Ethical Issues in Caring for Older Adults

Jarrod Marks, M.D., Iuliana Predescu, M.D., Laura B. Dunn, M.D.

As the population ages, we are witnessing an unprecedented increase in the number of older adults with various types and levels of cognitive impairment, including mild cognitive impairment (MCI) and major neurocognitive disorders (e.g., Alzheimer's disease, vascular dementia, frontotemporal dementia). Given that the number of geriatric psychiatrists remains insufficient to meet the needs of this growing segment of the population, the ability to evaluate, diagnose, and manage the myriad psychological and behavioral manifestations of cognitive disorders will become an increasingly important part of the skill set of psychiatrists.

Ethical issues abound in the care of older adults who present with psychiatric symptoms and syndromes (1). These issues range from questions of capacity (Is the patient able to provide informed consent for treatment? Is the patient capable of refusing treatment? If the patient cannot consent, who can or should provide surrogate consent?) to ethical implications of concerns about the patient's safety or well-being (Is the patient safe to live at home alone? Is the patient at risk of exploitation or abuse? Can the patient continue to drive safely?), to difficult questions about goals of care among frail older adults.

This column discusses several forms of decision-making capacity that often become relevant in the treatment of the geriatric population. Competence, also referred to as capacity (terms used interchangeably by the courts and in the literature), refers to the legal standards for determining specific functional abilities. There are two main categories of competencies in psychiatry and the law: criminal competencies and civil competencies. This column focuses on civil competencies, which encompass a wide range of decisions and acts, including the ability to enter a contract, consent to medical treatment, consent to research, or write a will.

Case 1. Capacity to Refuse Treatment and Leave Against Medical Advice

Mr. S., a 73-year-old male, presented to the emergency department (ED), stating, "I need help! My stomach is hurting." He also complained of having blood in his stool and endorsed significant weight loss but denies other symptoms. He stated that he had recently arrived in town and did not have a primary care doctor. After a thorough evaluation in the ED, he was diagnosed as having rhabdomyolysis, acute kidney failure, and mild anemia. He was admitted to the general medical floor.

You are the psychiatrist covering the psychiatric consultation service. You are paged by the inpatient medical team because the patient is extremely agitated. He is refusing treatment for his medical conditions and is demanding to leave the hospital immediately. The internal medicine doctor is very concerned because "Mr. S. still needs hydration and further evaluation for possible gastrointestinal bleeding." You are asked to evaluate the patient's decision-making capacity to refuse treatment as well as to leave the hospital against medical advice.

1.1. Which of the following questions should you consider in your evaluation of Mr. S.?

A. Does Mr. S. understand the nature of his illness?
B. Does Mr. S. appreciate the consequences of refusing medical care and leaving the hospital without treatment?
C. Can Mr. S. make and communicate a stable choice?
D. Is Mr. S. able to manipulate information rationally?
E. All of the above

Discussion

Leaving the hospital against medical advice is a common and challenging situation in which a patient with decision-making capacity decides to leave the hospital without completing the treatment team's recommended course of care (2). The treating physician has the ethical obligation to promote informed decision making by discussing the possible risks of premature discharge, the possible benefits and risks of inpatient treatment, and alternatives to inpatient treatment, as well as the risks and benefits of these alternatives (3). Leaving against medical advice is predicated on the patient's having the capacity to make such a decision. If the patient lacks the capacity to decline medical care and the physician does not think that it is safe to discharge the patient, the physician must choose a mechanism by which to hold the patient. If the patient has psychiatric illness and meets criteria for an involuntary psychiatric hold, mental health statutes and protocols in that jurisdiction can be followed. If the patient does not have

psychiatric illness and does not meet criteria for an involuntary psychiatric hold, the physician might choose to hold the patient on a "medical incapacity hold," which is generally based on specific hospital policies (4).

Discharges against medical advice are associated with greater risk of hospital readmission, increased costs, and higher rates of morbidity and mortality. Unfortunately, limited data are available regarding the rates of discharges against medical advice among the growing population of older adults in the United States (5). Factors contributing to discharges against medical advice among older adults include: concerns about costs of treatment, fear of infection or falls, family problems, issues related to pain management, and communication difficulties. Therefore, providing social service support, adequate pain management, clear instructions, and maintaining open communications with family members and primary care physicians are important strategies to enhance adherence to recommended treatment.

1.2. Which of the following conditions could affect a person's decision-making capacity to make treatment decisions?

A. Major neurocognitive disorder
B. Bipolar disorder
C. Delirium
D. A and C
E. A, B, and C

The case continues.

