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Perspective

Capable of More: Some Underemphasized Aspects of Capacity Assessment

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Background: *The 4-abilities model of decision-making capacity is vulnerable to constricted application and teaching.* **Objective:** *The authors attempt to assert the fundamentally clinical nature of capacity evaluations, while acknowledging that the concept of decision-making capacity must be legally grounded.* **Methods:** *Relevant aspects of clinical care are examined and emphasized as they apply to the evaluation of capacity for medical decision making.* **Results:** *Accessing patients' maximal abilities, attending to noncognitive aspects of choice, and identifying diagnostic explanations for patients' difficulties are important components of these assessments.* **Discussion:** *The evaluation of medical decision-making capacity is not a purely forensic task; it is enhanced by an approach that bridges the clinical-forensic divide.*
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"There is a grave error in equating the amount of health legislation passed, the good of the patient, and the ethical behavior of the physician. … We must not overdo a good thing as may happen when legislation begins to replace conscience."—Irvine Page[1]

INTRODUCTION

Capacity evaluations are increasingly requested of psychiatric consultation services.[2,3] Causes of this phenomenon are likely multifactorial. Greater recognition and acceptance of mental illness may make consultees more vigilant about psychopathology's effects on medical decision-making.[4] Fears of litigation and an "audit society" can encourage bringing in a perceived expert to negotiate the clinical-forensic border zone of capacity assessment.[5] Focusing on autonomy and paternalism in medical ethics[6–8] highlights an important concern but sometimes obscures others in its glare.[9]

Although paralleled by the development of medical ethics,[10,11] today's concept of medical decision-making capacity was "drawn directly from the law's approach, not from an *a priori* attempt to devise an ideal model."[12] Some feel that any initial contributions of moral philosophy in this area have become diluted or equated with law and regulation, especially regarding individual autonomy.[13,14] Meanwhile, clinical translation of capacity concepts was[15] and remains[16] carried out primarily by forensic psychiatrists.

Training and practice in the area of capacity center on the 4-abilities model (i.e., communicate a choice, understand the pertinent information, appreciate the circumstances and consequences, and rationally manipulate the information[16]) that emerged from this forensic work. This model provides a solid standard of care for capacity assessment. However, key figures within forensic psychiatry have warned physicians against being seduced by the associated "alluring rationality of legal thought"[17] and reduced to "informed consent technician[s]."[18] With basic civil rights at stake, capacity issues must have a legal

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reference point. Nonetheless, important clinical elements of capacity evaluation can be marginalized via narrow adherence to a legalistic approach.

In our experience, trainees are particularly (and probably necessarily) prone to strict application of the 4-abilities criteria. Just as experience and education are needed to help them move beyond a too criteria-bound approach to psychiatric diagnosis, similar guidance is needed here. The same might be said for experienced physicians who do not routinely assess capacity. This article focuses on some downplayed elements of capacity assessment. Case capsules are used to provide clinical emphasis of specific points. (*Note*: these vignettes are not meant to capture the totality of each case.)

The parts of capacity assessment reviewed in this article include accessing the patient's maximal abilities, accounting for noncognitive aspects of decision-making, and identifying the place of diagnosis in any unsolicited entry of medicine into people's lives. We do not believe that the 4-abilities model excludes these issues. Rather, we believe that in its rawest form the model can be vulnerable to narrow interpretation. We hope that by highlighting these elements of capacity assessment, this article might stimulate more explicit incorporation of them into education and practice.

ACCESSING CAPACITY

"Never do something for just one reason"[19] is good advice for assessors of capacity. A capacity evaluation is not a circumscribed task that begins and ends with satisfaction or not of the 4-abilities criteria. The inquiry is ideally conducted in a way that helps the patient bring all of his strengths to bear on the challenge before him. The word capacity itself refers not just to an ability but also to a potential maximum.[20] Each question or statement by the capacity evaluator potentially pursues the dual ends of not only *assessing* but also *accessing* the patient's optimum performance. Grisso and Appelbaum have elaborated on the idea that "there are good reasons why an attempt to correct or compensate for … deficits should be considered an essential part of the evaluation."[21] It is possible to see compromised confidentiality (via involvement of the court) or divided loyalties (between the patient's stated desires and those of others) as casting one in a purely forensic role during capacity assessment. Kim succinctly noted that most routine capacity-to-consent evaluations do not involve court proceedings and that loyalty usually remains to the patient alone; he identifies the interests involved as "the patient's welfare interests and the patient's autonomy."[22] It is in both of these patient-centered interests that one tries to bring out the patient's best performance.

