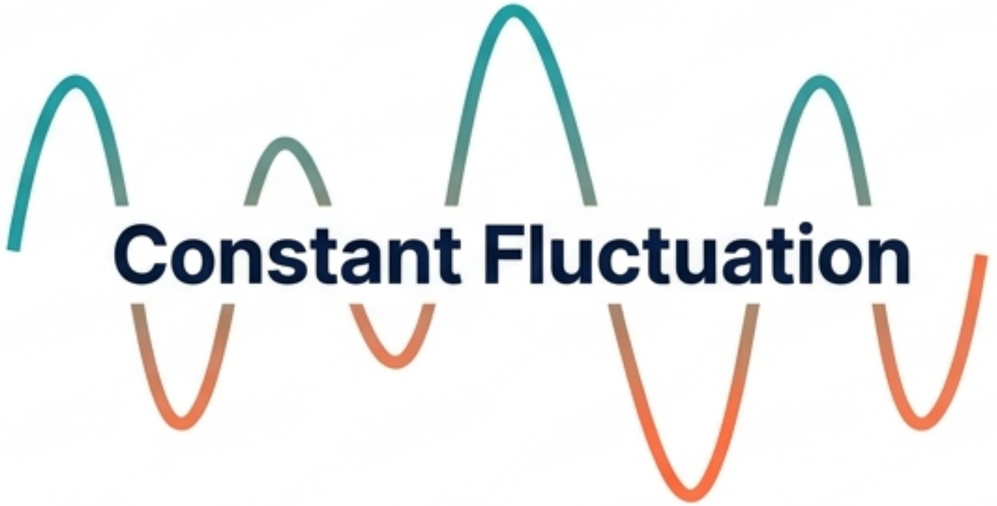
EHR Dashboard Widgets

Hospitalized patients presenting with impaired capacity.

EHR Dashboard Widgets

Dementia patients unable to consent.

EHR Dashboard Widgets



Capacity can change daily or hourly based on the underlying medical condition (e.g., delirium).

Separating the Bedside from the Courtroom

CAPACITY (Clinical)

Concept: Current functional ability.

Assessor: Determined by the physician at the bedside.

Timeframe: Fluid; may change daily or hourly.

Scope: Task-specific (e.g., 'Can they refuse this IV?').

Example: Consent to treatment, advance directives.

COMPETENCY (Legal)

Concept: Global legal status.

Assessor: Established by a judge via court order.

Timeframe: Rigid; highly stable legally.

Scope: Broad life implications.

Example: Competency to stand trial, manage assets, marry.

The Evolution of Evidence

1957

Natanson v. Kline: Informed consent enters American law; “reasonable person” standard.

1972

Canterbury v. Spence: Patient’s right to information established.

1980s

Appelbaum & Grisso: The Four Abilities framework operationalizes capacity for clinicians.

2000

MacCAT-T: Publication of the gold standard semistructured clinical tool.