"I'm leaving, I don't care what you people say!"

Mr. S.

You meet with Mr. S. and attempt to perform a full psychiatric evaluation. He is very talkative and is pacing about the room. He says that he feels fine and needs to be discharged so he can buy a house for his new wife. He tells you that he met his wife online 3 weeks ago and that she is "the most beautiful woman I have ever seen." He has been walking around neighborhoods for 10–12 hours per day, searching for the "perfect home." When you ask him why he wants to leave, he states that his roommate is very jealous and "tried to poison me by injecting something into my IV!" You explain that the doctors want to perform tests to find the cause of his bleeding. He responds that he is only being kept in the hospital to be a "lab rat for experimentation." When asked what will happen to him if he leaves the hospital and the bleeding continues, he states that he has the power to cure anything. Regarding his mental illness, he states, "I am not mentally ill. I just have high energy." When you explain that you believe he is having a manic episode, he says, "Psychiatrists have been telling me I'm bipolar for years, but they're all liars!"

1.3. Which of the following would be the most appropriate follow-up response to Mr. S. when he tells you that he believes that his roommate is poisoning him?

A. "What is your proof that your roommate is actually doing that?"
B. "I could imagine that would be very scary!"
C. "Your roommate looks very nice to me; I doubt he would do that."
D. "Sir, I am sure that's not happening. We can give you medicine to help with those thoughts."

You perform a comprehensive capacity evaluation and determine that Mr. S. lacks the decision-making capacity to refuse treatment as well as the capacity to decide to leave the hospital against medical advice. These determinations are each based on the patient's lack of insight into his mental and physical illnesses, as well as his inability to provide rational explanations for his desire to leave. He also does not appear to appreciate the consequences of his decisions.

1.4. Which of the following pieces of information would be the most useful in determining Mr. S.'s preferences regarding treatment?

A. The Montreal Cognitive Assessment (MOCA)
B. The Kohlman Evaluation of Living Skills (KELS)
C. Collateral information from family, friends, or previous providers
D. The MacArthur Competence Assessment Tool for Treatment (MacCAT-T)

1.5. Which of the following would be the most appropriate immediate next step in the management of Mr. S.?

A. Order 10 mg haloperidol.
B. Perform pharmacogenetic testing to help decide which psychotropic medication to start.
C. Arrange for Mr. S. to be moved into a room by himself with a one-on-one sitter.
D. Speak with family or friends and ask them to convince Mr. S to accept treatment.

The case continues. Mr. S. is now in a single room on constant observation. He is calmer and agrees to continue treatment and start olanzapine at a dose of 2.5 mg at bedtime. He allows you to contact his niece, who confirms that Mr. S. has a long history of bipolar disorder. According to the niece, he was stable until 3 weeks ago, when he stopped his medication and disappeared from the house. They have been looking for him since then. The main stressor was the death of his therapist due to COVID-19. The niece joins Mr. S. in the hospital and stays with him until he is discharged.

Case 2. Testamentary Capacity and Guardianship

Mrs. A. is an 83-year-old woman who has been seeing you in your outpatient psychiatry practice for the past 3 years for weekly psychotherapy. She entered therapy to discuss family issues and the process of aging. In the past year, she has missed six appointments, and each time you have phoned her to remind her of the appointment. You also noticed that over the past 6 months, she has had more difficulty finding words to express her feelings. You are unsure whether her forgetfulness is due to "normal aging" whether she may be

experiencing a neurodegenerative process, or whether there may be other factors affecting her memory. When you ask Mrs. A. directly about whether she has concerns about her memory, she says, with some embarrassment, "Oh, a little. Sometimes I forget why I went into a room, and sometimes I don't remember what I watched on TV just the day before!" According to the patient, she has had no other difficulties with taking care of herself at home, driving around town, or grocery shopping. Although she appears to be quite functional in her daily activities, you are concerned about her cognitive functioning and ask if you can perform a brief cognitive assessment. She scores a 23 out of 30 on the MOCA, with the following specific deficits: −3 points (out of 5) on delayed recall; −2 points (out of 5) on visuospatial-executive functioning; −1 point (out of 1) on verbal fluency; and −2 points on attention. Mrs. A. has had no recent illnesses and no other physical symptoms and has a normal physical exam. You order routine lab tests, which all show normal results.

