Ethics, Mental Health Law, and Aging

Daniel L. Ambrosini, Calvin H. Hirsch, and Ana Hategan

A. Hategan et al. (eds.), *Geriatric Psychiatry*, https://doi.org/10.1007/978-3-319-67555-8_9

9.1 Background

9.1.1 Demographic and Epidemiological Factors

Psychiatric illness does not discriminate by age. According to the United Nations' 2015 *Ageing Report*, "population ageing – the increasing share of older persons in the population – is poised to become one of the most significant social transformations of the twenty-first century" [1]. According to this UN report, the number of people who are aged 80 years or over, the "oldest-old" persons, is growing faster than the number of older persons overall [1]. As the rate of aging in the population accelerates, the prevalence of psychiatric illness among older adults is increasing. As a more racially and ethnically diverse group lives longer, this will, in turn, require clinicians to be aware of emerging issues in mental health law. As social demography evolves across time, the law will need to be sensitive and responsive to the needs of a vulnerable population.

It has been estimated that between 2015 and 2030, the number of people in the world over 60 years old will grow from 901 million to 1.4 billion, which represents a 56% increase [1]. By 2050, the global population of older persons is expected to reach nearly 2.1 billion [1]. To put this in perspective, in 1870 the population of the US population over the age of 65 was approximately 3%, whereas by 2050 the same group over 65 years will be more than 20% [2]. Geospatially, the older population is growing faster in urban centers than in rural areas. In Canada, the proportion of the senior population (aged 65 and older) has been increasing steadily over the past 40 years [3]. According to demographic projections, the proportion of Canadian seniors is expected to increase rapidly until 2031, when all the baby boomers will have reached age 65. Between 2015 and 2021, the number of seniors is projected to exceed the number of children aged 14 and younger for the first time ever in Canada [3]. As individuals live longer, it is likely we will have increased contact with older adults; while such relationships will bring increased opportunities for learning, it may also pose an increased risk of attitudes of ageism [2].

As the baby boomer population ages, healthcare providers caring for older patients will need to increasingly be educated about psychosocial, legal, financial, and cultural matters pertaining to this vulnerable, diverse group. Decreased premature mortality from heart disease, cancer, chronic lower respiratory disease, and other chronic illnesses will lead to older individuals developing competing contributors to morbidity and mortality, chief among them being neurocognitive disorders [4]. There are ethnic and cultural factors clinicians will need to consider, particularly in the face of rapidly changing immigration policies in many nations, as to various treatment alternatives and how the role of ethnicity in pharmacokinetics, pharmacodynamics, and pharmacogenomics of drug-metabolizing enzymes may contribute to differential drug responsiveness [4]. It is no longer sufficient as a clinician to have only a rudimentary knowledge of laws and policies, particularly in the area of mental health. The need to be aware of one's own cognitive biases in terms of ethical values is equally important. In this chapter, we address ethical and legal issues that are relevant to clinical practice with older adults with psychiatric illness.

9.1.2 Ethical Theories and Frameworks

Broadly speaking, ethics can be considered a set of moral standards for behavior on how individuals *ought* to act [5]. Ethics deals with questions of what is right or wrong. Some may suggest that "ethics are ethics," and as such, they apply equally to all people; it is not possible, according to some, to have one set of ethical principles for one group of people and then apply these differently to another group. Not all universally agree, however. Being an older adult, what some consider aged 65 and older could influence how ethical principles are applied, just as it does for children [6]. Either way, some ethical issues are more germane and relevant to clinicians working in geriatric psychiatry by virtue of the population of older adults with whom they work [7]. For example, how might one's ethical reasoning around issues of distributive justice toward the end of life differ if one were working with minors as opposed to older adults? Similarly, how paternalistic a clinician acts in dealing with an older adult suffering from progressive deteriorating mental capacity due to a major neurocognitive disorder may differ if the same person instead had delirium with fluctuating mental capacity with periods of intact decisional capacity.