2004-2010

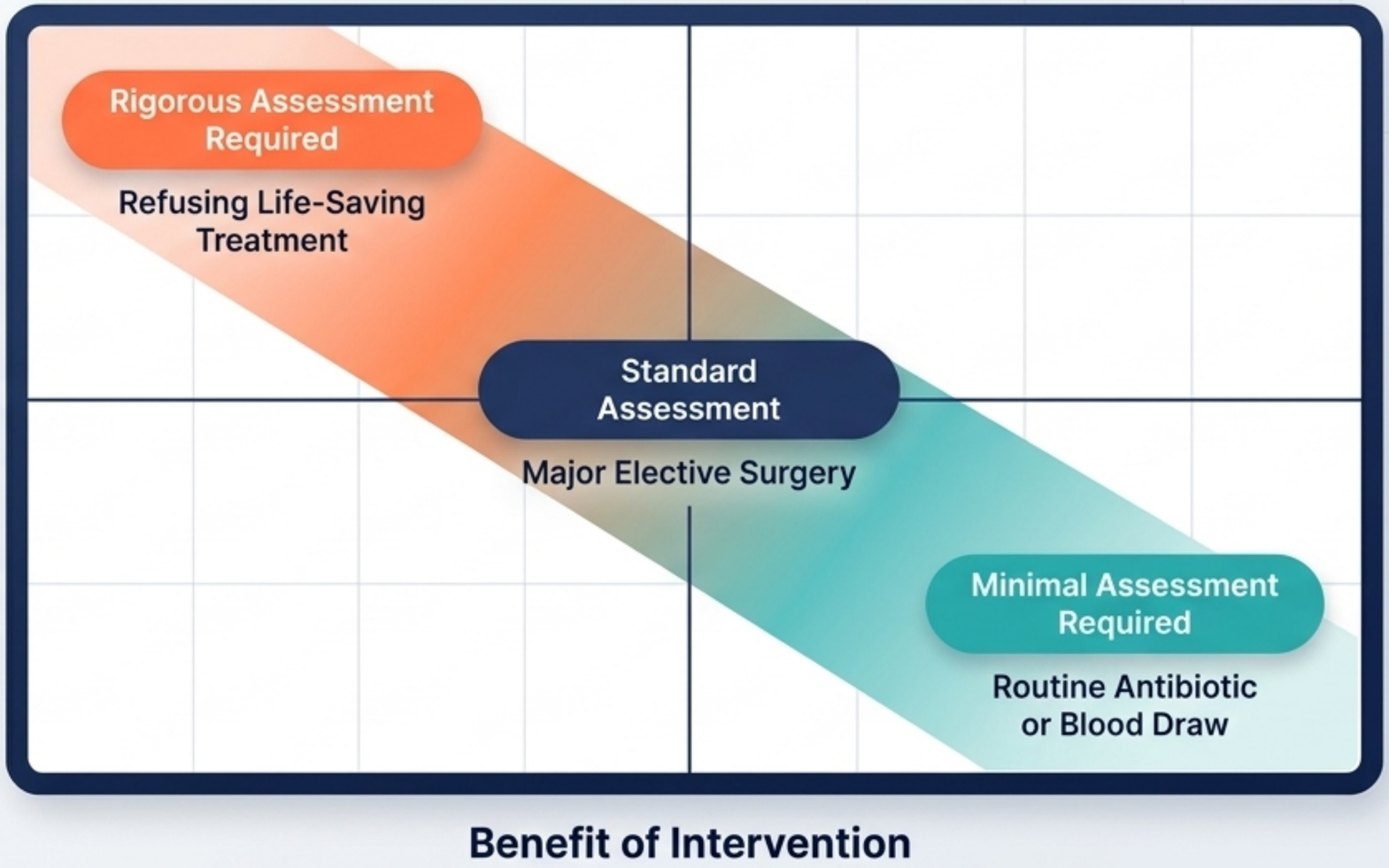
Brief screens (ACE, MiniCAC) bring assessment to general medicine.

2015-Present

Neurocognitive Integration: Executive function and working memory identified as core predictors.

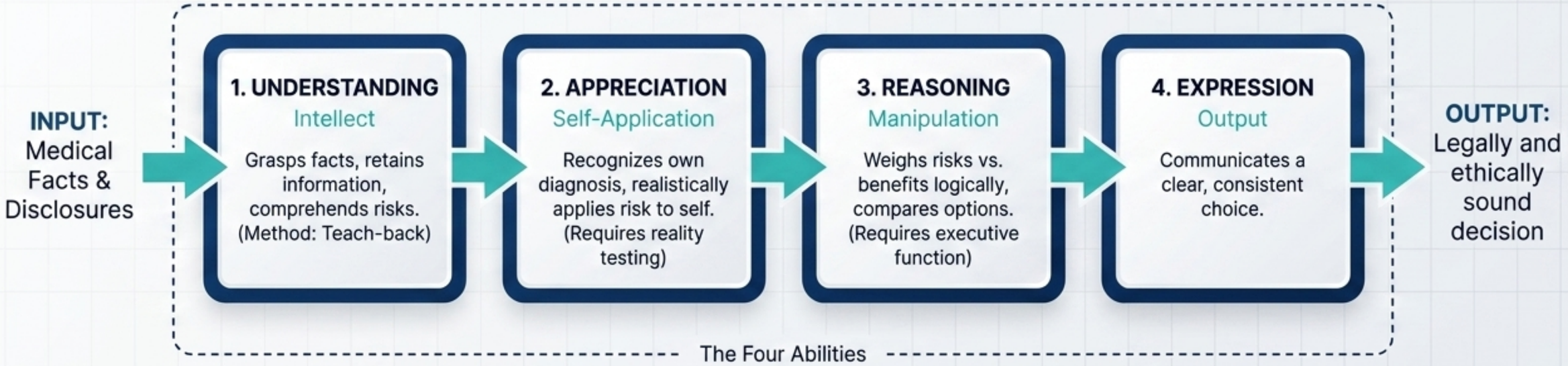
Calibrating Rigor to Risk

The degree of capacity required to make a decision is directly proportional to its risk-benefit ratio. Respect for **autonomy** must always be weighed against medical beneficence.