2.1. At this point in your assessment, what step would you take next?

A. Ask permission to speak with her daughter for collateral information.
B. Prescribe a cholinesterase inhibitor.
C. Admit to inpatient psychiatry.
D. Perform genetic testing for ApoE alleles.

After receiving permission from the patient, you speak to Mrs. A.'s daughter, who confirms that although Mrs. A. has been having some difficulty remembering recent events, the daughter has not noticed any other difficulties but is concerned about possible dementia. You order an MRI, which reveals generalized atrophy and reduced hippocampal volume.

You diagnose mild neurocognitive disorder due to possible Alzheimer's disease. Numerous therapy sessions are dedicated to helping Mrs. A. understand what this diagnosis means and what she might expect. She is anxious about losing her independence but gradually becomes more accepting of the diagnosis. In addition to individual psychotherapy, you arrange for several family sessions with the daughter present.

During one of the family sessions, Mrs. A. explained that she wants to start planning for the future, with the expectation that she will start to lose abilities as time goes on. The first thing she wants to do is write a will. Mrs. A.'s daughter is supportive of Mrs. A.'s treatment goals and wants to help her remain as autonomous as possible. During a session, Mrs. A. asked her daughter if she would be willing to take care of her when she can longer take care of herself. The daughter agreed to help as much as needed.

2.2. Which of the following are components of testamentary capacity?

A. Understanding that she is writing a will and the purpose of a will
B. The nature and contents of her property
C. Her natural heirs to the property
D. The manner in which the will distributes her property
E. All of the above

Discussion

The presence of mental illness does not necessarily cause a lack of capacity in a certain domain. Capacity is determined based on the patient's abilities at the time of the evaluation. At this point in Mrs. A.'s illness, she would likely be able to demonstrate the understanding required for testamentary capacity. Even if her illness were to deteriorate, her abilities would require new evaluation at some future time, specifically for the capacity question at hand.

The case continues. Mrs. A. continues to meet with you for weekly psychotherapy. You prescribe memantine and donepezil, which Mrs. A. tolerates well. Despite treatment, Mrs. A's cognitive abilities continue to decline. Within one year, Mrs. A. is having noticeable difficulty managing her bills and struggles to manage her medication regimen on her own. She stops driving, with some encouragement from her family, after experiencing multiple episodes of getting lost while driving. Her daughter has been spending more and more time assisting her mother and believes that Mrs. A. can no longer take care of her finances or make medical decisions. The family decides that it is time to initiate a petition to the probate court to appoint a guardian to make medical decisions for Mrs. A. and to take care of her property.

2.3. Which of the following persons could potentially be appointed as a guardian for Mrs. A.?

A. Mrs. A.'s daughter
B. An attorney
C. An accountant
D. A clergy member
E. All of the above

The case continues. The family's petition to appoint a guardian was successful. The court found that Mrs. A. was unable to take care of herself and her property and appointed her daughter to be her general guardian (i.e., a guardian not restricted to limited decisions such as health care or finances). The daughter contacts you and tells you that because the treatment has been so helpful for Mrs. A., she would like you to continue seeing her.

2.4. Which of the following statements is NOT true regarding Mrs. A., now that she has a court-appointed guardian?

A. Mrs. A. may no longer consent to treatment.
B. The guardian must consent to treatment-related decisions.
C. Since Mrs. A. is still the patient, she is responsible for paying for the treatment.
D. There is now a presumption that Mrs. A lacks testamentary capacity.

The case continues. You continue to treat Mrs. A. in psychotherapy and help her to navigate her new experiences. You remain in close contact with the guardian and form a relationship with her to best take care of the patient.

Discussion

The treatment situation described earlier raises many ethical and legal concerns that are complex and challenging. Thus far, we have described the legal process by which the patient's decision-making abilities were removed and placed in the hands of the guardian. This has obvious treatment ramifications, such as the need to obtain informed consent from the guardian, but how do these legal changes affect the treatment relationship?

The most dramatic shift in the treatment relationship, beyond the logistical changes, is the "crowding of the clinician-patient relationship." (6) What used to be a therapeutic dyad between the psychiatrist and patient has now widened to include a third party. Including the guardian in what was previously a confidential dyad might make the patient feel ashamed, sad, or angry. All these feelings should be explored. In general, transparency and honesty with the patient are essential to preserve the therapeutic alliance. Specific issues such as what information will be discussed with the guardian should be addressed as early as possible.

As some authors have noted, the "physician-surrogate" relationship has been underexplored (7). The relationship between the physician and the surrogate (i.e., the guardian) is essential for making sure that there is a collaborative effort to treat the patient based on her values, preferences, and best interests.