At times clinicians will be asked by their patients, and/or their family members/surrogate (or substitute) decision-makers (SDMs), to disclose their personal biases, whether cognitive, ethical, moral, or religious, and how those biases may be affecting their recommendation for a specific plan or course of treatment. Even when not challenged about their own biases and values as they pertain to treatment recommendations, clinicians should be forthcoming about this information so as not to appear disingenuous or dishonest. Patients and families/SDMs tend to respect and seek clinicians' expertise lending weight to the expression "In my opinion…" provided the opinion is backed up by evidence. As such, it is important for clinicians to a priori understand their own preferences and biases.

Modern psychiatric ethics has changed dramatically over the past 50 years, in large part due to its relationship with other specialties in medicine and the law [5]. As such, it can be helpful for clinicians to appreciate the value of ethical theories, frameworks, and reasoning. Ethics can be grouped into three broad areas:

1. Meta-ethics: understanding the *nature* of ethical properties, including the right or the good
2. Normative ethics: focusing on the *standard* and principles used to determine if an ethical action is right or good

3. Applied ethics: resolving the *application* of an ethical principle to determine what is the right or good action to take in a particular situation

Another distinction to keep in mind is the type of ethical theory one adopts to deal with a particular problem. As noted in ▪ Table 9.1, a *consequentialist* approach to a problem is concerned with the consequences of a particular action, whereas a *non-consequentialist* approach, also known as a *deontological* approach, is focused on the intentions of a person in making a decision. A non-consequentialist approach is focused on particular actions and whether an individual adheres to obligations and duties because it is the correct action. Contrast these ethical approaches with an *agent-centered* approach, where the focus is on the overall ethical status of individuals and less on the morality of certain actions.

Consequentialists typically take the position that the merit of any act can be found in the ultimate consequences. Within this camp are included theories of utilitarianism, ethical egoism, and the common good. A *utilitarian* theory focuses on the amount of degree of pleasure and/or pain that would be produced. The "greatest happiness" principle in utilitarianism holds that one must always act to bring about the greatest aggregate of happiness. In this respect, issues of involuntary psychiatric treatment of an unstable patient may be justifiable by some through an argument from utilitarianism [8]. An *egoistic* theory, on the other hand, focuses on the ethics of self-interest where the agent calculates the greatest benefit for oneself. Moral agents ought to do what is in their own self-interest as a prerequisite to self-respect and respect for others; in other words, the principle of self-interest trumps altruism. Under ethical egoism, clinicians might approach situations only from the position of what benefits themselves. A *common good* theory suggests that the best society ought to be guided by the general will of the people, and this will produce the best for people as a whole. Actions should contribute to communal life, and the focus is on respect and compassion for others. To take involuntary hospitalization as an example, a common good approach might be used to justify a psychiatrist's right to detain someone who is dangerous in the interest of public safety, while at the same time this could generate tension around individual clinician's responsibility to their patients or other third parties.

▪ **Table 9.1** Taxonomy of ethical theories

Approach	Theory	Description
Consequentialist	*Utilitarism*	Greatest benefit to the most people
	Ethical egoism	Self-interest
	Common good	Best for overall community
Non-consequentialist (deontological)	*Duty-based*	Having the proper intention
	Rights	Right to dignity
	Fairness or Justice	Treated without discrimination
	Divine command	God creates what is ethical
Agent-centered	*Virtue*	Entirety of person's life
	Feminist	Traditionally focus on principle of "care"

There are other ethical perspectives. A *duty-based* approach, in Kantian tradition, sees doing what is right as not about the consequences of our action (no control) but instead having the proper intention. A *rights-based* approach, very commonly adopted in psychiatry, focuses on the best ethical action as that which protects the rights of those affected. Ethical theories of *fairness or justice*, on the other hand, focus on just ethical principles that would be chosen by free and rational people in situations of equality. In this regard, all free people should be treated alike, and the focus is on the fair action, not the consequence.