The Cognitive Pipeline of Consent

The Appelbaum Model requires four distinct functional abilities to be present. If the chain breaks at any point, decision-specific capacity is compromised.



The Anosognosia Blockade

A patient may perfectly understand complex medical jargon while completely failing to appreciate its relevance to their own life. Lack of insight—not cognitive dysfunction—is the primary barrier to capacity in conditions like first-episode psychosis.

Clinical Warning: Specifically probe for self-application, not just factual recall.

Selecting the Right Instrument

Tool Selection Guide

RAPID SCREENS

Bedside / General Medicine

ACE (Aid to Capacity Evaluation)

12-question brief screen. Identifies need for fuller evaluation.

MiniCAC

Adapted cognitive screen focusing on understanding and appreciation. Limited reliability in complex cases.

PSYCHIATRIC STANDARD

Psychiatric Decision-Making

HCAT (Hopkins Competency Assessment Test)

Emphasizes understanding and reasoning. Good for psychiatric decision-making.

FORENSIC GOLD STANDARDS

Complex / High-Risk Evaluations

MacCAT-T

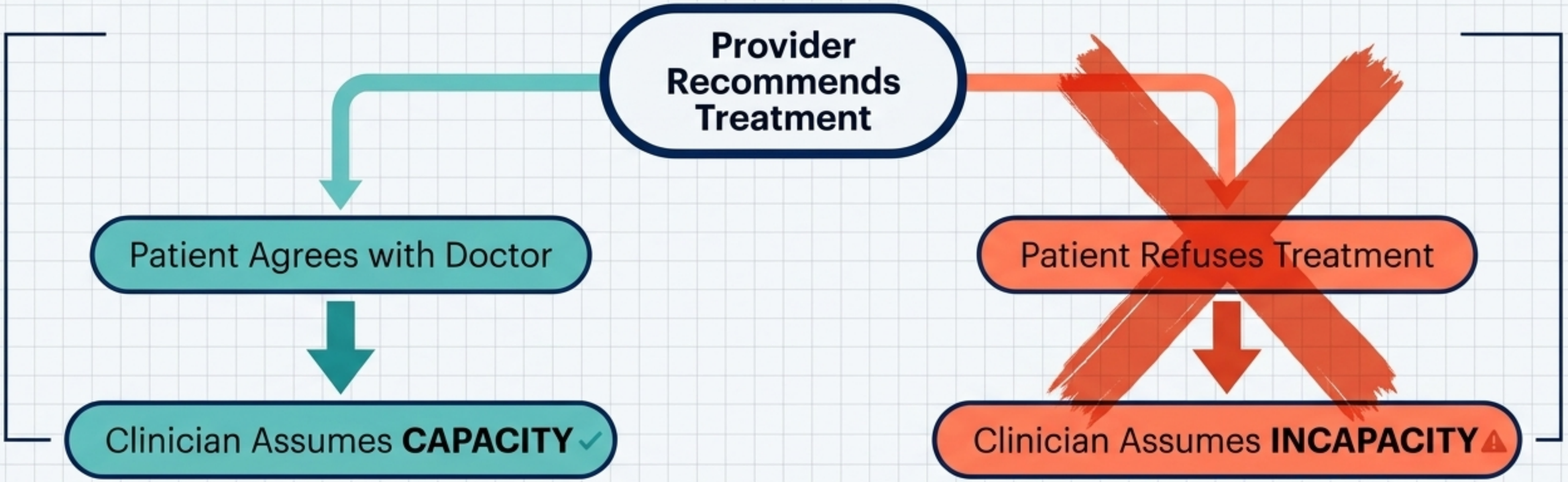
15-20 min semistructured interview assessing all four domains. The ultimate clinical standard.

CCTI

Detailed psychometric interview for research and heavy forensic documentation.

