The Two Million Dollar Cheque: Practical Issues on Capacity

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Background

- 95yr man, living alone on an acreage
- Never married, no children, nephew & niece in USA.
- Previously farmed, had significant assets after sale of farmland to Saskatoon developer.
- Multiple short term medical admissions for many health issues
- Patient had driving license suspended since 2003 but continued driving his car into the city, at one time hitting a motor home on his acreage

Background

- Had refused to consider home assistance or a private care home as he was reluctant to pay for it.
- When a niece arranged for home care which she paid for he would not let them into the house.
- Had always refused to give anyone enduring power of attorney, but had a will.

Presentation to Hospital

- Patient found lying on floor incontinent of stool & urine
- Unable to give clear history surrounding fall
- Said he had been lying on the floor for more than a day.
- Found to have end stage congestive heart failure and admitted
- During the course of hospitalization had fluctuating alertness and orientation parallel with cardiac functioning

Possible financial abuse raised

- Nephew observed by nurses going into patient's room, placing filled out $2 million dollar cheque in front of patient, and cued patient to sign his name.
- Nephew left for the bank with the cheque

Urgent psychiatric assessment

- Elderly man sitting up in Broda chair talking to non-existent person in room (while alone)
- Moaning extensively
- Arms covered in bruises

Urgent psychiatric assessment

- Patient agreed that he had written out a 2 million dollar cheque, but no recall of having a cheque book, who brought one in, no recall of names of lawyers, accountants or whether he had enduring power of attorney.
- Tired, weak, disorientated, short term memory loss, mood “I’m tired”, affect restricted, low tone, slurred speech, difficulty comprehending and expressing answers. Unable to provide details of understanding of POA.
- Mood “terrible”, in pain.
- Not oriented to time and date but knew he was in SCH
- No insight into illness

Psychiatric Assessment

- “Not competent to make medical, personal or financial decisions. Cannot assign POA”
- Psychiatry competed documentation of incompetence (now called incapacity) for the Public Trustee and provided to SW
- Social worker contacted the Public Trustee’s Office, faxed incapacity documentation.
- PT contacted bank, transaction blocked with nephew and the 2 million dollar cheques.

Followup

- SW set up meeting with the patient's two lawyers and long-standing financial advisor.
- Financial advisor confirmed that patient had a longstanding pattern of giving his niece and nephew $500,000 each year as he didn't want to leave any money to "the damn government"

Followup- later in the week (and earlier in the day)

- Able to speak clearly about wishes and finances.
- Able to explain concept of POA as well as potential benefits and risks
- Meeting with lawyer and financial advisor
- Enduring POA signed (to financial advisor) and cheques approved
- Patient continued to decline and died within a few weeks.

Components of Capacity

- The ability to communicate a choice
  - Sensory abilities (vision, hearing)
  - Speech/language
- The ability to understand the specific choice
- The ability to appreciate fully the broad ramifications (to him/her-self and others) of a specific choice

Factors Which May Influence Capacity

- Communication (Basic language skills, second language issues)
- Cognitive skills (MR, dementia, mild cognitive impairment, executive functioning)
- Education
- Mental illness
  - Depression
  - Psychosis
- Delirium
  - Medications
  - Physical illness such as UTI, URI

- Capacity is task specific
- Capacity may vary from time to time
  - Fluctuation throughout the day in delirium, but typically worse towards evening in dementia
  - Gradual decline with chronic disease such as Alzheimer's disease
  - Gradual improvement after recovery from an illness or changes in medications

- Capacity determination may be affected by tests administered to assess this and even on the assessor and their skill, outlook and experience
- Capacity determination may be affected by societal values
  - Relative value placed in individual self-determination versus the common good
- Capacity should be seen as a continuum: may range from severely impaired to fully intact
  - How does a person compare to the average person in a similar context

- Stringency of criteria related to incapability are affected by seriousness of decision
  - Risks of treatment versus non-treatment
  - Complexity (and possibly financial value) of assets
  - Potential impact on self and others
    - Heavy smoker with dementia causing fires in waste paper baskets compared to non-smoker with same level of dementia … both insist on living independently

Assessment of capacity

- Individual interview (separately from others persons with potential conflict of interest)
- Direct observation
- Family/caregiver and other collateral information (caution about motives)
- Objective evidence of functioning (bank records such as NSF cheques, residential documentation of non-payment of bills)

Cognitive and functional testing (occupational therapists, psychologists, speech-language therapists)

- MMSE (The Mini Mental State Examination; designed for typical Alzheimer's disease, less useful for other dementias with more executive dysfunction and less memory loss
- MoCA (Montreal Cognitive Assessment; short screen assessing for a more mixed cognitive impairment)
- The Executive Interview (Exit-25; captures executive cognitive deficits in mild and less typical Alzheimer's type dementia; longer and more complete than the MoCA)

Cognitive and functional testing (occupational therapists, psychologists, speech-language therapists)

- Trail Making Test (provides information about visual search speed, scanning, speed of processing, mental flexibility, as well as executive functioning)
- Cognistat
- Addenbrooke's Cognitive Examination
- Independent Living Scales

Particular challenges in cognitive testing for capacity

- Cognitive impairments due to non-Alzheimer dementias (Pick's disease, vascular dementia)
  - Impaired executive functions such as reasoning, insight, judgment

  yet:

  - Sometimes intact memory, speech, basic ability to answer questions

Questions?