What do doctors know about assessing decision-making capacity?

Greg Young, Alison Douglass, Lorraine Davison

ABSTRACT

AIMS: To survey hospital doctors (HDs) and general practitioners (GPs) on what they know about assessing capacity, and to determine their educational needs.

METHOD: A mixed-methods, cross-sectional survey was administered to a convenience sample of HDs and GPs. Respondents were asked about their roles, the prevalence of older patients they had seen, specific questions about capacity assessment, difficulties encountered and their preferred format for further education.

RESULTS: 152/980 (15%) HDs and 74/4,000 (2%) GPs responded. Most had been concerned about a patient’s capacity in the past year, but had not received training in assessing capacity since graduation. The average responder scored below 70% on knowledge questions. Lack of legal knowledge and time pressures were among difficulties encountered. One-third of respondents lacked confidence to assess capacity to a standard high enough to present in court. Many doctors were willing to improve their skills, requesting tutorials or short courses.

CONCLUSION: Respondents demonstrated gaps in their knowledge on assessing capacity, and a lack of confidence in their opinions. The findings of this survey suggest that further clinical and legal education of doctors in performing capacity assessments would be valuable.

Assessing decision-making capacity (‘capacity’) is an essential skill for all doctors in clinical practice, not least because it is integral to obtaining informed consent to treatment. Capacity is the legal threshold or ‘bright line’ for determining whether the law permits intervention in people’s lives, and to what extent. As capacity is decision- and time-specific, a patient’s capacity is assessed in relation to a particular task or decision, taking into account that incapacity may be temporary or fluctuate. In general, the outcomes of the assessment include: the patient has capacity to decide; they need support to make the decision; they are unable to make a particular decision; or they are unable to make any decision.

The essential components of informed consent involve a triad of adequate information, capacity to decide and voluntariness. Any doctor seeking consent to healthcare from a patient needs to be able to assess the patient’s capacity to give or refuse consent. Doctors may also be asked to assess a patient’s capacity to decide about their care and living arrangements, to make a will, to make or activate an enduring power of attorney (EPOA) or to make financial decisions.

Although capacity is a legal construct, the assessment of capacity is clinical. A capacity assessment may have significant implications for a patient’s ability to exercise their personal autonomy. It is important evidence for the legal processes that may follow and may be used in support of applications to the court for orders affecting a person’s care and welfare. The clinical assessment also aims to determine the extent, cause and possible reversibility of the patient’s incapacity.

Anecdotally, many doctors report a lack of confidence and skill in how to assess capacity. Young, and more recently Astell, have described approaches to capacity assessment for doctors within the New
Zealand context, but there has been limited research into what doctors know about assessing capacity.6,7 The prevalence of incapacity among people in New Zealand hospitals and elder care facilities is unknown. A review of 58 international studies of capacity reported that 45% of patients in psychiatric settings and 34% of patients in general medical settings lacked decision-making capacity.8 Dementia is a leading cause of incapacity and is expected to affect over 78,000 New Zealanders by 2026.9 In view of the growing prevalence of dementia, along with many other brain conditions that can affect capacity, it is likely that doctors will need to assess capacity more frequently in the future.

This survey was part of a wider comparative analysis of relevant New Zealand law and the legislative framework provided by the Mental Capacity Act 2005 (England and Wales) and its associated Code of Practice.10 The aims of this survey were to assess doctors' knowledge about capacity assessment and to investigate their educational needs and preferences. It was partly based on a previous US survey.11

**Method**

The survey was of a mixed-method, cross-sectional design comprising five parts:

1. Information about the respondents: seniority, specialty and frequency of experience with patients who may lack capacity;
2. Questions about a single, unidentified patient encountered in the previous year, who lacked capacity;
3. Technical questions about assessing capacity;
4. Questions about the respondent's postgraduate training in capacity assessment, confidence in conducting the assessments, whether they considered it to be within their scope of practice and how they might like to receive educational material in the future; and
5. A free text box asking the respondents to describe the main difficulties they experienced when assessing capacity.

