

RESEARCH REPORT

Using Conversation Analysis to explore assessments of decision-making capacity in a hospital setting

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Abstract

Background: Healthcare professionals (HCPs) have a responsibility to conduct assessments of decision-making capacity that comply with the Mental Capacity Act 2005 (MCA). Current best-practice guidance, such as the Mental Capacity Code of Practice and National Institute for Health and Care Excellence decision-making and mental capacity guidance, does not stipulate how to accomplish this in practice, for example, what questions should be asked, how options and information should be provided. In addition, HCPs struggle to assess the capacity of individuals with communication difficulties.

Aims: This study was a service evaluation that aimed to objectively analyse, using Conversation Analysis (CA), how real-life capacity assessments were conducted in a hospital setting with patients with acquired brain injury (ABI)-related communication difficulties. A second aim was to establish the feasibility of using CA to advance knowledge of the conduct of capacity assessment.

Methods & Procedures: Four naturally occurring capacity assessments were video-recorded. Recordings involved speech and language therapists, occupational therapists, neuropsychologists and patients with communication difficulties as a result of ABI. The methods and findings of CA were used to investigate the interactional behaviours of HCPs and patients during assessments of decision-making capacity. The analysis was informed by our knowledge of the MCA best practice guidance.

Outcomes & Results: An overall structure of capacity assessment that enacted some of the best-practice MCA guidance was identified in one recording, consisting of six phases: (i) opening, (ii) preparation, (iii) option-listing, (iv) test, (v) decision, and (vi) close. The preparation phase consisted of two sub-components: information gathering and information giving. Variation from this structure was observed across the dataset, notably in the way in which options were (or were not) presented.

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Conclusions & Implications: CA is a feasible empirical method for exploring the structure and conduct of capacity assessments. CA identifies and provides ways of describing interactional behaviours that align with and diverge from best-practice MCA guidance. Future CA studies including a wider range of health and social care professionals and patients have the potential to inform evidence based training for HCPs who conduct assessments of decision-making capacity.

KEYWORDS

acquired brain injury, aphasia, communication disorders, conversation analysis, decision-making capacity

WHAT THIS PAPER ADDS

What is already known on this subject

- The Mental Capacity Act (MCA) is poorly implemented in practice. Healthcare professionals (HCPs) find it challenging to assess the decision-making capacity of individuals with communication difficulties, and people with communication difficulties are often excluded from or insufficiently supported during capacity assessment. Research is limited to self-report methods. Observational studies of capacity assessment are required.

What this study adds

- This is the first study to use Conversation Analysis (CA) to explore how capacity assessments are conducted in a hospital setting by HCPs with people with communication difficulties as a result of acquired brain injury. One video-recorded capacity assessment was structured in six phases that aligned with best practice MCA guidance. However, other capacity assessments deviated from this structure. One phase, option listing, varied in practice and options were not always presented.

What are the clinical implications of this work?

- CA revealed interactional behaviours that align with and diverge from best-practice MCA guidance. Future CA studies are warranted to inform training for health and social care professionals who conduct capacity assessments.

INTRODUCTION

The Mental Capacity Act, 2005 (MCA) provides the legal framework for health and social care professionals conducting assessments of decision-making capacity. The MCA applies to any individual in England and Wales aged over 16 who may have impaired decision-making ability due to an impairment of the mind or brain. The MCA's statutory principles promote individuals to make autonomous decisions and access communication support

if needed. By promoting an inclusive and communication-accessible environment, the MCA and accompanying code of practice (MCA Code of Practice, 2007) aim to prevent discrimination against individuals based on their communication ability. In addition, the MCA provides guidance for the assessment of decision-making capacity. For example, according to the MCA, a functional test of capacity is required if there is evidence to doubt an individual's ability to make a decision. The MCA functional test of capacity (MCA, 2005, section 3.1) states that an individual is

considered unable to make a decision if they cannot understand, retain and weigh decision-specific information and communicate a decision.

There has been criticism around the implementation of the MCA into practice. The House of Lords post-legislative scrutiny report (2014) highlighted a significant lack of communication support provided to individuals during capacity assessments, including cultural and attitudinal barriers to successful implementation of the MCA, such as risk aversion and paternalism. A lack of time, reduced confidence and knowledge and a lack of training and resources have been highlighted as factors that prevent health and social care professionals implementing the MCA (Aldous et al., 2014; Borret & Gould, 2021; McCormick et al., 2017). Some health and care professionals have reported concerns that assessing capacity may affect therapeutic rapport with patients or result in disagreements between professionals regarding a patient's capacity (Murrell & McCalla, 2016).

Health and care professionals, including specialists, find it challenging to support the communication needs of individuals during capacity assessments (Jayes et al., 2017). Communication difficulties are common in a significant group of individuals comprising part of the hospital population, those with an acquired brain injury (ABI) as a result of stroke, traumatic brain injury, brain tumour or encephalitis. A third of stroke patients experience aphasia and three quarters of people with traumatic brain injury are at risk of motor speech or cognitive-communication difficulties (MacDonald, 2017; Mitchell et al., 2021; Struchen et al., 2011). In the initial stages of recovery following ABI, patients are required to make many decisions about their treatment and care which can be emotive and life-changing.

