AAPL EXAMINER
American Academy of Psychiatry and the Law

AAPL: Ask the Experts

Neil S. Kaye, MD, DLFAPA
Graham Glancy, MB, ChB, FRC Psych, FRCP
Ryan Hall, MD

Neil S. Kaye, MD, DFAPA and Graham Glancy, MB, ChB, FRC Psych, FRCP (C), will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send questions to nskaye@aol.com.

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Q. What are your thoughts on psychiatric clearance for medical procedures (organ transplants, sterilization, implants for stimulators, bariatric surgery, prophylactic oophorectomy or mastectomy, gender reassignment surgery, etc.)?

Kaye:
This qualifies as one of the trickiest questions we have tackled! This column is called Ask the Experts, not Try to Stump the Experts. My first thought is where is the psychiatric issue? If the patient has the capacity for informed consent, (1) the doctor must perform the procedure.

My psychologist colleague does a lot of "psych clearances" for surgical procedures. He is very careful to simply say that the person appears to have the capacity to weigh (no pun intended) the information they have received but that the proper informed consent must be done by the person who will be doing the procedure.

I might go for the double negative approach of "Nothing in my evaluation leads me to conclude that the person lacks capacity to engage in the standard informed consent process that is part of the usual delivery of this proposed medical procedure." I can

discuss a person's understanding and hopes of what the outcome might be and perhaps opine on how realistic they are, but that is a slippery slope.

The desire to shift liability to us by colleagues is disturbing to say the least, and it is also discrimination against people who see a psychiatrist or may have a mental illness, disease, or disorder. I don't see why we would go down that path without serious protest. Our medical colleagues (and insurers) really want us to tell them if a person is a good candidate for a procedure or will have a good outcome and in most cases, that's out of our wheelhouse and strains the ethical limits of striving for impartiality and objectivity.

Glancy:

I have to say I do not feel as discombobulated about this question as my good friend and colleague Dr. Kaye. Assessment of competency is a core component of forensic psychiatry. Capacity is defined differently in different jurisdictions but revolves around whether the evaluee has the ability to understand the information around the decision in question and secondly whether they can appreciate the consequences of making a decision (1,2). Different jurisdictions in the United States and Canada define capacity for various decision-making situations. It is important to note that capacity is specific to a particular task and time. An individual may be lacking in capacity at the time of an acute psychiatric illness but quickly restored to capacity through treatment.

The assessor must understand the specific legal criteria for the test in their own particular jurisdictions. One of the problems is that there is rarely a red line for measuring the threshold of incapacity. Screening instruments such as the MOCA or the MMSE may be helpful but not definitive, and they can only be said to have clinical utility. Similarly, neuropsychological testing, which, of course, is time-consuming and expensive, cannot specifically decide whether somebody does not have the capacity but can only guide the assessor.

The difficulty Dr. Kaye alludes to is that to assess capacity for treatment, the assessor needs to have at least some awareness of the content of the informed consent process. For example, if a surgeon tells the patient that there is a 1 in 10,000 chance of death from the anesthetic, the assessor needs to be aware of that instruction in order to test how the patient understood the statement. The assessor then would need to explore how the patient processed the consequences of the decision based on that information. Obviously, the informed consent process generally includes more than one piece of information, and

the assessor must have only some idea of what information the patient has been told and how they process that information in making the decision.

In general, terms, however, the assessor can come to the conclusion that the person has, for instance, severe neurocognitive impairment, delirium, or severe delusional disorder that impacts the capacity to make decisions. Like many other types of assessment that the forensic psychiatrist performs, the person at one end of the spectrum or the other is generally easier to assess, and it is regarding those in the middle that making a conclusion becomes much more difficult.

Perhaps one of the most apparent and clearest psychiatric symptoms that may impair capacity is the presence of delusions.

In the prevailing case in Canada of Starson v Swayze, even an intractable grandiose delusional system was ruled insufficient to overrule the dignity and autonomy of a patient. In this case, the patient, who even changed his name to Professor Starson, even though he was not a professor and this was not his name, refused medication on the grounds that it would slow his brain down and prevent him from becoming famous. The patient stated that he preferred his delusional state to the boredom of normalcy.

The Supreme Court ruled that even though his delusional system meant that he was not acting in his own best interest, this did not affect his capacity to make a decision. It is of note that 15 years after being found not criminally responsible, he gave an interview to the newspapers stating that he was 17,000,000,000 years old and about to publish groundbreaking physics research about the speed of light and other things but was still under conditions from the criminal code review board.

In one setting where I work, in an accredited psychiatric hospital within the boundaries of a prison, which shares space with a geriatric population, it is not uncommon for the general practitioner to ask for an opinion on the capacity to give or withhold treatment on some of his patients. In those with severe neurocognitive disorder, who may, for instance, be refusing an operative procedure, I can generally generate an opinion, which is helpful for the general practitioner.

In conclusion, *nil desperandum*—do not despair; have faith (3,) Dr. Kaye. Not only can we contribute to the assessment of the capacity to consent to treatment, but we can also use this article to refresh the memories of our members.