Agent-centered theories include virtue ethics and feminist theories. *Virtue ethics* is concerned with the whole or entirety of an individual's life, not just discrete individual actions. A person of good character is one who has attained certain virtues, and the theory focuses on the importance of having role models, education, and training in order to be virtuous. In psychiatry, for example, virtue ethics has been applied to what desirable qualities would be found in a virtuous psychiatrist, including those of compassion, tolerance, and prudence. A *feminist approach* focuses on experiences of women and other marginalized groups for ethical deliberations. An ethic of care is a legitimate and primary ethical concern and not impersonal justice. One of the most well-known ethical paradigms, particularly in Western medical ethics, is principles-based ethics (principlism) [9, 10]. There are four core ethical principles in medicine that compete with one another, and clinicians are called upon to weigh these when dealing with any particular ethical or moral dilemma. These include

1. Respect for autonomy – respecting individual's abilities to make reasoned informed choices
2. Beneficence – considering the benefits of treatment against the risks and costs to act in a way that benefits the individual
3. Nonmaleficence – avoiding causing harm to patients
4. Justice – distributing the benefits, risks, and costs fairly treating similar patients alike in similar circumstances

In the first half of the twentieth century, beneficence dominated, resulting in physicians taking a paternalistic approach. Concurrently, concepts of social justice played an important role, justifying, for example, the legal sterilization of developmentally disabled persons. In the 1970s and beyond, the patient's autonomy began to move to the top of the hierarchy, and in the twenty-first century, autonomy is generally considered the dominant value, with social justice falling to the bottom. The courts in the USA seem to have followed these trends in the relative importance of the tenets of principlism by supporting the primacy of autonomy. For example, in obstetrics, a pregnant woman has the right to refuse treatment that would save the life of a viable fetus in the third trimester.

Many public policies, social services, and other government-funded interventions for diseases such as major neurocognitive disorders are influenced by ethical values and norms [7, 11, 12]. Perhaps the single most cited ethical value in terms of protecting older persons is autonomy, the ability for individuals to self-govern and make decisions for themselves. Autonomy is fundamental and critical to older adults with psychiatric illness. As shown in ◘ Table 9.2, references to how autonomy is referred to and relied upon in practice often depend on issues of what time it is being referred to. For example, precedent autonomy (past), executional autonomy (current), and prospective autonomy (future) carry different weight based on issues of temporality. Although autonomy has become a pillar within the bioethics community, there are variations in cultural norms and societies as to how much value is placed on the role of autonomy.

There are numerous examples of how various cultural groups may place more or less weight on the value of autonomy. For example, among Christian fundamentalist Russians and some Southeast Asian immigrants, it is the cultural norm for the elder to play a passive role in complex medical decision-making pari passu ("on equal footing") with accepting the role of the dependent elder, sometimes to the point of not wanting or expecting to be told a serious, life-threatening diagnosis. Societal norms of ethics can run up against cultural relativism, forcing clinicians to try to reconcile their own beliefs, the patient's theoretical ethical rights, and the patient's cultural values. For cultural minorities, it is important for the clinician to directly inquire how much the older patient wants to be an active participant in medical decision-making and how much they want to defer to their family.

◘ **Table 9.2** Types of autonomy and temporality

Forms of autonomy	Description	Temporality
Decisional autonomy	Ability to make one's own choices	Present
Dispositional autonomy	Focus on person's life as a whole at the time	Present
Emotional autonomy	Grounded in human feelings	Present
Executional autonomy	Implementation of one's decisions	Present
Functional autonomy	Engagement in activities of daily living and mobility	Present
Precedent autonomy	Precedence over competing current interests	Past
Prospective autonomy	Looking forward from perspective of individual	Future
Rational autonomy	Grounded in logic and reason [subjective or objective]	Present
Relational autonomy	Reliance on others in decision-making	Present
Value autonomy	Independent views that align with personal value system	Present

Narrative-based ethics is another relevant theory not only for persons with psychiatric illness who may have lost their sense of agency but also for older adults who by virtue of their age have a life history to share [13]. Narrative ethics refers to both the story being told and the telling of such story. Indeed, clinicians working with older patients suffering from major neurocognitive disorder, for example, understand that an individual's ability to construct their own narrative can be challenged when physicians are called upon to be coauthors of their life story, at times through obtaining collateral evidence from others. From a clinician's standpoint, a patient's narrative can be a critical determinant of medical decision-making when the patient loses, temporarily or permanently, their decisional capacity. The patient's narrative involves values or opinions they have expressed over a lifetime that can inform what they would have chosen if capable of providing informed consent or refusal. For example, if a patient expressed to his family that he never wanted to end up permanently on a ventilator or ever to be forced to live in a nursing home, this could at least inform decisions about aggressiveness of care in the absence of an advance directive. These "life narratives" can conflict with the wishes of surrogate decision-makers, creating an ethical and legal dilemma that sometimes requires careful education of the surrogate and, on occasion, redress by the court.