There is some general guidance on assessing decision-making capacity. Best-practice guidelines (National Institute for Health and Care Excellence [NICE] MCA, 2018 [NG108]; MCA Code of Practice, 2007) emphasise the importance of providing all practicable supports including supports for individuals with communication needs. The guidance also highlights the need to provide individuals with relevant information and options for the decision in question. The NICE decision-making and mental capacity guidance provides advice on how to conduct aspects of a capacity assessment such as preparing for an assessment and how to record the outcome of an assessment. The MCA Code of Practice provides some explication of how to conduct the functional test of decision-making, for example, the relevant information that may need to be conveyed to a person for them to make an informed decision. However, neither provide advice on how to put the guidance into practice, for example, what questions should be asked, how options and information should be provided (outside of recommendations on the medium of doing so, for example,

to use simplified language, communication aids and supports). Given this, capacity assessments may be affected by idiosyncrasies of the assessor (Braun & Moye, 2010; Braun et al., 2009).

The lack of empirical research into the conduct of capacity assessments has been recognised by the National Institute of Health and Care Research (NIHR, 2018). Evidence from case law and ethnographic studies indicates that capacity assessments are conducted informally via semi-structured interview (Emmett et al., 2013). The NIHR has called for research to identify the components of effective capacity assessments and training for health and social care professionals on how to conduct assessments. One way to achieve this is through observational studies which are not subject to reporting bias by participants. Self-report methods, which are subject to variable recollection, have been the main approach to capacity assessment research in the literature to date (Jayes et al., 2020).

Conversation Analysis (CA) is an observational method that would permit investigation of the conduct of capacity assessments. CA is an inductive method which examines the structure and social actions underpinning naturally occurring talk. CA has proven to be a useful tool to reveal a difference between what truly occurs during healthcare interactions versus the perception of what occurred according to those involved (Reuber et al., 2015). Two concepts that are critical to the interactional study of decision-making are deontic authority (the legitimate rights and social obligations to determine another's actions) and epistemic authority (power of knowledge and experience). Decision-making sequences in interaction are influenced by how recipients acquiesce to or resist proposals or assertions of commitments to future actions in talk (Stevanovic & Peräkylä, 2012). Healthcare professionals (HCPs) may withhold or share information or deploy the use of different types of questions, such as known-answer questions, to assert a position of epistemic authority; thus influencing patient autonomy in choice-making or their response in healthcare encounters (Heritage et al., 2006). CA has informed our understanding of effective communication strategies between people with a variety of communication disorders arising as a result of ABI and other conditions in both hospital and domiciliary settings (Allwood et al., 2017; Beeke et al., 2014; Bloch & Barnes, 2020). Findings from these studies have been used to inform communication skills training for health and social care professionals and family conversation partners (Beeke et al., 2018; Lock, 2020; O'Brien et al., 2018). The CA method has promise therefore to both advance knowledge of the conduct of capacity assessments and to inform training on how to conduct assessments of decision-making capacity with individuals with communication difficulties.

TABLE 1 Patient inclusion and exclusion criteria.

| Inclusion criteria | Exclusion criteria |
|--|---|
| Individual with communication difficulties due to ABI | Individual requiring a capacity assessment relating to end of life or palliative care decisions |
| Individual requiring a capacity assessment as part of usual care | Individual requiring care or treatment under the Mental Health Act (2007) |

Abbreviation: ABI, acquired brain injury.

This study aimed to objectively analyse, using CA, how real-life capacity assessments were conducted in a hospital setting with patients with ABI-related communication difficulties. A second aim was to establish the feasibility of using CA to advance knowledge of the conduct of capacity assessment.

METHODS

Design

This service evaluation used CA to explore video-recorded capacity assessments undertaken within a hospital setting by HCPs with patients with communication difficulties as a result of ABI. Capacity assessments were not staged for the camera; they occurred as part of the patient's routine care.

Ethical considerations

The MCA states that capacity is decision-specific. As decisions vary in complexity, it was possible to recruit patients who demonstrated capacity to consent to take part in this service evaluation whilst their capacity for a complex decision such as discharge location was in need of assessment. To promote the inclusion of individuals with communication difficulties, consent forms were adapted in line with the National Health Service (NHS) Accessible Information Standard (2016). Inclusion and exclusion criteria were agreed with key stakeholders, that is, HCPs specialising in ABI employed at the recruitment site.

Sampling and recruitment

Recruitment took place across three wards specialising in stroke, trauma and neuro-rehabilitation in one English hospital. Due to the 12-month time period for this study, a convenience sampling method was used. The first author provided information via a series of talks to various HCPs including doctors, nurses, occupational

therapists (OTs), physiotherapists (PTs), neuropsychologists (NPs) and speech and language therapists (SLTs). HCPs who consented to being video recorded when carrying out a capacity assessment then identified from their caseload potential patient participants who fulfilled the inclusion and exclusion criteria (see Table 1). The first author then provided information with a communication-accessible information sheet and established patient consent.