The questions were refined following an initial pilot survey at Hawkes Bay DHB (data not included). A modified survey was distributed via internal email to all hospital doctors (HDs) working at Capital and Coast and Hutt Valley DHBs and to general practitioners (GPs) throughout New Zealand via three different email lists (New Zealand Doctor, Vital Signs and e-Pulse). The number of GPs was extrapolated from the 2014 National Workforce Survey: In 2014 there were 3,770 GPs and 160 other doctors in primary care. The increases from 2013 to 2014 were 2.5% and 6.1%; using these figures, a total of 4,034 was calculated for 2015. The number was an approximation only and therefore rounded to 4,000. The number of hospital doctors was provided by offices of the chief medical officers. These denominators indicate the size of the groups targeted in the survey. The email explained the purpose of the survey, invited participation and noted that ethics approval had been obtained, that responses were anonymous and that responding would be taken as consent to participate. The University of Otago Human Research Ethics Committee gave ethical approval for the survey (D15/213).

The data for HDs and GPs were analysed separately to understand the differences between the groups' experience, knowledge and educational needs. Data description is by simple tabulation.

The scores for the responses to 13 multiple-choice questions about technical aspects of capacity assessments were aggregated for each respondent. Respondents were given a score of 2, where the response reflected good knowledge; 1, reflecting some knowledge; and 0, reflecting poor or no knowledge. The total score could range from 0 to 26, with a higher score reflecting better knowledge.

The free text comments were categorised into common themes, which were cross checked and refined by the authors until a consistent set of themes was identified.
Results

The response rate for hospital doctors was 152/980 (15%) and for GPs 74/4,000 (2%). House surgeons, who have not yet specialised, totalled n=10 (7%); the remaining three (2%) participants did not state their specialty. Among GP respondents, 64 (87%) were vocationally registered, four (5%) were GP registrars and six (8%) identified as ‘GP other’.

Table 1 shows a description of the characteristics of the practices of the respondents, the experience of completing capacity assessments and the reasons for capacity assessments.

Table 2 describes the methods reported by respondents for assessing capacity.

<table>
<thead>
<tr>
<th>Exposure in previous year</th>
<th>HDs</th>
<th>GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;20% of patients over 65 years</td>
<td>109 (72)</td>
<td>45 (61)</td>
</tr>
<tr>
<td>Concern about capacity on a few occasions</td>
<td>141 (93)</td>
<td>72 (97)</td>
</tr>
<tr>
<td>At least one capacity assessment</td>
<td>141 (93)</td>
<td>67 (91)</td>
</tr>
<tr>
<td>At least one legal document completed</td>
<td>99 (65)</td>
<td>44 (60)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason</th>
<th>HDs</th>
<th>GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive impairment or dementia</td>
<td>87 (57)</td>
<td>52 (70)</td>
</tr>
<tr>
<td>Patient had a mental illness</td>
<td>13 (9)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Concern of nurses, colleagues or family</td>
<td>8 (5)</td>
<td>11 (15)</td>
</tr>
<tr>
<td>Clinical intuition</td>
<td>12 (8)</td>
<td>5 (7)</td>
</tr>
<tr>
<td>Patient could not communicate</td>
<td>12 (8)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Patient could not explain his or her reasons for the decision</td>
<td>9 (6)</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Previously found to lack capacity</td>
<td>3 (2)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Patient was making a bad decision</td>
<td>2 (1)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Serious potential consequences of decision</td>
<td>1 (1)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>No answer</td>
<td>6 (4)</td>
<td>2 (3)</td>
</tr>
</tbody>
</table>

Table 1: Respondents exposed to capacity assessments in previous year and main reason for suspecting incapacity.

