



EDITORIAL

How to assess competence of the critical ill patient? Ever closer to the answer[☆]

¿Cómo determinar la competencia del paciente crítico? Cada vez más cerca de la solución

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The capacity to decide is the essence of personal freedom in life. The capacity to give consent, or psychological maturity for making decisions referred to life, is based not only on cognitive development, intelligence and will, but it also implicates affectivity and feelings—hence the difficulties in deciding which all people experience at one time or other.

The principal of autonomy is legally contemplated under article 10.1 of the Spanish Constitution, and in the health-care setting implies that each person has the right to decide about his or her own life.

All physicians have the legal and moral obligation to request informed consent from their patients before providing treatment,¹ and in order for such consent to be valid, the patient must be competent. Determination of the competence of the critically ill patient is therefore essential, not only in observance of personal autonomy but also to protect those patients in which the capacity to decide has been altered as a consequence of illness, for example.

When the patient is not competent for deciding, we must seek a relative or person capable of legally representing the patient in decision making. A range of psychological and psychopathological factors influence cognitive capacity and the emotional condition of the patient admitted to the Intensive Care Unit (ICU). Delirium, also referred to as ICU psychosis, confusional syndrome or confusion, is the most common psychiatric disorder in the critical patient, and is accompanied by physiological and psychological alterations that have an impact upon the clinical course and outcome.

It is associated with important morbidity-mortality, affects patient quality of life at hospital discharge,² and is moreover underdiagnosed.³ Disability can affect up to 48% of all patients admitted to hospital clinical areas,⁴ and according to Ely et al. delirium can affect up to 80% of all patents admitted to the ICU,^{5,6} while Dyer et al.⁷ has reported a mean prevalence of up to 37% in postoperative cases—among other reasons due to the use of psychoactive drug substances.⁸ Critical disease and verbal communication difficulties complicate cognitive evaluation of the patients.

Act 41/2002 under articles 5.3 and 9.3.a. attributes the function of evaluating purported patient incapacity or disability only to “physicians”, and the authority and responsibility pertains to the “physician attending the patient” or to the “supervising physician”.¹ Nevertheless, before deciding possible patient incapacity, a physician can ask for formal evaluation to be made by another specialist, e.g. psychiatrist or clinical psychologist. In any case, however, the ultimate responsibility belongs to the physician, and cannot be delegated to anyone else. Considering the above, it is essential to have reliable means and tools for evaluating the competence of critical patients.

One of the most commonly used instruments for this purpose is the 30-item Mini-Mental State Examination (MMSE).⁹ Its main inconvenience is that an important proportion of patients in the ICU are unable to perform the test.

The Confusion Assessment Method (CAM), developed and validated for use by healthcare personnel (physicians and nurses) without psychiatric training, is the most widely used instrument,¹⁰ though it cannot be used in patients subjected to mechanical ventilation. Recently, Ely et al.⁶ modified the CAM for use in evaluating patients on mechanical ventilation who cannot communicate verbally, ad referred to the instrument as the CAM-ICU. Toro et al.¹¹ validated the

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CAM-ICU (Spanish version) applicable in our setting to patients either with or without mechanical ventilation. Critical illness and verbal communication problems complicate the cognitive assessment of the patients.

The article published by Bernat et al.¹² in this same number of the journal offers relevant information on evaluation of the competence of critical patients in relation to decision making, based on their cognitive capacity, ability to interact with the environment, and the role attributed to the patient and to the relatives, physicians and psychologists that intervene in the disease process.

From the legal perspective, four fundamental criteria have been considered and evaluated in this context: the understanding of information, comprehension of the situation and its consequences, reasoning of the therapeutic options, and the communication of choice.¹³ However, in clinical practice there are no intervention guides other than a series of general orientating recommendations. As has been pointed out by our authors¹² using the fully validated MMSE for evaluating cognitive capacity,⁹ 85.2% of the patients in their observational study suffered impaired cognitive capacity, and in 51.8% of the cases such impairment proved moderate to severe.

Regarding the elements causing stress—an important factor—the authors found that emotional variables, the MMSE score and subjective parameters relating to decision making all correlate increased anxiety and depression to lesser cognitive capacity ($p=0.048$), and that age and a low educational level have a negative impact upon competence—in coincidence with the observations of other investigators.

According to the questionnaire for the subjective assessment of the information and decision making process in the hospital setting (*Cuestionario de valoración subjetiva del proceso de información y toma de decisiones en el ámbito hospitalario*, CITD), developed by Ballester et al. on an ad hoc basis (2009), patients wish their family to be informed of their condition, treatment and prognosis. However, they assume their own autonomy and feel capable of making the decisions that correspond to them (65.6%). In addition, almost two-thirds would like to receive prior notice of the possibility of death, if a fatal outcome is anticipated. This underscores the current tendency to abandon paternalistic attitudes on the part of the physicians in benefit of increased respect for patient autonomy, in the context of the mutual relationship between both parts—this being known as the so-called psychosocial or “patient centered” model.

Another interesting observation of this study is that the physician–patient relationship is increasingly appreciated: most patients (74.1%) agree that bad news should be given by the physician, and that the presence of a psychologist in the ICU is desirable as a means for facilitating the relationship. These findings invite to a profound updating of the physician–patient relationship, in the way started by Balint in his work.¹⁴ It is not surprising that the lack of information on the part of the professionals is the main factor of stress for the patient, in coincidence with the observations of other authors.¹⁵

In reference to one of the main findings of the study, emphasis must be placed on the manifest wish of critical patients to assume their own autonomy, to have the physician nearby, and to receive more information.

Lastly, adherence to the recommendations of the authors in reference to individualization of the determination of patient competence based on neuropsychological assessment, maximum respect of autonomy, and the avoidance of a stressing environment, contributes to bring us ever closer to solving the problem of establishing competence in the critical patient.

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