Data characteristics

Ten HCPs consented to participate, six SLTs, two NPs, one OT and one discharge planning nurse. Of these 10, four were video-recorded—two SLTs, one OT and one NP—during four capacity assessments, see Table 2. One of the SLTs was recorded twice with two different patients (P3 and P4). Recorded capacity assessments were dyadic ($n = 3$) or triadic ($n = 1$; involving two HCPs). The average length of a recording was 23 min 15 s, ranging from 10 to 48 min. The total dataset comprised 92 min and 6 s. Each recording captured a different decision: discharge destination, care needs on discharge, the need for a door sensor on discharge and management of dysphagia.

Data collection

Capacity assessments were recorded using a tablet. To ensure no change to usual care, HCP participants were responsible for managing the recording process. Immediately after the recording, the first author transferred the recordings onto an encrypted hard drive for storage and deleted them from the tablet.

Analysis procedures

In line with CA methods, the first stage of analysis consisted of unmotivated looking across all four samples for interactional phenomena of interest. Particular attention was given to the structure, turn-taking organisation and sequence organisation of the capacity assessments, and to

TABLE 2 Video-recorded capacity assessments.

| Sample title | Patient | Diagnosis | Communication difficulty | Decision to be made | Sample length | HCP undertaking the capacity assessment |
|--------------------------|---------|--|---|--------------------------|---------------|---|
| P1_Care_needs | P1 | Left intra-cranial haemorrhage secondary to traumatic brain injury | Mild-moderate receptive and severe expressive aphasia | Care needs on discharge | 00:21:53 | SLT |
| P2_Door_sensor | P2 | Right lacunar stroke | Cognitive-communication difficulties | Door sensor on discharge | 00:12:11 | OT |
| P3_Dysphagia | P3 | Posterior fossa craniotomy resection | Dysarthria and mild memory difficulty | Swallowing difficulty | 00:10:37 | SLT |
| P4_Discharge_destination | P4 | Left subdural haematoma secondary to traumatic brain injury | Cognitive-communication difficulties | Discharge destination | 00:48:32 | SLT and NP |

Abbreviations: HCP, healthcare professional; NP, neuropsychologist; OT, occupational therapist; SLT, speech and language therapist.



HCPs' turn design. Collections of identified phenomena were analysed to reveal the social actions underpinning talk, for example, questioning. The analysis was informed by our knowledge of the MCA best practice guidance, that is, the MCA Code of Practice and NICE decision-making and mental capacity guidance [NG108]. We sought to find phases of the interaction that appeared to map onto recommendations outlined in this guidance. Where we saw an overlap between phases of the interaction and recommendations within the guidance, we used the guidance label to name that phase. Preparation is defined in the guidance as the actions the practitioner should take in anticipation of an assessment (NICE Recommendation 1.4.10) and includes information gathering, understanding the full range of options to present to the person and what information the person needs in order to be able to explore their options and make a decision. Consideration of this guidance in relation to the data led to the identification of one sample with six sequential phases of interaction that enacted some of these recommendations (video P3_Dysphagia). In the three remaining samples, similarities and differences in phases and their order were noted, which was further explored during the analytic process. Once phenomena of interest were identified, CA methods as described by Jefferson (2004) were used to analyse in detail the turns and sequences, including gesture, intonation and volume. Phenomena were considered in the context of the institutional setting. Group data sessions took place within the research team (J.F., A.V., S.B.) to ensure analytical rigour.

RESULTS

Firstly, the six-phase structure of capacity assessment that aligned with best-practice MCA guidance identified in one sample will be presented. Deviations from this phased structure occurring in the other samples will be shown, with a particular focus on one phase, concerned with delivery of options.

Six-phase structure of capacity assessment

The six-phase structure followed a linear sequence that aligned with best-practice NICE decision-making and mental capacity guidance as outlined here:

- i. Opening
- ii. Preparation
 - Information gathering
 - Information giving
- iii. Option-listing
- iv. Test
- v. Decision
- vi. Close

Extracts 1–7 from recording P3_Dysphagia have been chosen to illustrate each phase. Where possible, the analysis of phases reflects shared features across all samples.

EXTRACT 1 P3_Dysphagia—Opening [00:00:03–00:00:22].

00:00:03 → 001 HCP so we were talking earlier about um: (0.2) your swallow muscles
 002 potentially being a bit affected like your speech muscles are
 003 [as well]
 004 PAT °yep°
 [((nods))]
 005 HCP probably to do with the ↑surgery in the [brain that you've had]
 [((points to head))]
 006 and °h um: and that [throughout your admission] sometimes you
 [((hand gesture))]
 → 007 feel like drinks are going the wrong way:
 00:00:22 008 PAT [yeah yeah]
 [((nods))]


EXTRACT 2 P3_Dysphagia—Information gathering [00:00:27–00:01:06].