That facilitation of capacity is achieved by experienced capacity evaluators is suggested by studies repeatedly showing that many patients end up cooperating with medical advice following the consultation.[23–25] This cooperation is not always owing to successful treatment of an incapacitating illness—patients change their minds.[26] Of course, cooperation with doctors does not imply capable decision-making. It does, however, show that opportunities for clarification, negotiation, and persuasion exist within the seemingly narrow confines of a capacity evaluation. Simon pointed out that even among patients ultimately found to lack medical decision-making capacity, these efforts might help gain their assent to the choices later made by surrogates.[27]

The actual work of accessing capacity is usually uncomplicated. Repeating information and breaking it up into manageable chunks or down to essentials may be all it takes to "activate" cognitively-limited patients.[28,29] Doing so can render subjects with schizophrenia indistinguishable from controls on the MacArthur Competence Assessment Tool.[30] Conversely, the addition of even a small amount of extraneous information to an informed consent discussion was found by Kennedy et al. to incapacitate 50% of previously capable deciders with psychotic disorders.[31] Bridging language, culture, and education gaps can clear up opaque decision-making in those who are unable to explain, or are unaware of, the nature of those gaps, as the following case illustrates.[32]

> A 66-year-old male Christian Scientist is found lying on the sidewalk unconscious. He is discovered to have end stage renal disease, likely due to long-undetected hypertension and type 2 diabetes mellitus. Upon waking, he rigidly refuses all interventions, including hemodialysis, on the basis of his religious beliefs. His family members, also adherents to the faith, are not as strict in their views on medicine. Although they disagree with his decision, they respect it as normative. The consultant confirms the cultural norms involved and mirrors the family's approach to the patient, which leads to a rich discussion and the conclusion that he has the capacity to refuse dialysis. Efforts shift to helping all involved prepare for the future.

More subtle than the aforementioned factors, cognitive biases can underlie what initially seem like irrational choices. Brock and Wartman identified several of these biases, including myopic approaches to problem-solving, downplaying of risk, optimistic framing of problems, and blindness to the effects of one's decisions on others.[33] Shea recommended that psychiatric interviews begin with several minutes in which the patient is encouraged to speak uninterrupted.[34] During this time, the patient spontaneously reveals what is foremost on his mind and how it is being processed. In a capacity evaluation, subsequent discussion can be an exchange between doctor and patient that includes inquiry, education, advice, and respectful challenging. The last of these might employ "devil's advocate" probing that attempts to access and confirm (or not) the internal consistency of the patient's decision and reasoning. The 4 abilities emerge from all of this in a more fluid and full way than they do from direct questions. In the process, the patient's decision-making is subject to change, and the evaluator retains possession of the tools and obligations of a physician caring for a patient.

Use of those tools can at times generate concerns about paternalism.[35,36,9] There are distinctions between coercion, pressure,[37] persuasion, and advice, which cover a lot of relational territory and exist on a continuum of permissibility that varies with the clinical situation.[38] Because patients are considered competent until proven otherwise, persuasion and advice may not be unduly coercive, even when incapacity is suspected.[39] These activities are parts of the doctor-patient relationship as "a cooperative relation between expert and non-expert."[40]

The physician's rhetoric and educational efforts can reinforce information and the patient's understanding. Further, in provoking an exchange, they probe a patient's reasoning abilities and bring private processes (rational or not) into the interpersonal open. Once out there, the patient's thinking on the medical issue may not only clarify capacity issues but also challenge the physician's flexibility and sensitivity in considering the patient's best interests. Such is the case in the familiar, yet always difficult, situation presented here.

> An 80-year-old woman with early Alzheimer's dementia and osteoarthritis is admitted with rhabdomyolysis after a neighbor found her lying on the floor in her home. Concerned about further falls, physical therapy recommends placement in a skilled nursing facility. The patient refuses, stating that she found 2 prior skilled nursing facilities demoralizing. With limited recall of her fall, she denies aspects of it but acknowledges being an unsteady walker. She wryly asks if gravity exists in nursing homes. Her physician concedes the point but counters that nurses exist in nursing homes and she would not find herself on the floor for days. The patient states that she would rather "die on the floor in my home than rot for a few years in a nursing home."