Table 2: Assessment tools used to assess capacity in each case.
For the aggregate score reflecting knowledge of the technical aspects of capacity assessment, the median (interquartile range) score for HDs was 19 (16 to 21) and for GPs 18 (16 to 21). For HDs who reported extra training about capacity assessment, the median (interquartile range) score was 21 (19 to 23) and for GPs 21 (19 to 22).

Both groups performed well on questions 6 and 7 (see appendix) regarding informed consent. Question 6 asked whether the doctor knows about the risks and benefits involved, and question 7 whether the doctor doing the capacity assessment should ensure the patient has all the relevant information for the decision. For question 6, 127 (84%) of HDs and 65 (88%) of GPs gave the correct answer of 'Essential'. Likewise, for question 7, 132 (87%) of HDs and 54 (73%) of GPs gave this correct response.

Both groups performed poorly on some questions (numbers 1 and 2 in the appendix) regarding the approach to capacity assessment in non-urgent treatment situations, and the generalisability of one capacity assessment to another, different decision. For question 1, 27 (18%) of HDs and 14 (19%) of GPs incorrectly nominated that the next of kin can give consent. For question 2, 50 (33%) of HDs and 40 (54%) of GPs were either incorrect or didn’t know that a capacity assessment for a particular decision does not generalise to other decisions.

Cultural competence was considered essential or desirable by 142 (93%) of HDs and 71 (96%) of GPs.

Table 3 shows the extent to which the doctors lacked confidence in undertaking capacity assessments.

<table>
<thead>
<tr>
<th></th>
<th>HDs</th>
<th>GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/152 (%)</td>
<td>n/74 (%)</td>
</tr>
<tr>
<td>Not confident</td>
<td>50 (33)</td>
<td>23 (31)</td>
</tr>
<tr>
<td>Confident for straightforward cases only</td>
<td>60 (39)</td>
<td>40 (54)</td>
</tr>
<tr>
<td>Confident for most cases</td>
<td>42 (28)</td>
<td>11 (15)</td>
</tr>
<tr>
<td>No answer</td>
<td>1 (&lt;1)</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

Table 3: Confidence of GPs and hospital doctors to assess a patient’s capacity to make a treatment decision, to the standard that they would be prepared to have their opinion presented in court.

Both groups showed equal preference for a short course, an online protocol or a tutorial or teaching session on how to assess capacity.

The themes that emerged from both the HD and GP responses were: lack of time; lack of knowledge and skill; uncertainty regarding legal aspects; difficulty with grey-area or high-stakes cases; lack of confidence and difficulty with family dynamics.

Several of the HDs’ responses indicated difficulties that were possibly more common in hospital, such as fluctuating capacity and ambiguity about whose job it was to assess capacity. Some respondents also reported indecision regarding the threshold for intervention, and a difficulty in assessing capacity when the patient may have a psychiatric disorder.

Emergency medicine doctors reported time pressures, competing priorities and that a lack of collateral information hampered their assessments. Intensive care doctors noted that the majority of their patients were under general anaesthetic, thus raising issues of surrogate decision-making. Anaesthetists commented upon lack of time, one-off interviews and a lack of knowledge of the patient’s prior functioning as difficulties.

Far fewer RMOs (n=40) completed the survey compared to SMOs (n=112). Of the comments received from resident doctors, there was acknowledgement of lack of confidence and skill, and uncertainty as to whether resident doctors were permitted to assess capacity. Table 4 shows themes and comments from hospital doctor respondents.