- 00:00:27 → 001 HCP yeah so you said something about biscuits did ↑you
 002 PAT yeah: it's um like certain biscuits (unintelligible)
 003 um when I have a cup of tea or a cold drink afterwards (.)
 004 um: it makes me cough (.) it's as if it's gone the wrong
 005 way (.) um:
 → 006 HCP ↑ok (.) how often is that happening?
 007 PAT (1.0) I suspect e-every-every other time I have a drink
 008 HCP °every other time you have a drink° h° OK (0.2) so it's
 → 009 when-when you cough on the food it's when you're
 → 010 having a [drink to ↑clea:r] the food is it?
 [((gestures drinking))]
 011 PAT °it is [yeah°]
 [((nods))]
 → 012 HCP is the food feeling like it's getting stuck ↑somewhere?
 013 PAT no you know (unintelligible) not stuck
 → 014 HCP it's just when you're drinking while you're ↑eating
 00:01:06 015 PAT yeah! yeah yeah

Phase i: Opening

Openings across all four samples were brief, ranging from 1 to 3 min duration. No introductions were given in any of the four samples because HCPs and participants knew each other. Interestingly, openings referred to previous conversations about the issue to be discussed. HCPs mentioned the need to 'recap', or 'talk about again', or referred explicitly to prior discussions, for example, 'yesterday I talked to you about...' Notably, none of the HCPs in any sample informed patients that their capacity to make a decision about treatment or care was being assessed. Extract 1 provides an example of a typical opening.

Here, the HCP refers to a previous conversation 'so we were talking earlier' (line 001) and introduces the issue to be discussed 'drinks are going the wrong way', framed as the patient's report (007).

Phase ii: Preparation

This phase had two elements, information gathering and information giving. It was not present across all four

recordings, but may have occurred in previous unrecorded conversations which were often alluded to in the phase i opening.

Information gathering

When phase ii was observed, the information gathering phase consisted of HCPs asking questions to obtain information from the patient relevant to the decision. For example, in Extract 2, the HCP asks the patient questions to elicit information about his dysphagia.

The HCP invites the patient to tell about his trouble with swallowing with an open question (001). The following turns involve the patient participating in 'troubles telling' (Heritage et al., 2006) by providing a description of his difficulty (002–005). The HCP asks a focussed question about symptom frequency (006) which the patient answers (007) and the HCP acknowledges (008). A question-answer sequence with yes/no question format then follows (010–015), similar to 'history-taking' that typically occurs in primary care encounters (Heritage et al., 2006). The information provided by the patient is used to inform the

EXTRACT 3 P3_Dysphagia—Information giving [00:04:27–00:04:56].

00:04:27 001 HCP (1.0) °h um: a:nd (.) that's what we call (.) something we call
002 aspiration. ↑sometimes people get something called an aspiration
003 ↑pneumonia (.) which means it's from food or drink or saliva
004 having gone the wrong [way]
005 PAT right
006 HCP I suspect um: (.) the reasons drinks are difficult for you is
007 because we know that (.) a lot of your problem is to do with
008 co-ordination (.) with your speaking (.) and that
009 co-ordinating your muscles ↑quickly enough (.) and because drinks
00:04:56 010 drinks are very fast flowi:ng (.) and very RAPID

treatment options and is part of the functional test of capacity.

Information giving

This is where, as part of the preparation phase, the HCP provided information to inform the patient's decision-making. In Extract 3, information is given regarding the nature and possible consequences of a swallowing impairment.

The HCP provides an accessible definition of aspiration, followed by information about the potential risks of this condition based on her specialist knowledge, that is, developing pneumonia (001–004). She then explains the nature of the patient's dysphagia (006–010). The explanation for medical terminology is in keeping with the NHS Accessible Information Standard (2016) and MCA guidance.

Phase iii: Option-listing

The third phase, option-listing, involved HCPs presenting a range of options to deal with the issue at hand, to facilitate decision-making by the patient. The way in which options were presented appeared to influence whether options (and ultimately the decision) remained in the patient's or the HCP's epistemic and deontic domain. In their study of decision-making in neurology, Reuber et al. (2015) found that three practices encouraged patients to take an active role in expressing choices. Firstly, constructing the decision as yet to be made (e.g., the use of conditional versus imperative tense) was found to keep the decision open. Secondly, equipose involved options being presented neutrally, with all potential options equally valid. Finally, a

patient view elicitor comprising open questions or direct invitations for patients to share their thoughts resulted in patients providing a reason for, or short narrative about, their choice. Our data revealed these three option-listing practices were in use and appeared to encourage patients to take an active role in decision-making. Extract 4 provides an example of these practices in action in capacity assessment.

