

Appendix B.

Cognitive functioning

B

B1. Mini-mental state examination

(Folstein et al. 1975)

This test could not be included for copyright reasons. It is available from:

Psychological Assessment Resources Inc (PAR) 16204 North Florida Avenue, Lutz, Florida 33549

Website: www.parinc.com

Email: custserv@parinc.com

B2. GPCOG patient examination

This is a new screening test developed in Australia for use in general practice. It is shorter than the MMSE and incorporates the clock drawing test (*Appendix 2.2*). Only if the test result is in the doubtful area does it need to include some additional information to be obtained from a suitable informant.

The test is set out on next page.

Scoring

Add correct scores from items 2-6:

9 = cognitively intact – no need for informant interview

4 or less = cognitively impaired – no need for informant interview

5-8 = uncertain – needs informant interview

Informant interview score:

No, 3 or less = cognitively impaired

Reference: Brodaty H, Pond D et al. The GPCOG: a new screening test for dementia designed for general practice. J Am Geriatric Soc 2002; 50: 530-34

Appendix

GPCOG Patient Examination

Unless specified, each question should only be asked once.

Name and address for subsequent recall test

1. "I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington." (Allow a maximum of 4 attempts but do not score yet)

Time Orientation

2. What is the date? (exact only)

Correct

Incorrect

Clock Drawing (visuospatial functioning) - use page with printed circle

3. Please mark in all the numbers to indicate the hours of a clock (correct spacing required)
4. Please mark in hands to show 10 minutes past eleven o'clock (11:10)

Information

5. Can you tell me something that happened in the news recently? (recently = in the last week)

Recall

6. What was the name and address I asked you to remember?

John

Brown

42

West (St)

Kensington

Scoring guidelines

Clock drawing: For a correct response to question 3, the numbers 12, 3, 6, and 9 should be in the correct quadrants of the circle and the other numbers should be approximately correctly placed. For a correct response to question 4, the hands should be pointing to the 11 and the 2, but do not penalize if the respondent fails to distinguish the long and short hands.

Information: Respondents are not required to provide extensive details, as long as they demonstrate awareness of a recent news story. If a general answer is given, such as "war," "a lot of rain," ask for details—if unable to give details, the answer should be scored as incorrect.

GPCOG Informant Interview

Ask the informant: "Compared to a few years ago,

	Yes	No	Don't Know	N/A
I. Does the patient have more trouble remembering things that have happened recently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
II. Does he or she have more trouble recalling conversations a few days later?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III. When speaking, does the patient have more difficulty in finding the right word or tend to use the wrong words more often?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV. Is the patient less able to manage money and financial affairs (eg paying bills, budgeting)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
V. Is the patient less able to manage his or her medication independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VI. Does the patient need more assistance with transport (either private or public)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B3. Decision making capacity

C Bridges-Webb, RACGP NSW Projects, Research and Development Unit.

Determination of a patient's capacity (a word preferred to the more strictly legal one of competency [1]) to make decisions may be an important role of the doctor. This usually applies in one of three situations:

- consent for medical treatment
- giving an advance care directive
- making a will.

It may also apply to other tasks such as managing financial affairs or arranging living circumstances.

Whatever the task, there are a number of important principles to be observed:

- Capacity is task specific, and must be assessed separately for each decision.
- Assessment is best made over time, rather than at only one interview, because determination of consistency of response is important.
- Information from others, with the patient's consent, is desirable.
- There are no studies which define threshold, and only modest correlation between scores on scales such as MMSE or IADL and capacity to make decisions (2).

Records should be kept as fully as possible, with emphasis on information that explains the basis for the decision.

Factors to be considered

The following factors need to be considered in determining capacity (3):

- **Attention** – can the patient maintain attention for long enough? Maintaining conversation for at least 1 minute is a minimum. Assess using subtraction of serial 7's from 100 (need 7 correct responses), or ability to count forward by 3's from 1 (no more than one error in 30 seconds), or counting backwards from 20 (finishing within 20 seconds) (3).

- **Language – comprehension**, by hearing or reading. This can be tested by conversation and/or with suitable simple multi-choice questions given orally and/or in writing.
- **Language – reply**, may be made by the patient in speech or writing, or by gesture, pointing or other understandable means. These forms of communication should not be overlooked when speech or writing is not possible.
- **Memory** – short and long term memory need not be perfect, but should be relevant to the task.
- **Awareness** of the significance of the interview: Does the patient understand who is doing it and why? How does it relate to the patient's social situation, family, interests, activity? What are the likely consequences?
- **Judgement** – can the patient appreciate outcomes, control impulses? How does what they say compare with what they do? How consistent are their responses? History from others is important for this.

Consent to medical treatment

In assessing capacity to consent to medical treatment the following factors must be clear (1):

- what are the options?
- the benefits and risks of each
- the values the patient wants to uphold or goals they wish to reach
- the stability of the decision over time; the consent must be given on at least two different occasions
- the patient must always be included in the decision process to the extent possible
- there must be no coercion or undue pressure from others.

If the patient has not the capacity to consent, then someone other than the treating team members **MUST** make the decision.

Even in the presence of an advance care directive it is important to 'try to understand also the present subjective experiences' of the patient (1).

Advanced care directives

In making an advanced care directive the patient must understand that (4):

- the choices being made are for the future
- it will be used only if the patient has become incapable
- some choices are about future treatment
- some choices are about who will then decide
- the choices made could threaten life
- coma or dementia means that no choice in the future will be possible
- choices may change over time
- directives should be updated and changed if necessary each year
- choices made in the directive override later choices if the patient has become incapable.

A protocol to ensure a patient centred approach for the assessment of competence to complete advance care directives, using two vignettes of hypothetical medical problems and ten questions in a semi-structured interview, has been found to be valid and reliable in one British trial (5).

Making a will

In determining capacity to make a will there are a number of specific requirements (2):

- The patient's lawyer should first be consulted.
- Assessment should occur on two different occasions, the second preferably on the day of executing the will.
- The presence or absence of witnesses to the assessment, and if any, who they should be, should be considered.
- The patient must be free of undue influence, such as from family member or carer.
- The patient must not have delusions or hallucinations that could influence the decisions.

In the assessment the patient must:

- understand the nature and purpose of the interview, and what he/she is doing. Ask them to explain what a will is
- be able to describe the extent and nature of his/her property
- be able to understand and state the claims of potential heirs
- state who is to benefit, in what way each will benefit, and give a sensible explanation of why that benefit to that person is desired.

Corroborative information should be sought, with permission of the patient and his/her lawyer, from medical records, other clinicians, family or others involved with the patient.

References

1. Fellows LK. *Competency and consent in dementia*. Journal of the American Geriatrics Society 1998; 46:922-26.
2. Peisah C, Brodaty H. *Dementia and the will making process: the role of the medical practitioner*, Med J Aust. 1994; 161:381-4.
3. Freeman M, Stuss T, Gordon M. *Assessment of competency: the role of neurobehavioural deficits*. Annals of Internal Medicine 1991; 115:203-8.
4. Silberfeld M, Nash C, Singer PA. *Capacity to complete an advance care directive*. Journal of the American Geriatrics Society 1993; 41:1141-3.
5. Fazel S, Hope T, Jacoby R. *Assessment of competence to complete advance care directives: validation of a patient centred approach*. British Medical Journal 1999; 318:493-7.