The Disagreement Bias

Systematic use of standardized tools is required to protect against the clinician's own biases. Capacity must be determined by **functional ability**, not by the **perceived wisdom of the patient's choice.**



System Warning: Avoid using incapacity determinations as a mechanism for imposing preferred treatments on autonomous patients.

The Functional Specificity Framework

Capacity is not a global trait or a rigid score. A patient's required **functional threshold dynamically shifts** based on the **specific decision at hand.**

Scenario A: Routine Blood Draw

Risk Dial

Low

Understanding	ON
Appreciation	OFF
Reasoning	OFF
Expression	ON

Low threshold passed. **Capacity demonstrated.**

Scenario B: Refusing Amputation

Risk Dial

Maximum

Understanding	ON
Appreciation	ON
Reasoning	ON
Expression	ON

All four nodes must be robustly demonstrated and documented to clear the high-risk threshold.

The Bedside Assessment Algorithm

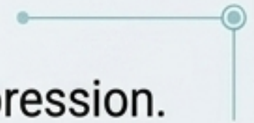
1. **Define the Specific Decision**
   Narrow the scope. Do not assess global capacity.

2. **Calibrate the Risk**
   Assess the risk-benefit ratio to determine the required rigor.

3. **Select the Tool**
   Choose MacCAT-T for high-risk decisions, or ACE for rapid baseline screening.

4. **Probe for Appreciation**
   Specifically test for reality-testing and anosognosia.

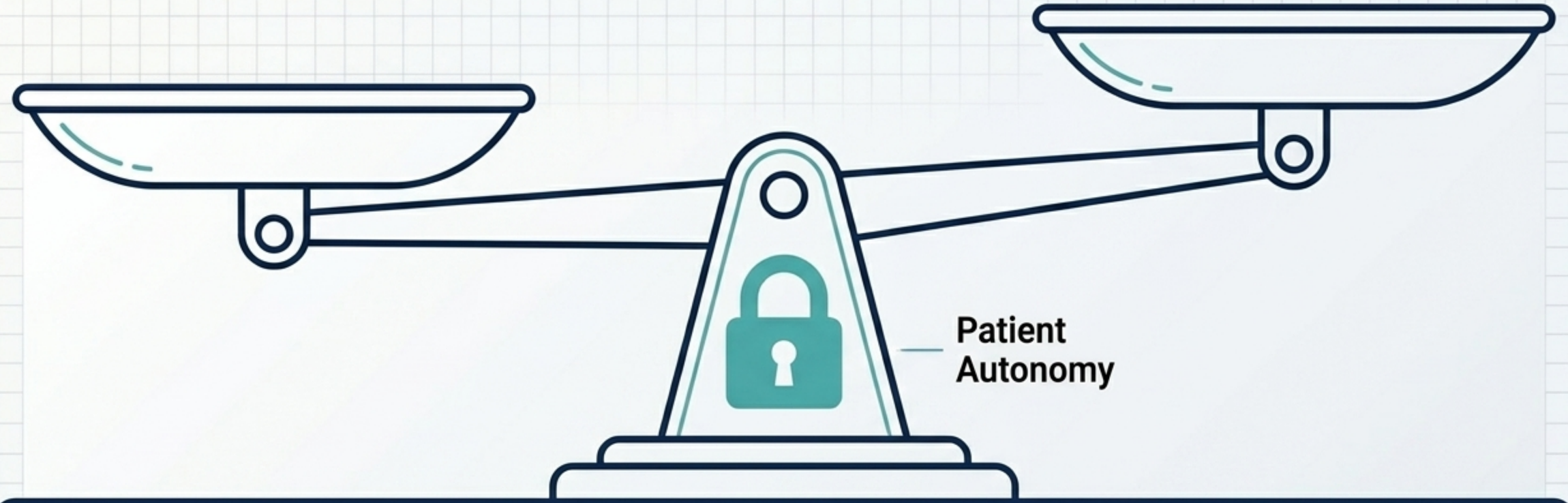
5. **Document the Four Abilities**
   Record specific patient quotes for Understanding, Appreciation, Reasoning, and Expression.



6. **Seek Multidisciplinary Consensus**
   For marginal cases, involve ethics, neurology, or psychiatry.

The Default is Autonomy

The burden of proof always rests on the clinician to demonstrate impaired capacity based on clear, specific, and documented functional evidence.



Presume capacity until proven otherwise.