Obviously, in trying to access a patient's maximal capabilities, one must take care not to manufacture them. There is a danger of putting words in a (compromised) patient's mouth. Although this danger cannot be discounted or fully eliminated, it can be mitigated by the examiner's self-awareness and empathy. Attunement to one's own preferences and hopes can protect against mistaking them for the patient's.

NONCOGNITIVE FACTORS

The standard model of capacity has been criticized for being an overly cognitive one.[41–43] This cognitive focus may be a byproduct of the model's legal heritage, the measurable nature of cognition, and concern about introducing highly subjective variables into civil liberty issues.[12] Also, some basic ideas about human dignity hinge on our rational capacities.[44] Nonetheless, the idea of "persons as rational and more" is generally acknowledged by contemporary philosophers, psychologists, and neuroscientists.[41,45] As such, it seems reasonable to go beyond cognitive considerations when facing questions about why, when, and whether to respect patients' decisions.[46–48] Some patients who at first blush seem lacking in 1 of the 4 abilities "may be using 'non-rational' strategies to reach an appropriate and valid decision."[49]

A range of views exists on the role of emotions in decision making. Challenged by Charland[42] on the issue of "emotional capacity," Appelbaum acknowledged its relevance but was cautious about its practical application.[12] Halpern focused on the potential for "concretized emotion-belief complexes" to "derail" the decision-making process.[43] There is a long history of those who hold emotions to "always involve a false estimation of the objects of our emotions. They compare emotions to diseases."[40] Of course, emotions sometimes literally are signs of disease, but "strong

feelings" are routinely identified by people as influencing their decisions.[50] "Strong thoughts," by contrast, is an awkward expression and an uncommonly invoked motive. Callender noted that desires and emotions can "override values" and rationality but he allowed for the possibility that a patient might capably account for those feelings as informing "what she 'really wants.'"[50] Integrating multiple viewpoints, White asserted that emotions are indispensible to decision-making and are actually legitimate, necessary pieces of information.[41]

A capacity evaluator might immediately be struck by a patient's intense affect and the extreme medical situation producing it. A patient overcome by fear, sadness, or anger, and rejecting presumably reasonable medical advice, always appears irrational—and he very well might be, but not by virtue of his affect alone.[51] Just as a standardized cognitive examination score does not, in and of itself, determine incapacity, no type or intensity of emotion does so either.[52]

Overwhelming affect can prevent a patient's meaningful participation in a capacity evaluation. In this case, the emotion might be either a signal that the patient cannot tolerate the situation or evidence of a pre-existing vulnerability that heightens the intensity of an otherwise manageable situation. In the spirit of accessing the patient's best performance, the evaluator expresses concern, offers help, and returns later. Assessment cannot be deferred indefinitely (or, sometimes, at all), though. If intense affect proves intractable and obstructive, it might, in sufficiently high-stakes medical situations, overcome the legal presumption of competence. The evaluator is then left with the unsatisfying, but unavoidable, conclusion that the patient's inability to demonstrate capacity is effectively the same as lacking it.

More often, patients' emotions are not so impenetrable. The "rational and more" viewpoint then informs a sensitive yet direct examination of emotional contributions to decision-making. Simultaneously experiencing and discussing feelings can help a patient articulate and determine how they contribute to her choice. Emotions being less clean-cut than cognition, they can lead to less clean-cut decisions. In the following case, the patient's ambiguous, inconsistent decisions seemed arbitrary until emotional factors were accounted for.

> A 40-year-old woman has been hospitalized for 2 weeks with locked-in syndrome following a brainstem injury sustained in a skiing accident. Psychiatry is consulted to assess her capacity to make decisions about continuation vs termination of life-sustaining care. She has reportedly expressed different preferences at different times. Through an intense yes-no interview conducted via eye blinks, the patient expresses grief and fear about both life and death. Both patient and psychiatrist come to realize that she does not know what she wants; she is overwhelmed and needs time. A plan to address her evolving feelings and decision-making over the coming weeks and months is discussed.

Emotions are important causes and effects of the values and desires that guide behavior.[41,53] Medical beneficence is sometimes equated with minimizing risk and maximizing longevity; in this framework, any treatment refusal can seem irrational.[9] However, these are not every person's highest values, nor always unconditional ones for a given patient. In the end, "health is only one value among many."[54] Immersed in our profession, physicians can lose touch with the diversity of values that compete with health. Engelhardt emphasizes that in a pluralistic society, "the patient will need to know the moral and professional ideals of the physician.[55] So too, the physician will need to understand the patient's expectations."