Some GP responses included: not knowing a patient well enough, difficulties with family dynamics and whether...
### Table 4: Themes arising from hospital doctor respondents.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Example comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>“Time pressures”</td>
</tr>
<tr>
<td>Knowledge/skill</td>
<td>“Knowing what to ask”; “Lack of knowledge and experience”</td>
</tr>
<tr>
<td>Grey-area cases</td>
<td>“..important but non life threats in a pt with grey area issues—e.g., mild cognitive/psychiatric or intoxication issue…”</td>
</tr>
<tr>
<td>Fluctuating capacity</td>
<td>“As I deal frequently with patients with brain tumours their status is in a constant state of flux…”</td>
</tr>
<tr>
<td>Legal aspects</td>
<td>“The confusing and often contradictory web of legislation.”</td>
</tr>
<tr>
<td></td>
<td>“Lack of knowledge of NZ law.”</td>
</tr>
<tr>
<td>Confidence</td>
<td>“Being sure I have accurately assessed their capacity.”</td>
</tr>
<tr>
<td>Roles</td>
<td>“Not having psychiatrist, psychologist or other trained people readily available to do a formal capacity assessment.”</td>
</tr>
<tr>
<td></td>
<td>“Fitting it into a busy outpatient clinic setting where it is not ‘core business.’”</td>
</tr>
<tr>
<td>Family dynamics</td>
<td>“Influence of family.” “Can be difficult when the family is quarrelling over the patient’s money.”</td>
</tr>
<tr>
<td></td>
<td>“Complex family dynamics.”</td>
</tr>
<tr>
<td>Psychiatric disorder</td>
<td>“Where religious ‘beliefs’ morph into delusions compromising competence…”</td>
</tr>
<tr>
<td>Inter-professional dynamics</td>
<td>“The challenge of engaging colleagues in different disciplines to contribute their expertise to the capacity assessments.”</td>
</tr>
<tr>
<td></td>
<td>“To get every health care staff involved in the care of the ‘index person’ to agree on the assessment decision.”</td>
</tr>
<tr>
<td>Threshold for intervention</td>
<td>“Depth of ability to understand risk associated with surgical (anaesthetic) procedures.”</td>
</tr>
<tr>
<td></td>
<td>“I frequently encounter patients who make decisions incompetently, so it would be impracticable and harmful to the therapeutic relationship to intervene in every case. It is therefore difficult to determine the threshold at which intervention is justified.”</td>
</tr>
</tbody>
</table>

### Table 5: Themes arising from GP respondents.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Example comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>“Time is often a factor, I can be hurrying.”</td>
</tr>
<tr>
<td>Knowledge/skill</td>
<td>“Knowing how to do the assessment and what factors to consider.”</td>
</tr>
<tr>
<td>Grey-area cases</td>
<td>“Assessing borderline cases where the patient may have partial capacity.”</td>
</tr>
<tr>
<td>Family Dynamics</td>
<td>“Sometimes the next of kin are in disagreement with each other…sometimes there are major family rifts where the family are at opposite poles…”</td>
</tr>
<tr>
<td>Legal aspects</td>
<td>“Lack of knowledge of legal issues.”</td>
</tr>
<tr>
<td></td>
<td>“Not knowing full legal requirements.”</td>
</tr>
<tr>
<td>Confidence</td>
<td>“Shouldering the responsibility of being the one to make this decision, plus concern at the possibility of being challenged, eg, by family, court system, lawyers…”</td>
</tr>
<tr>
<td>High stakes</td>
<td>“Testamentary capacity in a person with mild dementia”</td>
</tr>
<tr>
<td>Familiarity with patient</td>
<td>“Who do you believe? Especially when family members vocal about things and pressuring GP, and do not know patient or family well.”</td>
</tr>
</tbody>
</table>
another doctor should carry out capacity assessments in case an adverse finding compromised their relationship with the patient and their family. There were also comments about not knowing how to charge for capacity assessment. Some GPs were daunted at taking sole responsibility for capacity decisions, and some feared litigation. Table 5 shows examples of themes and comments by GPs.

Discussion

In general, the respondents' knowledge about the principles of capacity assessment was adequate and there was some evidence of better knowledge among those who had had training in capacity assessment. However, the majority of doctors were either not confident or confident only for straightforward cases, in being able to do capacity assessments to a medico-legal acceptable standard, that is, to a standard high enough to have their opinion presented in a court. The majority of respondents did not use a structured method of assessment. These findings suggest the respondents were aware of a need to improve their capacity assessments and that any teaching should focus on providing a structure for doing so.