The HCP orients to the fact that a range of options are available for this patient in terms of his problem, that some food and drink may be going down the wrong way, and constructs the decision as to what to do about this as yet to be made, by deploying the conditional and subjunctive tense, for example, 'we could' (001 & 012), 'might' (026). The HCP lists the option to be: further investigation via either a 'video X-ray' that involves swallowing barium or 'video camera scope' which is described as 'invasive' (006–008, 010) or no further investigation; however, this option is present implicitly. The HCP talks about 'we would only do it if we feel like it's going to change your decision' (012–013). In doing so, the HCP ensures options are presented in equipose by explaining advantages (e.g., 'see exactly what's happening') and disadvantages (e.g., 'invasive'). A patient view elicitor (029–030) comprises an open question ('I don't know what your thoughts are on thickening?') which leads the patient to share his views (031–032). These practices coupled with the HCP's rapid ceding of the floor during overlapping talk (014) appear to do work to respect the patient's epistemic and deontic authority to make the decision.

Phase iv: Test

The test phase aligns with the functional test outlined in the MCA (2005). It consisted of question-answer

EXTRACT 4 P3_Dysphagia—Option-listing [00:05:08–00:06:24].

00:05:08 → 001 HCP we ↑could do: something where we: (1.0) look inside your throat
 002 and see exactly what's ↑happening: it would perhaps
 → 003 show us some other strategies you could try: (.) I suspect
 → 004 slowing down and having smaller sips would probably help
 005 anyway even without looking in your throat um: (.) but if
 → 006 did that kind of assessment one way is a-an xray of your
 → 007 swallow (.) a video xray and we watch you swallow barium
 → 008 and another way is a video camera scope through your nose
 009 and look down as you swallow that way h° (0.5) which is a
 010 bit [invasive]
 011 PAT [oh yeah]
 → 012 HCP I mean we could do those things h° um: (2.0) but then we would
 013 only do it if we feel like it's going to change your decision
 014 and your outcome at the end of it (.) [sometimes]
 015 PAT [s'not I don't think]
 016 HCP it's not yeah h,heheh
 017 PAT (1.0) (unintelligible speech) slowly
 018 HCP yeah (.) yeah
 019 PAT and I g-g-glug normally
 020 HCP yeah [h,heh]
 021 PAT [yeah]
 022 HCP maybe we need (PAT's wife's name) to tell you to slow down a bit
 023 PAT yes! slow [down a bit] °yeah°
 024 HCP [h,heh] (0.5) h° um: yeah (.) and sometimes the
 025 outcome can be if we ↑do see something that is going the wrong
 → 026 way actually then things might be recommended like thickening
 027 up your drinks (.) h° but then that cha:nges the enjoyment and the
 028 PAT [yeah]
 [((sips drink))]
 → 029 HCP pleasure of the drink really and I don't know what your thoughts
 030 are on thickening?
 031 PAT no I don't think I need it I mean I haven't coughed since I've
 00:06:24 032 been drinking this



EXTRACT 5 P3_Dysphagia—Test [00:06:57–00:07:30].

00:06:57 001 HCP given all that information (0.5) um (1.0) and considering
 002 how um I've kind of presented that to you (.) something
 → 003 that we [↑]have to check is: have you understood [↑]what
 → 004 I've said and is there anything you need
 → 005 [↑]clarifying
 006 PAT no (.) no th-that's clear
 → 007 HCP and are you able to repeat back kind of what your
 → 008 understanding of (.) is of the risk of continuing on
 → 009 w-with just normal drinks like that
 010 PAT yeah from what it sounds like there's a er a little bit of
 00:07:55 011 fluid is getting down (.) to the lungs h

sequences, and distinctive requests to display knowledge, as shown in Extract 5.

The HCP explains that there is a need to check if information they provided has been understood and asks the patient if clarification is needed (001–005). The HCP shifts to the pronoun 'we' (003) to invoke a professional body or institution when accounting for this understanding check. In doing-so, the HCP asserts a position of deontic authority. After the patient confirms the information was 'clear', the HCP requests the patient to 'repeat back' his understanding of the risks of continuing with normal drinks (007–009), a turn that directly enacts the requirements of the MCA (2005) functional test of capacity.

Phase v: *Decision*

Decisions made in all four recordings directly related to the specific issue discussed, that is, to continue drinking despite a risk of aspiration; to return home with carers visiting four times a day (care needs); to return home instead of moving into a care home (discharge destination) and to return home with a door sensor for safety (door sensor). Extract 6 illustrates this.

The HCP places the responsibility for the decision within the patient's deontic authority by asking a yes or no question (001). In response, the patient expresses an explicit and autonomous decision (002) to not proceed with further investigations for his dysphagia, thus implicitly deciding to continue drinking thin fluids despite a risk of aspiration and chest infection. It is recognised in CA literature that identifying a decision in talk is not straightforward; it lies in the exchange of information, opinions and commitment to future action (Boden, 1994; Huisman, 2001). Here, the decision to continue drinking with risk of

aspiration displayed in the interaction through the opinions shared by the patient during the option-listing phase (see Extract 4) and further evidenced in Extract 6 in the turns involving commitment to actions arising as a result of hypothetical events, that is, the patient's response to the HCP's question about what he might do in the event of a possible chest infection (003, 009, 010).