2.5. Which of the following is the least helpful way to build rapport with the guardian?

A. Initiate and maintain regular contact.
B. Listen to the guardian's emotions, values, and wishes for the patient.
C. Withhold your own treatment-related opinions from the guardian.
D. Discuss the patient's wishes with the guardian.

Answers

1.1. The correct answer is E. The four key components (also called "abilities") to address in a capacity evaluation include: the ability to communicate a stable choice, the ability to understand the relevant information pertaining to the illness and proposed treatment, the ability to appreciate the situation and the consequences of refusing treatment, and the ability to rationally manipulate information (8).

1.2. The correct answer is E. Any disorder that may affect cognition, judgment, insight, or impulsivity can also impair decision-making capacity. Therefore, disorders including delirium, major neurocognitive disorders, intellectual disability, psychotic disorders, and bipolar disorder, as well as severe major depression, have the potential to affect decision-making capacity. It is important to emphasize, however, that diagnostic categories alone do not equate with the presence or absence of decision-making capacity (9); therefore, the treating team or consulting psychiatrist must conduct a systematic assessment of capacity and document that assessment.

1.3. The correct answer is B. The most therapeutic response to suspected delusional material is to attempt to make contact with the patient's current emotional experience. Relating empathically to the patient will help develop the relationship and encourage the patient to speak more about his thoughts and feelings. Using the words "I could imagine" allows you to demonstrate empathy but leaves room for the patient to correct or clarify his emotional state. The other choices are all forms of challenging that patient's thoughts, presumably an attempt to understand the patient's beliefs and their connection to reality. The responses described in options A, C, or D all would risk closing down the interview as opposed to opening and exploring.

1.4. The correct answer is C. To establish a person's preference for treatment when that individual is no longer able to communicate their wishes, it is helpful to obtain collateral information from family, friends, previous providers, or other people who know the patient's preferences regarding medical treatment, personal values, and expressed wishes. The MOCA (a screening tool for neurocognitive disorders) and the Kohlman Evaluation of Living Skills (an assessment of basic living skills) neither specifically assess nor help inform clinicians regarding a patient's treatment preferences. The MacArthur Competence Assessment Tool for Treatment (MacCAT-T), a semi-structured interview tool, provides a structured format for assessing treatment capacity, tailored to the specific treatment decision at hand. The MacCAT-T has been used to measure decisional capacity in people who are severely depressed or with schizophrenia and schizoaffective disorder (10).

1.5. The correct answer is C. The next step in the management of Mr. S. is moving him into a room by himself, with constant observation. With these supportive measures, Mr. S. will be provided with a calmer environment, and elopement risk is mitigated. Involving family or friends in his care can be helpful but may be difficult if the patient is unable or unwilling to share any contact information for such individuals. Although options of last resort, the use of physical and chemical restraints can sometimes be justified if the patient is an imminent danger to himself or others. Performing pharmacogenetic testing would not be clinically useful at this point.

2.1. The correct answer is A. The correct next choice is to ask for permission to speak with Mrs. A.'s daughter. It is important to hear the perspective of family members who have observed the patient and can offer an independent perspective on the patient's functioning, especially given that patients will have varying levels

of insight into their own illness. Before prescribing any dementia-related medication, it would be important to conduct a full psychiatric evaluation that would include gathering collateral information. The patient does not have any acute psychiatric or behavioral concerns that would warrant an inpatient psychiatric hospitalization at this time. Genetic testing would not be the next appropriate step in management (11).

2.2. The correct answer is E. Clinicians and forensic evaluators will often be asked to evaluate whether a person has the capacity to write a will. Sometimes, if the testator (the person making the will) is deceased, a retrospective evaluation will be completed to determine whether the testator had competency to write the will at the time it was written. To meet the legal threshold of testamentary capacity, Mrs. A. must understand that she is writing a will and the purpose of the will. She must understand generally the nature and extent of her property and to whom the property would go naturally, if a will were not created. She must also understand how the will distributes the property after her death (12).

2.3. The correct answer is E. A guardian is appointed by the court after a judicial proceeding formally adjudicating the person as incompetent. For a guardian to be appointed, the court must find that a guardian is necessary and that there are no other less restrictive alternatives. The court may choose to appoint a member of the family as a guardian, or it may appoint an attorney, accountant, or clergy member. If the guardian is not a family member, that person is often compensated by the incapacitated person's estate. If there are no family members available, and there are insufficient funds to compensate a professional to act as guardian, the court may appoint a lawyer willing to act as a guardian pro bono, or the court may utilize public guardian services (13).