A majority of respondents regularly encountered older patients and could recall concern about a patient's capacity on at least a few occasions in the previous year. Cognitive impairment or dementia were the most frequently reported reasons for the suspected incapacity. These findings highlight the importance of the skill of assessing capacity.

It is of some concern that one-third of responding HDs and over half of responding GPs did not appear to know that a capacity assessment applies to a specific decision. Many respondents incorrectly believed that a patient's next of kin, without having an enduring power of attorney (EPOA), could give legal consent on the patient's behalf. A significant number of respondents (HDs: 30%; GPs: 24%) did not consider capacity assessment to be within their scope of practice. This response is surprising considering the assessment of a patient's capacity is integral to obtaining informed consent.1

The Medical Council of New Zealand has advised that all doctors should be able to assess capacity.12 Education efforts could include an emphasis that capacity assessment falls within every doctor's scope of practice.

A limitation of this survey was the low response rate, particularly for GPs. The low response rate by the GP group in particular may be useful information for future research. The non-random selection of the sample prevents both quantitative and qualitative inferences being made.

Free text answers gave insight into difficulties doctors encountered in assessing capacity. Grey-area or high-stakes cases, and those associated with family conflict caused particular unease. Respondents reported varying capacity assessment problems that related to their particular specialties.

Deciding whether a person has decision-making capacity is a legal determination informed by medical and other evidence. Capacity can be difficult to assess, may not be clear-cut and involves value judgments about people's preferences and beliefs. The Code of Health and Disability Services Consumers' Rights (HDC Code)13 has no definition of incapacity, and no clear legal standards against which capacity is to be assessed. Where a patient lacks capacity to consent to medical treatment and healthcare, and there is no authorised decision-maker, Right 7(4) of the HDC Code sets out the legal position for giving treatment to a patient if it is considered to be in their best interests. Doctors may find themselves in a position where they need to justify progressing treatment without the patient's consent.

New Zealand's adult guardianship law, the Protection of Personal and Property Rights Act 1988 (PPPR Act) is complicated and has multiple tests for incapacity. Underlying both the PPPR Act and the HDC Code is the principle of presumption of capacity. The burden of proving incapacity to make decision(s) always lies with the person who considers that it may be necessary to take a decision on the person's behalf. The presumption of capacity does not, however, diminish the duty of care owed to patients or displace the duty to assess capacity as part of the provision of care.14

The United Nations Convention on the Rights of Persons with Disabilities (CRPD)
has added new impetus towards understanding the presumption of capacity and ways within clinical practice patients can be supported, where possible, to make decisions for themselves in the exercise of their legal capacity. The United Nations committee has cast doubt on New Zealand’s compliance with the CRPD and the Government is yet to progress integration of modern concepts of legal capacity into domestic law and practice. Moreover, carrying out capacity assessments requires doctors to be culturally competent and to recognise cultural diversity, especially if the person is from a different culture than the doctor. A capacity assessment may inform what measures can be implemented to support someone to make their own decisions, even where they may be impaired.

The survey suggested that medical education in this area is particularly urgent, given that the majority of respondents regularly encounter older patients and could recall concerns about a patient's capacity on at least a few occasions in the previous year.

The results of the survey have informed the development of a guidance, a Toolkit for Assessing Capacity, which aims to provide a consistent and systematic approach to assessing capacity within the New Zealand healthcare setting.

**Conclusion**

This research suggests that many of the doctors surveyed had deficiencies in their clinical and legal knowledge on assessing capacity, and lacked confidence in their opinions. Efforts to educate doctors on the importance of, and how to perform, a capacity assessment would be beneficial and well-received. Education needs to be offered in all modalities (tutorial, workshop, online) as no single method was preferred. Opportunities to discuss difficulties encountered with assessments may encourage doctors to do assessments that they may otherwise have referred on. This would augment training and could form part of continued professional development. Attention needs to be given at a higher level to the question of reimbursement of general practitioners as capacity assessments require more time than that available in an ordinary consultation. The role of other clinicians on the multidisciplinary team in assessing capacity could be developed further, possibly reducing costs and saving valuable GP time.