Phase vi: *Close*

The closing sequence was identifiable by the presence of a plan for future action. Future actions agreed in the close phase were concrete and ranged from organising family meetings through to making community referrals. At times, patients were informed of necessary future actions. At other times, HCPs offered patient choice regarding future actions, as Extract 7 illustrates.

Here, the HCP offers the patient choice when discussing onwards referral to community on discharge (001–004). The patient chooses to be referred to a community SLT (005–006), which the HCP acknowledges (007).

In summary, six phases of capacity assessment that align with the MCA guidance were clearly observable in sample P3_Dysphagia. The other three samples deviated from this structure in that the order of phases was variable and occasionally a phase was omitted. One key way in which this deviation manifests is in option-listing (phase iii), and this will be analysed next.

Option presentation

MCA NICE guideline [NG108] recommendation 1.4.10 (p21) states that 'in preparing for an assessment the


EXTRACT 6 P3_Dysphagia—Decision [00:09:09 – 00:09:55].

00:09:09 → 001 HCP so would you like us to proceed with any kind of ↑investigation
 → 002 PAT no: no I guess it is how it is isn't it if it gets
 → 003 WORse I'll just give you a call

00:09:12 004 HCP ↑yep
 005 PAT [um:]
 006 HCP [what] would you do when >because I know< you're going ↑home
 007 ↑soo:n >if you feel like you're getting a chest infection at
 008 home what ↑might you do?

009 PAT um: ring my GP fir:st (unintelligible) tell him about my
 010 [history] (.)

00:09:20 011 HCP yep
 [((nods))]

EXTRACT 7 P3_Dysphagia—Close [00:10:14–00:10:27].

00:10:14 → 001 HCP do you think it's worthwhile us referring to the
 → 002 community speech ↑therapist to keep an eye on ↑this
 → 003 or would you want to see your GP and put in a referral
 → 004 at that point if it gets worse?

005 PAT probably worth writing some ref-ref (unintelligible)
 006 so someone can pick it up

00:10:27 007 HCP [yep]
 [((nods))]

assessor should be clear about the decision to be made and the options available to the person in relation to the decision'. The number of options presented, and the timing of option presentation varied across this dataset. There were three variations: (1) a range of options were presented (as seen in Extract 4); (2) no options were presented; (3) there was a delay in presentation of options. Patterns 2 and 3 will be discussed in turn.

No options

In two of the four recorded capacity assessments, no options were presented. Instead, HCPs were observed to provide a professional recommendation to which patients could either assent or decline. In each case,

the professional recommendation followed an extended test phase (phase iv) and the preparation phase (phase ii) was omitted, that is, phase i opening led directly to phase iv. Extract 8 provides an example, taken from P2_Door_Sensor, a capacity assessment concerning the fitting of a door sensor for a patient with cognitive communication difficulties. This is an alarm that alerts staff to the fact that a resident has opened the door to their accommodation, enabling staff to either prevent the person from going out or supervise the person whilst out in community.

The HCP asks a known-answer question about risks to this patient of accessing the community alone (001–002). This is the final test question in a prior extended test phase (not shown for brevity) consisting of seven questions and lasting approximately 8 min (the sample is 12 min 11 s long, see Table 2). After a 20 s attributable pause

EXTRACT 8 P2_Door_Sensor—No options [00:09:13 – 00:10:35].

00:09:13 001 HCP and what might ↑happen (1.0) if you got to the co-op* (.) and you
002 couldn't remember how to get ↑back

003 PAT [(20.0)] I'd put myself in a (4.0) <DANGerous> situation
[((looks down))]

004 (6.0) whereby: I: (.)°from which° (.) I could not r-remo:ve MYself

005 HCP (2.0) i-it would be very difficult [↑wouldn't it]
[((nods))]

006 PAT [yeah]
((looks towards HCP))

→ 007 HCP [((nods))] °yeah° (2.5) <would you be> ↑happy: (2.0)

→ 008 then (0.8) for me to request that a <door sensor> is put on your

→ 009 ↑door

010 PAT [(7.0)]
[((looks down))]

→ 011 HCP ↑to prevent that from ↑happening?