9.1.3 Legal Overview

Mental health law as an area of practice has existed for decades. In recent years, the field of elder law has emerged as a relatively new area to deal with the impact of laws affecting seniors. Historically, in the USA, the *Older Americans Act*, passed in 1965 was intended to help older citizens by providing grants to US states for community-based social and health-related services [14, 15]. Elder law is essentially rooted in the *Older Americans Act* and evolved as a specialty of law directing services to the needs of older people [16]. In 2003, the *Elder Justice Act* was passed in the USA as comprehensive legislation to develop a mechanism to "prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation" [17]. Similarly, in Canada there have been amendments to federal legislation to protect seniors. For example, in 2012 the *Protecting Canada's Seniors Act* amended section 718.2(a) of the *Criminal Code* to allow sentencing judges to consider vulnerability due to age as an aggravating circumstance for sentencing purposes [18].

As the field of elder law has grown, lawyers began dealing with older adults as a potentially vulnerable group and offered specific legal services catered to their unique needs. Academic conferences, journals, and courses focusing exclusively on elder law were developed. Some have even referred to the development of "geriatric jurisprudence" in reference to attempts to combine jurisprudence and geriatrics, essentially a medicolegal theory of aging [19]. In mental health law, the framework of *therapeutic jurisprudence* grew out of a need to study how legal rules or practice promoted the psychological well-being of the people affected [20]; in elder law, the framework of *geriatric jurisprudence* appears to have a similar aim but focused on older adults [21]. In California, for example, problem-solving "elder courts" were commenced that allowed judges to focus on the various needs of older individuals all at the same time, including, for example, cases comprising civil or criminal matters, elder abuse, and guardianship/ conservatorships [22]. Lawyers practicing in the area of elder law have been cited as focusing on the four "Cs": (i) know who your *client* is, (ii) understand the importance of *confidentiality*, (iii) be alert to the potential of *conflicts of interest*, and (iv) inquire into the *capacity* of the client [16, 23].

How does one determine who their client is? At face value it may seem obvious, but when one's client lacks decisional capacity or has decisional capacity but cannot meet his or her needs despite a desire to remain independent, serving the needs of the individual can become a delicate fiduciary balancing act that represents an outcome that protects the senior physically and financially while granting the maximum amount of autonomy. For example, a cognitively intact patient, who lives alone and wants to remain at home despite several injurious falls resulting from weakness after a stroke, may not have the ability to live safely at home. The offspring may want to place the patient in a residential care facility against his will. If the family consults an elder care attorney explicitly to help "Dad," which client does the attorney serve?

9.1.4 Informed Consent

Informed consent is grounded in both ethics and law. The doctrine of informed consent was developed in large part in an attempt to redress some of the inequality of information that characterized the doctor-patient relationship. Voluntarism is critical to informed consent as it embodies respect for the person as a human being and as a moral agent with fundamental rights in society [24]. Informed consent allows individuals the basis to determine their own course of action regarding their healthcare. Whether or not others agree with a patient's healthcare decisions is irrelevant, so long as the patient has the capacity to make their own healthcare decisions. For clinicians seeking to obtain consent to treatment, there are generally four factors to consider: (i) consent must relate to the treatment; (ii) consent must be informed; (iii) consent must be given voluntarily; and (iv) consent must not be obtained through misrepresentation or fraud. In order for consent to exist, it must be informed (knowledgeable), given when capable (mental status), voluntary (free of coercion or duress), not given under fraud or misrepresentation (impairs consent), and disclosed (whether implied or expressed).