Hall:

In general, forensic psychiatrists all know the most basic aspect of capacity is one needs to knowingly *(I want a procedure that will change my body and its functioning*), voluntarily (*no one is forcing me or applying undue influence*) and with understanding (*these are the risks and these are the benefits*) appreciate the actions they are about to partake in, in order to have capacity; whether that is entering a contract or having a medical procedure done. In general, we also know capacity is assumed unless there is behavior or a situation which raises the question if a person lacks it.

However, this question is getting to the specifics of the surgical medical fields or operations where voluntary in-the-moment capacity is not enough. Hence, more in-depth and specific evaluation to try to determine if the patient is psychologically healthy enough to be a candidate for what is being planned. This is where I think a big difference comes with my view on this question compared with Dr. Kaye's. Dr. Kaye notes that if a patient has capacity, the procedure must be done. In general, I would agree with that for most imminent lifesaving procedures (*e.g. appendectomy*), life prolonging procedures (*e.g. Whipple operation*), or physical pain reducing procedures (*e.g. orthopedic diskectomy*). I may even generally agree with it for most elective cosmetic procedures such as tummy tucks, nose jobs, or even liposuction, where there is no ongoing or daily lifelong maintenance required and assuming there is not a concern for a potential psychiatric condition such as body dysmorphia or a delusional disorder being related to the procedure.

So why do some fields of surgical medicine require that a mental health evaluation be done prior to the operation being done? Coming from an optimistic perspective, I will assume that many of the fields that require it is due to the "do no harm" aspect of medical ethics. It may be no different than requiring a patient after a certain age or certain medical history to obtain cardiac clearance before performing an operation. In addition, other ethical issues such as "medical stewardship" of limited resource may also justify this type of scrutiny in certain circumstances. The last general cause for these requirements which I will raise is that. often, these procedures were historically seen as "radical in nature" when they first came out, which resulted in a higher level of scrutiny to occur to limit the chances of harm. For an oversimplified and somewhat hyperbolic example, early on, bariatric surgery was seen as radical in that instead of diet, exercise, and medications to control weight, the surgeon was going to do an irreversible surgery, like a Roux-en-Y, that

may result in chronic pain, vitamin deficiencies and other unforeseen consequences over the rest of the patient's potentially long life.
I will not address the much larger question of whether mental health providers even have the ability to accurately predict how a patient will act after a future surgery just as some also question our ability to accurately look at future violence risk assessment. I agree with Dr. Kaye's raising this question though. Whether we do or do not, there is no one else but us to aid our surgical colleagues and the patients.

It is also important to recognize that mental health has been asked/forced to be part of the process because these procedures, in a very fundamental way, result in lifelong changes which frequently require maintenance (*e.g.: lack of reversibility, lifelong commitment to taking medications, lifelong required daily behavioral changes*). In addition, in certain fields, such as bariatric surgery or gender reassignment surgery, the organs being operated on are often functional, non-diseased parts of the body. Another element that must also be acknowledged is that the people who are undergoing these interventions are often thought to have a psychological element to their condition or for why they need/want the intervention.

While trying to not sound inflammatory, I am acknowledging that there is often an inherent psychological or behavioral element as to why the procedure is being done. For example, with certain organ transplants there historically was a significant number of the procedures needed due to psychologically influenced behaviors such as IV drug use or alcohol consumption. For individuals considering bariatric surgery there are often concerns about impulse control and sticking to a post operation diet which, if not followed, could be detrimental to the individual's health; more so than being left in an untreated state. For gender reassignment surgery, theoretically there are functional body parts but there is a psychologic element where the individual does not feel that their identity matches their biologic sex. For spinal cord stimulators there is the question about chronic pain's mental impact on the individual.

In the context of acknowledging that there are mental health or psychologic elements "generally" found in the majority of the individuals undergoing a procedure that requires psychologic clearance, it is understandable why additional mental health oversight was sought just like cardiac clearance. The real question going forward will be what does the evidence base show regarding this extra level of scrutiny? Does it really reduce harm and provide benefits to the patient or is it just a hurdle which unnecessarily limits access to treatments?

As surgical fields and medical ethics progress, will the psychiatric and psychological fields also improve in objectively providing these evaluations which often look at factors beyond just general capacity? At some point will it be determined that psychologic clearance is no longer required for every individual patient undergoing a specific procedure? One day these questions will be answered, but for right now mandatory evaluations are still required as part of the standard of care for certain treatments and are hopeful of reducing harm to patients and not just being a hurdle or a way to spread risk or blame for failures.

Take-Home Points:

We have all been challenged by this question and addressed it from different perspectives. It seems that part of the problem is that there is inherent ambiguity in the question itself. What is the real question for which you are being consulted? Is it help in ascertaining the capacity for informed consent for a specific procedure, in which case knowing enough about the procedure/outcomes could be relevant, or is it more of a request to help predict the patient's ability to tolerate the procedure, is there some reason a psychiatric condition would affect the outcome, and can the patient comply with expected aftercare needs or necessary lifestyle modifications. In the latter, we may have more to offer as experts in behavior.

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