**Appendix 1: The survey**

What do you know about assessing capacity and what would help you do it better?

Impaired capacity to make decisions about treatment or other matters is becoming an increasing issue of concern in contemporary medical practice, and yet not all doctors are familiar with how to assess a patient's capacity. As doctors we routinely ask patients to make decisions about their treatment and other issues, but many older patients have complex medical comorbidities and cognitive impairment or dementia and may not have the capacity to make these decisions. Being unsure of what to do in situations like this can cause delays in decisions being made, increased length of stay, frustration for clinical teams and may result in poorer outcomes for patients.

However, doctors vary in how much they know and how much they need to know about capacity assessment. Medical education time is precious and it is important that sufficient but not excessive information is made available to doctors, in a variety of ways to suit the individual needs of the doctors.

Drs Greg Young and Crawford Duncan, psychiatrists at Capital and Coast DHB have been involved in doing, teaching and helping others with capacity assessments and are working with Alison Douglass, a lawyer, researching how we might update New Zealand's mental capacity law. We have prepared this survey to help us understand better what our medical colleagues know, and need to know, about assessing capacity. We plan to use the information from the survey to help us design teaching and information resources.
Please could you help us by spending no more than ten minutes completing this survey? The survey is anonymous, but we are interested in your area of work and level of training. The survey has been approved by Otago University Human Research Ethics Committee (number D15/213).

**Your completion of the survey will be regarded as your consent to participate.**

In this survey, a ‘formal’ assessment of capacity means an assessment that is based on a procedure that has been described in a book or article; an ‘informal’ assessment is based on intuition or clinical experience, but does not follow a protocol or structure.

**Are you a** (please circle one)

- House Surgeon / Registrar / Medical Officer / Consultant / Vocationally trained GP

**Which of the following best describes your medical specialty** (please circle one)

- Medicine / Geriatrics / Palliative Care / Surgery / Anesthetics / Emergency Medicine
- Psychiatry / Paediatrics / General Practice / Other (including house surgeon)

**Approximately how many of your patients are older than 65 years:**

- None
- 1% to 20%
- More than 20%
- All
- Don’t know

**In the past 12 months, how many times have you been concerned that a patient may not have had the mental capacity to consent to or refuse treatment?**

- Never
- A few times (<6)
- Quite often (6 to 12 times)
- Many times (more than 12 times)

**In the past 12 months, how many times have you assessed, either formally or informally, a patient’s capacity to make a treatment decision?**

- Never
- A few times (<6)
- Quite often (6 to 12 times)
- Many times (more than 12 times)
In the past 12 months, how many times have you had to complete a legal document or medical certificate relating to a patient's capacity to make a decision or decisions (e.g., an application to the court for a personal order, or activate EPOA).

- Never
- A few times (<6)
- Quite often (6 to 12 times)
- Many times (more than 12 times)

For the next five questions, please think about one occasion when you thought a patient might not have had the capacity to make a decision about treatment or discharge arrangements.

What was the main reason for you thinking that the patient might not have had capacity in this case? (Please select one response only)

- Patient was making a bad decision
- Patient was cognitively impaired or had dementia
- Clinical intuition
- Nursing staff, other colleagues or family expressed concern
- Patient could not communicate
- Patient could not explain his/her reasons for the decision
- Patient had previously been found to lack capacity
- Patient had a mental illness
- The decision had very serious potential consequences

Did the patient have any of the following conditions? (Circle as many as appropriate)

- Moderate to severe dementia
- Mild dementia
- Delirium
- Problems with communication (e.g., CVA with aphasia)
- Psychiatric disorder
- Patient needing emergency, life-saving treatment
- Patient required an anaesthetic
- Patient was intoxicated and needing medical treatment

What was the decision?