Some questions to consider when obtaining informed consent include: What is the *nature* of the consent given? What *effect* will the consent have? Is the consent *valid*? How does one *manifest* informed consent (written, verbal, video)? Assuming a patient is capable to make an autonomous decision, clinicians still need to determine which course of action is feasible in a given context. What are the reasonable consequences of each treatment option? Oftentimes, the consequences of specific treatment options are not, or cannot, be known as to how they may impact a patient's ability to make an informed decision. If there is a rare chance of an adverse outcome with a specific treatment, a clinician may or may not choose to disclose such information depending on the probability of that event occurring. Standards of disclosure may differ from physician to physician, impacting a patient's ability to make an informed decision. Clinicians have a duty to disclose material and probable risks, and this duty to disclose continues even as the facts change.

Whether it is in clinical or research settings, there can be problems of proof in working with older adults with psychiatric illness. Was the patient provided enough information at the time consent was obtained and is the clinician reasonably confident that there was no coercion involved? At times, a clinician providing information about a specific medication may be acting as a learned intermediary between the patient (who typically has the least information) and a pharmaceutical company (who generally has the most information). Some older patients may exercise their "right not to know" about specific diseases or trajectories of their psychiatric illness. The amount of information provided to a patient may also depend on cultural differences and perceptions of how physicians are perceived. This concept applies to the ability of patients to be able to provide informed consent in a particular situation despite lacking overall decisional capacity. For example, a patient with short-term memory impairment suffering from an early stage of major neurocognitive disorder might be able to understand the risks and benefits of a procedure and give consent, although he or she might forget the conversation several hours later.

9.1.5 Mental Capacity

As noted above, clinicians are required under law to ensure they determine whether someone has provided their informed consent to treatment. As such, one of the main roles of clinicians is to determine whether their patient is capable to consent to treatment. This is particularly important for older patients who may lose their ability to make truly independent choices due to clinical factors, including major or mild neurocognitive disorder or major depressive disorder [7]. Capacity and competence are often terms used interchangeably, although some have distinguished the two where mental capacity is determined by clinicians and competence is a binary judgment determined by a judge [25]. Decisional capacity forms the basis for determining legal competence. A psychiatrist or another physician can determine decisional capacity, but only the court can establish incompetence, and cognitive impairment or decline does not always mean there will be a legal determination of incompetence.

Mental capacity includes the ability to utilize information in order to come to a decision that is congruent with the patient's values, beliefs, and wishes. Across jurisdictions, there are different legal standards and statutory tests in deciding whether someone is capable to consent or not. Notwithstanding statutory differences, in general there are four legally relevant criteria to explore in deciding whether someone is incapable; note there is always a presumption of mental capacity. These criteria include the ability to [25]:

1. *Communicate* a choice.
2. *Understand* the relevant information.
3. *Appreciate* the situation and its consequences.
4. *Reason* about treatment options.

The following is a case example. A bedbound but cognitively intact 82-year-old man with a presacral pressure ulcer demands to go home at the end of a prolonged hospitalization, even though he lacks the physical capacity to provide essential self-care, including meal preparation, shopping, timely dressing changes, transfers, toileting, and access to his physician. A social worker's assessment indicates that community resources are insufficient to meet these needs. However, the patient keeps insisting that he can get enough help by asking a neighbor or his ex-wife to help him and refuses to enter a nursing home, which he calls a "snake pit." He knows the neighbor only by her first name, and he cannot provide her telephone number. His ex-wife is his age and does not live nearby. Which of the four legally relevant criteria of mental capacity does this individual possess? Promoting autonomy endorses his preference, even if such a course contradicts medical recommendations. However, the patient's reasoning appears deeply flawed, if not fanciful, and he therefore may lack decisional capacity for discharge destination. The principles of beneficence (ensuring the availability of necessary treatment) and nonmaleficence (preventing harm to the patient that inevitably would result from a discharge directly to home) are likely to override his autonomy because of his unrealistic thinking.

One must also consider what aspect of cognitive capacity is being evaluated; some patients may lack decisional capacity for one task yet retain capacity for another. A patient with early stage of major neurocognitive disorder due to Alzheimer disease may retain capacity for informed consent for a procedure yet lack capacity for finances. Capacity assessments are often conducted for the following: consent to treatment, independent living, financial management, testamentary capacity, research consent, sexual consent, voting, or driving [7, 26]. When a clinician makes a finding of incapacity, it is critical to remember that one is ultimately making a human judgment that occurs in a social context.