012 PAT (1.0) YES (.) I er don't think I-I would object

013 [too: much]
[((looks towards HCP))]

00:10:35 014 HCP GOOD that's really [↑good]
[((nods))]

*co-op is a supermarket

the patient answers that it could be dangerous (003, 004). The HCP acknowledges this by emphasising the difficulty, ending the turn with a tag question with rising intonation 'wouldn't it?' (005) strongly framed for patient agreement, which it elicits (006). The HCP is then observed to propose a professional recommendation via a permission-seeking question (007–009). The patient pauses for 7 seconds while looking down (010), which may indicate resistance to a professional recommendation (Butler et al., 2010). In response, the HCP accounts for why the request should be granted (011) by invoking the risks the patient voiced in lines 003–004. Following this re-emphasis of risk, the patient assents (012–013). In CA literature, it is rare for patients to refuse a request or recommendation, as refusals are considered dispreferred actions (Heritage et al., 2006). Here, the lengthy pauses attributable to the patient and his lack of eye contact signal dispreference, but ultimately (if

reluctantly, i.e., 'I wouldn't object too much') he complies. Although the professional recommendation (007–009) is in one sense a proposal that seeks patient collaboration and therefore has lower deontic authority than a pronouncement (Stivers et al., 2018), the lack of an option presentation phase as recommended in the MCA (2005) suggests the interaction is focused on consent, rather than decision-making.

Delayed presentation of options

In the capacity assessment involving two HCPs and a patient with cognitive communication difficulties regarding discharge destination (P4_Discharge_Destination), one option (to return home) was presented out of phase order, immediately after the opening (phase i). As shown in


EXTRACT 9 P4_Discharge_destination—Delayed presentation of options [00:30:05 – 00:30:26].

[00:02:10 – 00:30:05] Test Phase (not shown)

| | | | |
|----------|-----|------|---|
| 00:30:05 | 001 | HCP1 | just so we know that you're weighing up all the risks |
| | 002 | | and benefits I suppose |
| | 003 | PAT | yep yep |
| | 004 | HCP1 | what we've kind of covered is if you go <u>ho:me</u> the |
| | 005 | | benefits are that it is your ↑life's work and |
| | 006 | | your life's passion |
| | 007 | PAT | exactly. [oh yes] |
| | | | ((nods)) |
| | 008 | HCP1 | [everything] (.) it's very <u>important</u> to you |
| | 009 | PAT | yep |
| | 010 | HCP1 | it's with a risk of potential (0.2) h° for example damage |
| | 011 | | to the house say if you accidentally started a ↑fi↓re |
| | 012 | PAT | oh: [YES] |
| | | | [((nods))] |
| | 013 | HCP1 | or death to you if you accidentally fell somewhere and |
| | 014 | | couldn't get the help you ↓needed |
| | 015 | PAT | °yes yes° |
| → | 016 | HCP1 | the alternative to that I ↑suppose would be: (.) perhaps |
| → | 017 | | moving somewhere else: |
| 00:30:26 | 018 | PAT | oh I'd <u>hate</u> that |

Extract 9, a second option was presented 30 min later, after an intervening and lengthy test (phase iv). The preparation phase (ii) was once again omitted.

The HCP summarises what has been covered during the preceding test phase concerning the risks and benefits of the option introduced right at the outset of the assessment, namely to return home (001–002, 004–006, 010, 011, 014–015). The patient readily agrees with the HCP's account (007, 009, 012). An alternative option 'moving somewhere else' (016, 017) is then presented. This occurs 30 min into a 48-min long capacity assessment, the sole focus of which is to decide where the patient will live after discharge from hospital. The alternative was not presented with the option of returning home, at 2 min into the assessment. The language 'somewhere else' appears designedly vague but implicitly refers to a care home. The option is preceded

by 'suppose', 'would' and 'perhaps', language that mitigates the suggestion and indicates the HCP has predicted active resistance to this alternative, which is demonstrated in the patient's emphatic 'oh I'd hate that' (018). The two options are not presented in equipoise (Reuber et al., 2015), thus potentially compromising the collaborative decision-making process and removing the opportunity to observe the patient weighing options and risk.

DISCUSSION

This study is the first to use CA methods to understand how capacity assessments are conducted. It has focused on a stroke, trauma and neuro-rehabilitation setting with patients with communication difficulties as a result of

ABI. Four capacity assessments occurring during usual care were video-recorded, capturing a range of HCPs and patients with different communication difficulties.

A linear six-phase structure for capacity assessment was identified in one sample that closely aligns with the MCA and best-practice guidance (NICE, 2018 [NG108], MCA Code of Practice, 2007). During the option-listing phase iii, the HCP created an active role for the patient in decision-making by constructing the decision as yet to be made, providing options in equipoise, and using a patient view elicitor. Although observed clearly only in this one sample, a phased structure and related interactional practices appeared to support effective implementation of the MCA and permitted a patient with mild speech and cognitive difficulties to reach a capacitous decision.

Some of the six phases were present in the other three recordings but differed in their order. In some cases phases were omitted. The preparation (ii) and option-listing (iii) phases were prone to omission with options sometimes presented later in the assessment after an extended test phase (iv). Due to the small sample size, it is not possible to fully explain why this variation occurred; however, potential factors will now be discussed.