Health and longevity are core concerns of medicine and the usual goals of those seeking health care. However, many patients do not invite medical attention. Others, once aware of their options, see them as conflicting with values such as independence or pain/fear avoidance, which then assume higher priority. That is, a patient's values hierarchy might be arranged *or rearranged* incompatibly with medical advice. Patients do not always offer these explanations; they initially might not even be aware of them. Physicians also use "values-based reasoning," which has been shown to introduce considerable bias and variability into capacity evaluations.[56] Treating capacity assessment as a "dialogue" in which honest ideas about personal and professional values are exchanged can clear things up for both parties and sometimes create room for negotiation.[57,58]

There is some debate as to what rearrangement of values means regarding decision-making capacity. For instance, Halpern suggested that both deviation from previously held values *and* fixed decision-making can be evidence of incapacity.[43] White, on the contrary, accommodated situations where a patient newly and

capably figures that "the self to which all future therapeutic endeavors will apply is a self that is not related to her in any meaningful way" and re-sorts her values accordingly.[41]

These ideas bring into play the concept of authenticity, which might be thought of as the "self" part of the self-legislation often used as a shorthand definition of autonomy. Kraemer defined authenticity as the ability of individuals to "recognize their own feelings as their own and identify with them."[59] Decisionwise, authenticity has a longitudinal element. It strings our choices together in a way that keeps them from being arbitrary or cross sectional; it gives life coherence.[61,62] Because self and circumstances vary across time, Nelson et al. find authenticity unnecessary to the concept of informed consent.[62] Still, many see authenticity as integral to capacity concerns and even as the object of the respect that autonomy warrants.[63,60,61] Fistein pointed out the face validity of "long-standing values … [as] morally significant," going so far as to imagine "an argument that the capacity for autonomous action is retained as long as … [these values] persist."[64] The following case illustrates how long-standing values can intersect with concerns about mental illness, creating a need for skilled assessment.

> A 75-year-old man with type 2 diabetes mellitus is admitted with left foot cellulitis and osteomyelitis. Amputation of the foot is recommended, but declined by the patient. He recognizes that the infection will likely spread but states only, "if it's my time, it's my time." He denies thinking about suicide but states that he would welcome death. He has been unsuccessfully treated for major depressive disorder (MDD) for the past year in the context of restricted physical functioning. His primary care physician corroborates that the patient has long had a minimalist attitude toward medical intervention, which likely contributed to his recent troubles. His providers hope that a psychiatry consultation will "sort this out."

Whether owing to ineloquence, stubbornness, paranoid delusions, or cognitive impairment, many patients cannot or will not explain their contested, high-stakes medical decisions. Before reaching a conclusion of incapacity, evaluators can try to view the decision against the broad sweep of the patient's prior life choices. Doing so may help the evaluator give voice to the patient's perspective. Speculating out loud about the patient's past choices and current position can stimulate a conversation that accesses capacity. Even if the patient remains inscrutable or incapable, the information gained can be of future use to a surrogate decider.

It is argued both that emotions, values, and authenticity are accounted for and neglected by the 4-abilities approach.[65,66,12,42] These arguments usually revolve around the appreciation component of the 4-abilities model, which is seen as the most complex of the group. Some see appreciation as able to accommodate noncognitive aspects of decision-making. There is unresolved tension between ideas that these aspects of decision-making are already accounted for in the current model and that they are also too unwieldy to carry much of a legal or ethical load. Regardless, the recurrent nature of these debates suggests the need to remind clinicians that these noncognitive factors are complicated and important when thinking about capacity. Paradoxically, that very complexity might be behind their utility in cases where a strict 4-abilities approach produces ambiguous conclusions and an uncomfortable evaluator.

INCAPACITY AND PSYCHIATRIC DIAGNOSIS

Cognitively or non–cognitively based, impaired decision-making capacity points to profound psychologic dysfunction. We suggest that every incapacity determination (excepting those associated with devastating neurologic conditions such as coma and severe mixed aphasia) be backed up by a psychiatric diagnosis. Rather than returning to a time when the presence of mental illness implied incapacity, we advocate an approach where the suspicion or presence of incapacity triggers pursuit of mental illness–based explanations for it.[11]