All central nervous system illnesses, grouped as "neuropsychiatric" disorders, can impact an older adult's decisional capacity. One may find that capacity can fluctuate over time, a patient can be deemed incapable at one point in time and then be capable shortly thereafter, or alternatively a clinician may find there is progressive cognitive decline that has influenced one's capacity to make decisions [6]. As such, clinicians should not adopt a mindset of arbitrarily assessing patients' capacity every 6 months, for example. There could be a significant change in mental status that requires reevaluation at different points in time.

Many older adults are understandably preoccupied with ensuring that they have sufficient financial savings for retirement. Most people do not anticipate they will lose their capacity to make important or, for that matter, even basic decisions about financial matters, or they may believe that any such cognitive incapacity will occur very late in life. As such, the outcome of a financial capacity assessment can deeply affect an older adult's sense of autonomy, particularly if it is being challenged by a clinician due to the presence of a major neurocognitive disorder [27]. Many neuropsychiatric disorders can influence one's financial skills. It is critical that assessments are objective, well documented, and tracked across time. Such assessments may include clinical interviews, standardized neuropsychological tests, or performance-based evaluations [26, 28]. A clinical assessment of mental capacity of an older adult often includes the following five steps: (i) determination of the specific type of decisional capacity to be assessed, (ii) collection of collateral information about the older adult from significant others and healthcare professionals, (iii) general assessment of mental state, (iv) specific assessment of decisional capacity, and (v) professional judgment of decisional capacity that integrates these components [29].

9.1.6 Advance Directives

Advance directives are legal documents that offer individuals an opportunity to express their prior capable wishes in the event they become mentally incapacitated at some point in the future [6, 30]. Advance directives have many different terms, as noted in ▣ Table 9.3, depending on one's jurisdiction. They have also been referred to as living wills, Ulysses contracts, and powers of attorneys. Where an individual is found to be incapable, decisions can be made according to their previously expressed values, wishes, and beliefs. Some advance directives are *instructional* in nature in that individuals can include detailed instructions about what to do in a given situation, whereas others are *proxy* in nature whereby someone else is named as an agent to make decisions for the incapable person.

Legal, ethical, moral, and religious issues often surface in clinical settings where a family member contests the wishes of an older adult who no longer retains mental capacity.

Table 9.3 Types of advance care planning documents

Name	Description
Advance agreement	Term used by the *English Mental Health Act* Legislation Committee to describe plan of care between patient and treatment provider
Advance directive	General term for document with statutory authority for capable person to state wishes of what should happen to them if becomes incapable
Advance healthcare directive	Term used in Newfoundland and Labrador and Prince Edward Island
Advance refusal	A stronger version of advance directive that highlights refusal rather than "directed"
Advance statement	A weaker version of advance directive in that person's wishes are stated rather than "directed"
Authorization	Term used in Nova Scotia
Healthcare directive	Term used in Manitoba and Saskatchewan
Joint crisis plan	Currently a research intervention in the United Kingdom where facilitator negotiates with person and comes to some agreement
Living will	Term used to highlight that the document can only be used while the person is alive. In wider use in the USA than Canada
Mandate in case of incapacity	Term used in Quebec
Mill's will	Term used to refer to John Stuart Mill's which highlights self-determination and the right to refuse and accept treatment
Nexum contract	Advance agreement that follows a contractual model in that it is inherently bilateral
Odysseus contract, pact, or transfer	Greek term for Ulysses emphasizing different aspects of the document
Personal directive	Term used in Alberta and Northwest Territories
Physician's Order for Life-Sustaining Treatment (POLST)	A legally binding advance directive signed by patient [or surrogate] and physician as an order through enactment a California, USA, statute. Original kept by patient and placed in a conspicuous location [e.g., on refrigerator door] to prevent emergency medical services from inappropriately initiating or not initiating resuscitation and transport
Power of attorney [continuing, durable, enduring, springing]	Terms used in New Brunswick and Ontario
Pre-commitment contract	Used to highlight that individuals with recurrent and treatable conditions could make a wish before becoming ill
Psychiatric advance directive	Widely used term in the USA stressing the importance of autonomy
Psychiatric will	Original term proposed by Thomas Szasz in 1982 to protect patients from coercion or psychiatric neglect
Representation agreement	Term used in British Columbia
Ulysses commitment contract	Term used to reflect a commitment to follow through on the self-binding contract
Ulysses contract	Roman term used to highlight different issues around self-binding wishes
Ulysses clause	Proposed in this article to reflect that a legal provision can be included into the advance directive making the document irrevocable
Ulysses directive	Term avoids reference to any contractual relationship as through a Ulysses contract
Ulysses statement	Less strong than a Ulysses directive or contract
Voluntary commitment contract	Term highlights that document is not entered into under undue influence or coercion