Variation in option presentation occurred during capacity assessment relating to discharge from hospital, a finding reflected in Emmett et al. (2013) for patients with dementia. Patients are more likely to explicitly reject professional advice when discussing topics that are within their own domain of personal experience, and typically the HCP needs to do interactional work to overcome such objections (Bloch & Antaki, 2022; Heritage, 2006). HCPs have legitimate moral, ethical, legal and professional duties to determine future actions for patients in terms of treatment and care, which gives them deontic authority. They also have access to professional knowledge and expertise, which gives them a particular type of epistemic authority. Yet, decisions about going home and where best to live are concepts that are firmly within the realm of the personal experience, knowledge and opinions of the patient. Therefore, one explanation for the observed variation in option presentation during discharge-related capacity assessments might be the conflicting orientations of HCPs and patients regarding their deontic and epistemic rights to make decisions about something as central to one's personhood as what constitutes home. Additionally, these findings suggest that sometimes HCPs may perceive themselves to be conducting capacity assessments, but perhaps instead are delivering professional recommendations for patients to consent to or navigating patient objections to professional recommendations. Similarly, Reuber et al. (2015) found discrepancies between neurologists' perceptions of choices given to patients and what occurred in practice. It is possible that HCPs in this dataset

felt it easier to provide a course of action to be agreed or disagreed with, rather than a range of options. Future studies investigating capacity assessment practice should therefore supplement observational methods such as CA, with interviews with HCPs about their rationale for what they said when conducting specific capacity assessments, to ensure the robustness of findings.

Specifically, CA provides a method for examining the conduct of complex social actions such as decision-making through sequences of turns, which are constructed using multimodal resources. It uncovers the ways in which professionals conduct capacity assessment through information-giving and questioning. Some extracts suggest interactional features such as pausing may indicate patient disagreement or resistance. It is valuable that we understand how these decision-making interactions happen, in order to provide training for HCPs in strategies to enable best practice capacity assessment, for patients with and without communication difficulties.

Video recording required the research team to secure a suitable recording device and ensure data were stored in line with data protection laws. Although this required a number of weeks to set up, once systems for this were in place (e.g., immediate transfer of videos from a tablet onto a secure drive, communication-accessible processes for participant informed consent for data management), there were no barriers to video data collection. Overall this study shows that it is feasible to record naturally occurring capacity assessments with HCPs and patients with communication difficulties for the purposes of CA.

Clinical implications

NICE MCA guidance states that information and options are to be provided before a test of capacity occurs and a decision is reached. One sample in this dataset, in which a patient with mild speech and cognitive difficulties was observed to make a capacitous decision about dysphagia management, conformed to this guidance, as revealed across six phases of capacity assessment (opening, preparation, option-listing, test, decision, close). HCPs may find it beneficial to consider a phased approach to such assessments. Findings also suggest that it is important to consider the number and timing of options provided, and the way options are delivered. In this dataset, strategies that facilitated autonomous decision-making for a patient with mild cognitive and speech difficulties were constructing the decision as yet to be made (using verbs like 'could' or 'would'), providing a range of options in equipoise (equally weighted), and providing a patient view elicitor (such as 'what are your views on x'). We acknowledge that severity of communication difficulty

may play a role in the feasibility of using such strategies, and further observational research on strategies such as the use of key words and visual aids is warranted.

Limitations and future directions

Currently, these findings are limited by the small sample size. Although the phased structure aligns with MCA best practice guidance, it was present in a straightforward manner in only one sample. It may be no coincidence that the patient involved in this capacity assessment had the mildest communication difficulties in the dataset, and the decision was focused on follow-up investigations not on hospital discharge issues. Clearly further research is warranted to investigate whether the phased structure holds for all types of capacity assessment. As data were from the stroke, trauma and neuro-rehabilitation service of one hospital, findings may be influenced by cultural attitudes and biases of this institution and service and may not account for MCA practice in other geographical locations or clinical settings. Additionally, it was not possible to recruit medical and nursing staff, despite attempts to do so. This meant the diversity of professions represented in the samples was limited. Future research should aim to recruit a range of professionals from diverse backgrounds to broaden findings. Lastly, future research could combine CA with ethnography to investigate factors in the environment that might be relevant when considering the interactional features of capacity assessments, for example, local procedures for discharge planning.

Conclusions

This CA study identified a six-phase structure of capacity assessment (opening, preparation, option-listing, test, decision, close) that aligned with best practice MCA guidance. Interactional practices that diverged from this structure and thus from best practice included option-listing. Although further research is needed, this study takes a first and important step towards addressing the NIHR objective to understand the components of an effective MCA assessment, which will lead to improved training for HCPs conducting capacity assessments.

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CONFLICT OF INTEREST STATEMENT

The authors report there are no competing interests to declare.

PATIENT CONSENT STATEMENT

HCPs who consented to being video recorded when carrying out a capacity assessment then identified from their caseload potential patient participants who fulfilled the following inclusion and exclusion criteria (see Table 1). The first author then provided information with a communication-accessible information sheet and established patient consent.

DATA AVAILABILITY STATEMENT

Video-recorded datasets generated and/or analysed during the current study are not publicly available due to ethical restrictions related to sharing of video data.

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