Requiring diagnoses is not just about identifying reversible causes of incapacity. Why are physicians permitted to question and intervene against a person's presumed autonomy? The doctrine of informed consent and the duty to act beneficently toward patients are 2 major reasons. These, and other parts of medicine's professional morality, carry privilege as well as duty.[67,68] If medicine's ethical code creates and justifies situations where patients' decision-making capacities are questioned then that suggests that we should stay within the profession's bounds in those situations. Disease is the main place where doctors have the expertise and social sanction to enter and

sometimes intrude into people's lives.[69] Without diagnoses, we risk stretching the boundaries of that remit. When that happens, pure value judgments, good intentions, and psychologic intuitions can become the bases of incapacity determinations.[70]

Diagnoses, accompanied by patient-particularized connections to incapacity, identify what Silberfeld and Checkland called "causal influences" and fill "inferential gaps."[71] That is, they say what is incapacitating the patient and how. It is useful from the start of a capacity assessment to pose the question, "If this patient is incapacitated, what is he incapacitated by?" At the beginning, the answer will involve one or more broad symptom domains, and this will give structure to the interview and examination. For instance, assessing understanding in a patient with cognitive impairment is quite different from doing so in one with anxious avoidance of medical issues. A symptomatic-diagnostic perspective thus contributes to both the process and the outcome of the evaluation. It also puts a check on understandable but premature movement from prepackaged psychiatric diagnoses to conclusions about incapacity. Rather than presuming that an incapacitated patient with a mood disorder is incapacitated by his mood disorder, one asks: How is that illness incapacitating this patient? Is another illness present? Are we confident about our assessment? Answering these questions fills the inferential gap.

Any 1 of the 4 abilities can be affected by different types of psychopathology. Likewise, any given psychiatric disorder can impair capacity in multiple ways, sometimes in a single patient. Schizophrenia demonstrates this idea. Poor insight and delusional beliefs are striking, seemingly obvious explanations for incapacity in these patients.[72,73] In exceptional cases,[74] incapacity in schizophrenia and other psychoses does result from the patient's positive symptoms.[75,76] However, among patients with schizophrenia and compromised decision-making, incapacity correlates most robustly with cognitive (and, to a lesser degree, negative) symptoms.[77,78] As seen in the next case capsule, the cognitive symptoms of schizophrenia can sometimes go initially unnoticed at the bedside, where structure is present and aversive stimuli absent. At the actual moment of decision, those conditions often fall away, and problems with set-shifting and response selection emerge.

A 48-year-old woman with schizophrenia presents with weight loss and hematochezia. Colonoscopy is advised. The patient refuses and psychiatry is consulted. No active positive symptoms are discerned. She understands the nature and reason for colonoscopy, but reports strong aversion to it. She desires a "CAT scan" instead. After further education and attention to her concerns, she agrees to the colonoscopy. When the time comes, she again declines and demands a "computed tomography scan." The cycle repeats itself once more before the psychiatrist attributes her lack of a stable choice to cognitive and behavioral inflexibility related to executive dysfunction now noted on bedside screening.

Usually causing impaired understanding and reasoning, cognitive deficits can be an incapacitating feature of several major mental illnesses (though this could be an artifact of capacity's being a mainly cognitively-based construct).[79] For example, manic patients seem to be more often incapacitated by cognitive symptoms than by grandiosity and impulsivity.[80] Cognitive impairment is heterogeneous. For example, in the dementias the impairment varies according to the type of dementia and its most affected cognitive domains.[81] Traumatic brain injury, stroke, and delirium all affect capacity in different ways depending on their causes and localization.[82] Whenever possible, it is advisable for a clinical assessment of incapacity due to cognitive impairment to be supported by cognitive screening that includes a standardized instrument (e.g., the Montreal Cognitive Assessment[83]).

Cognitive deficits are, of course, not the only route by which psychopathology affects decision-making. Specific cognitive deficits are present in MDD,[84] but these patients tend to retain capacity.[85,21] When capacity concerns do arise in MDD, they tend to involve patients' depressive biases. A patient might be cognitively intact on bedside screening, but a (not always inaccurate) negativistic bias can produce controversial medical decisions.[86] An anergic, amotivated patient might simply not care about choices and consequences. Suicidal ideation or other morbid desires can inform a depressed patient's refusal of life-sustaining treatment.

Elliott invoked authenticity as important in figuring out if the patient's seemingly pessimistic or morbid decisions are MDD-based.[87] It is helpful to look back at any previous relevant decisions made while euthymic before concluding that the current ones are essentially "internally coerced" by MDD (seen as a

disease entity that exists independently of the patient[88]). Ganzini et al. prospectively found most "negative" hypothetical treatment decisions made by actively depressed patients to remain unchanged after euthymia was achieved.[89] Depression does not necessarily invalidate all seemingly pessimistic or morbid decision-making.