2.4. The correct answer is C. Before the appointment of a guardian, Mrs. A. entered a treatment contract in which two consenting adults agreed to engage in treatment, which involves boundaries and a framework that involves financial compensation for treatment services. Now that Mrs. A. has a guardian, she may no longer enter a contract with you. It is now the guardian's responsibility to arrange for payment of services. Mrs. A. is no longer able to consent for treatment—this responsibility now falls on the guardian. Regarding testamentary capacity, it is normally presumed that a person has testamentary capacity. However, after an adjudication of incompetence and appointment of a guardian, there is a presumption that the ward lacks testamentary capacity. The burden of proof shifts to whoever is a proponent of the ward's testamentary capacity to prove that they did, indeed, have capacity at the time of writing the will (14).

2.5. The correct answer is C. To build a relationship with the guardian, it is important to initiate and maintain regular contact. If you are seeing the patient for weekly psychotherapy, it might be helpful to schedule regular conversations with the guardian, in addition to being in contact at clinically appropriate times (e.g., a proposed change in treatment). The guardian, especially if she is a family member, will often have her own thoughts, wishes, and fears about the patient's care. It is important to listen to the guardian empathically. It is ethically appropriate to share the patient's wishes with the guardian, because this will help the guardian make treatment-related decisions. Response C is the "least helpful" way to build rapport, as it is the physician's ethical duty to share any relevant clinical information and offer treatment recommendations to the guardian, who is now making medical decisions on behalf of the patient.

AUTHOR AND ARTICLE INFORMATION

Department of Psychiatry, SUNY Upstate Medical University, Syracuse (Marks); University of Pittsburgh Medical Center Altoona, Altoona, Pennsylvania (Predescu); Department of Psychiatry and Behavioral Sciences, Stanford University, Stanford, California (Dunn). Send correspondence to Dr. Marks (jarrodamarks@gmail.com).

Drs. Marks and Predescu report no financial relationships with commercial interests. Dr. Dunn receives royalties from American Psychiatric Association Publishing.

Focus 2021; 19:325–329; doi: 10.1176/appi.focus.20210011

REFERENCES

1. Rabins PV, Black BS: Ethical issues in geriatric psychiatry. Int Rev Psychiatry 2010; 22:267–273
2. Miller RD: Problems in Health Care Law, 9th ed. Sudbury, MA, Jones and Bartlett, 2006
3. Berger JT: Discharge against medical advice: ethical considerations and professional obligations. J Hosp Med 2008; 3:403–408
4. Cheung EH, Heldt J, Strouse T, et al: The medical incapacity hold: a policy on the involuntary medical hospitalization of patients who lack decisional capacity. Psychosomatics 2018; 59:169–176
5. Lelieveld C, Leipzig R, Gaber-Baylis LK, et al: Discharge against medical advice of elderly inpatients in the United States. J Am Geriatr Soc 2017; 65:2094–2099
6. Appelbaum PS, Gutheil TG: Clinical Handbook of Psychiatry and the Law. Philadelphia, Wolters Kluwer/Lippincott Williams & Wilkins, 2007
7. Torke AM, Alexander GC, Lantos J, et al: The physician-surrogate relationship. Arch Intern Med 2007; 167:1117–1121
8. Appelbaum PS, Grisso T: Assessing patients' capacities to consent to treatment. N Engl J Med 1988; 319:1635–1638
9. Baruth JM, Lapid MI: Influence of psychiatric symptoms on decisional capacity in treatment refusal. AMA J Ethics 2017; 19:416–425
10. Grisso T, Appelbaum PS, Hill-Fotouhi C: The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions. Psychiatr Serv 1997; 48:1415–1419
11. Mayeux R, Saunders AM, Shea S, et al: Utility of the apolipoprotein E genotype in the diagnosis of Alzheimer's disease. N Engl J Med 1998; 338:506–511
12. Melton GB, Petrila J, Poythress NG, et al: Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers, 4th ed. New York, Guilford Press, 2018
13. Gutheil TG, Appelbaum PS: Clinical Handbook of Psychiatry and the Law, 5th ed. Philadelphia, Wolters Kluwer, 2020
14. Rosner R, Scott C: Principles and Practice of Forensic Psychiatry, 3rd ed. Boca Raton, CRC Press, 2016