- To consent to an investigation or treatment
- To refuse an investigation or treatment
- A decision about discharge arrangements
- Other
Which of the following ways of assessing capacity did you use in this case?

• Informal, based on general discussion and clinical intuition
• Informal but also based on information from team members and family
• By asking particular questions that were specific to assessing capacity
• Using a capacity assessment protocol or questionnaire
• Referred the patient to a colleague (within or outside of the MDT) for a formal capacity assessment
• Didn't specifically assess capacity in this instance
• The issue resolved itself because the patient accepted medical advice

Did this patient lack capacity to make a particular decision, or did they lack capacity to make all decisions, or didn't you know?

• A particular decision
• All decisions
• Didn't know

The following questions are about capacity assessment more generally.

If an adult patient appears not to have capacity to make an important, non-emergency treatment decision and there is no Enduring Power of Attorney or Welfare Guardian, would you: (please select one)

• Make a treatment decision based on what is in the patient's best interests
• Get consent from the next of kin
• Refer the patient to a colleague for a capacity assessment
• Do a formal assessment of capacity yourself and decide what to do after the assessment
• Don't know

Once a patient has been formally assessed as lacking capacity to make a decision about medical treatment, s/he can be safely assumed to lack capacity for all future decisions about medical treatment:

Always true / Mostly true / False       Don't know

Once a patient has been formally assessed as lacking capacity to make one decision about medical treatment, s/he can be safely assumed to lack capacity any other decision about medical treatment:

Always true / Mostly true / False       Don't know
When formally assessing a patient's capacity to make decisions about medical treatment, how important are the following?

The patient is able to give logical reasons for his/her decision

Essential / Desirable / Irrelevant  Don’t know

The patient knows the benefits and risks involved:

Essential / Desirable / Irrelevant  Don’t know

The patient follows medical advice

Essential / Desirable / Irrelevant  Don’t know

The doctor doing the assessment knows about the risks and benefits involved:

Essential / Desirable / Irrelevant  Don’t know

The doctor doing the capacity assessment ensures that the patient has all the information relevant to the decision:

Essential / Desirable / Irrelevant  Don’t know

The doctor doing the capacity assessment ensures that any reversible condition that could impair the patient’s capacity has been treated:

Essential / Desirable / Irrelevant  Don’t know

The doctor doing the assessment considers other information about the patient’s functioning as well as what the patient says at the assessment:

Essential / Desirable / Irrelevant  Don’t know

How important do you consider cultural competence to be for capacity assessment?

Essential / Desirable / Irrelevant  Don’t know

The patient is able to “pass” a cognitive test, such as the MMSE?

Essential / Desirable / Irrelevant  Don’t know
In deciding if a patient has capacity to make a decision, which is the more important:

• The outcome of the decision, ie, what the patient decides
• The process by which the patient makes the decision
• They are equally important
• Don’t know

In general, would you expect a patient with a severe psychiatric illness such as schizophrenia to have capacity to make decisions about non-psychiatric treatment?

• Yes
• Approximately 50% of the time
• No
• Don’t know

Have you received any extra training in doing capacity assessments since you graduated?

• Yes
• No

How confident are you that you could assess a patient’s capacity to make a treatment decision, to the standard that you would be prepared to have your opinion presented in court?

• Confident for most cases
• Confident for straightforward cases only
• Not confident

Do you consider capacity assessment to be within your scope of practice?

• Yes, in most cases
• No
• Don’t know

How would you prefer to get information about how to conduct a formal capacity assessment?

• None, this is not in my scope of practice
• A tutorial or teaching session (1 to 2 hours)
• A short course (1/2 to 1 day)
• A webinar (online lecture or tutorial)
• An online protocol
Competing interests:
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