Even more complicated situations arise with patients suffering from psychiatric disorders that are less temporally and symptomatically circumscribed. Addictions, eating disorders, and personality disorders, by nature or definition, can cast their shadows over much of the life span, and even over the self. What authenticity is there to appeal to in a capacity evaluation when the disease seems indistinguishable from the person herself?

Tan and colleagues propose "pathologic values" (i.e., the premium placed on thinness) as being relevant to capacity in their subjects with anorexia nervosa.[90,65] They nonetheless concede that this idea is ethically fraught because many of their subjects "thought of anorexia as an important part ... of their personal identity." In alcoholism, there may be a subtle convention of restricting incapacity determinations to those patients with demonstrable alcoholic or Korsakoff dementia.[91,92] Nonintervention in the rest might be pragmatic, but it might also reflect our struggles with the idea of whether addictions are free-will-removing disease entities. Consideration of personality disorders and capacity seems to focus on suicidal ideation.[93] However, difficult questions also arise when entrenched maladaptive attachment and affective tendencies collide with newly demanding medical circumstances. In all of these pervading pathologies, appeals to authenticity are complicated and confusing; a standard of minimal self-interest might sometimes be more applicable to these patients.[88]

Finally, there is the issue of adjustment disorders. We feel that this category can be sparingly applied to patients whose incapacity is characterized as "defensive" or as due to overwhelming emotional factors, such as terror.[85] While acknowledging a "sliding scale" standard to capacity, Appelbaum stated that "only patients with impairment that places them at the very bottom of the performance curve should be considered to be incompetent."[16] This maladaptive extreme of psychologic defense and emotional experience in the face of medical stressors seems very consistent with the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition definition of an adjustment disorder.[94]

One could legitimately argue that adjustment disorders are really just overly convenient diagnostic placeholders for emotions that are hard for clinicians to explain or accept.[95] Nonetheless, we feel it is important for the capacity evaluator to "put her nickel down" and clearly state when a patient's response to a situation is considered *disordered*. Doing so meets Appelbaum's requirement in a way that explicitly stakes a claim for medicine's obligation to intervene against that impairment. That the patient's response might be understandable is an important consideration. But just as a broken fibula might be a "normal response" to a hard fall, there are rare instances where a normal psychologic response might represent a serious injury. Without objective studies to detect psychologic injury, this call is a very hard one to make, as the following case depicts,

> A 30-year-old man with a 10-year history of Crohn's disease, following several operative interventions, presents with severe malnutrition and constipation that has not responded to conservative care. An exploratory laparoscopy and probable lysis of adhesions are proposed. Already somewhat irritable, he angrily refuses further intervention and asks to be sent home to die. Although he is dysphoric, a depressive disorder is ruled out, and he is not suicidal. His refusal of care is out of character and often framed by the patient as retaliatory toward his physicians. His irritation and anger get in the way of his discussing other motives behind his decision. With some reservations, the psychiatrist concludes that the patient lacks the capacity to refuse the operation and attributes his incapacity to an adjustment disorder with depressed mood.

In situations like this one, past decision-making patterns should be investigated with an eye toward authenticity. At the same time, the evaluator recognizes that unprecedented decisions in unprecedented circumstances are not necessarily inauthentic. Medical stressors can certainly compromise any of us through fear and powerlessness, but these feelings can also legitimately inform us about what we can handle and want to avoid. We are not our true selves only under the best of circumstances. "Who are you when you are backed into a corner?" may be the pivotal question to pose for patients suspected to be suffering from adjustment disorders.

CONCLUSIONS

Physicians are practical. We have to get things done and act, often amid uncertainty. Questions of medical decision-making capacity frequently add ambiguity to clinical situations. The 4-abilities model of medical decision-making capacity does the necessary job of breaking down a highly elaborate, knotty concept into some workable components. However, that very virtue of the model can lead to its constricted application. Beyond the basics of the 4 abilities, capacity evaluations also require facilitating the patient's best performance, appreciating noncognitive aspects of decision-making, and applying explanatory diagnoses.

Perhaps these aspects of capacity assessment are underemphasized because they are not specific to it. They are parts of good clinical care. Although the concept of capacity has a necessary legal core, the physician's role in capacity evaluation is still a fundamentally *clinical* one. It therefore carries with it all of the privileges, obligations, and challenges of the rest of our work with patients in the "muddy reality of medical concerns."[96]

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