Unfortunately, many individuals do not engage in advance care planning until they have been diagnosed with a terminal illness. This creates questions surrounding mental capacity at the time that the advance directive was made. Some argue that patients have become saddened, depressed, or hopeless once the terminal illness diagnosis was made, and this may have influenced their ability to execute the advance directive. If family members dispute the advance directive of a loved one, it can become necessary for legal and medical professionals to analyze the capacity of the person at the time it was made. Where no witnesses were present when the advance directive was made, it becomes even more difficult to assess the capacity retrospectively. Some lawyers and others assisting in preparing such documents have started videotaping individuals at the time of execution of these instruments as valid proof.

Even if a patient was capable at the time the advance directive was completed, it may still be an extremely difficult task to interpret those wishes in the context of a specific healthcare dilemma. Imagine if a patient were to state as part of their advance directive, "I would like to receive medical interventions which will improve my health care condition and which will not result in significant pain." This type of statement opens a myriad of questions because it is still quite broad. What does "improve" a healthcare condition mean? What should be considered "significant pain?" Older adults need to ensure their goals recorded in an advance directive are outlined in such a way as to provide specific guidance while at the same time providing flexibility for novel healthcare situations. Ensuring that advance directives can be readily found in the event of an emergency is another important consideration.

A patient's preferences for life-sustaining treatment can vary over time, and this can pose a dilemma when an otherwise valid advance directive has not been updated despite a significant change in the patient's health status. Ethically, clinicians should honor their best interpretation of expressed or clearly inferred current values, beliefs, and preferences when it appears an advance directive contradicts these preferences. A patient whose earlier advance directive indicated that she wanted everything done to keep her alive may not reflect the misery she has expressed to family after being forced to move to a care home following a stroke after the advance directive was prepared.

9.1.7 Decision-Making for Older Adults Without Family and Guardianship (The "Unbefriended Patient")

Clinicians may find themselves in situations where their patients lack capacity, and there are no surrogate decision-makers available [31]. Many approaches are used to make decisions for incapable older patients who do not have a family. These have included hospital committees and advance directives, where available, or a public guardian and trustee, or even computer-based systems [30]. The length of stay in hospitals for incapable patients without family members can be significantly longer than the average length of stay for incapable patients with family members. Unless considered medically inappropriate, the default approach is to follow a course of life-sustaining care that meets the medical standards for that illness. It takes a significant amount of time to proceed through court processes when appointing a legal guardian. During that time, patients are cared for by hospital staff where there is nowhere else for them to go. Third, even contacting or attempting to locate family members of such patients can be time consuming and stressful [30].

Two legal standards are generally used for decision-making in this context, one being "substituted judgment," where the patient's wishes are known to the surrogate, or a "best interest" standard, where the patient's wishes are not known [6]. Understandably, not having the ability to choose a surrogate decision-maker can have a serious impact on the mental well-being of an aging patient. Some patients may place more importance on the surrogate rather than the decision the surrogate makes. Individuals who find themselves in such situations would like to know that the appointed individual who cares about their well-being is acting in their best interests. Patients without family are forced to rely on individuals whom they may not know well or to rely on others whom they do not know at all as in the case of a public guardian and trustee.

While it is possible for some patients to ask a friend to become their surrogate decision-maker, other patients without families live in long-term care homes where their friends/co-residents are of a similar age. Whether these friends have the time, energy, or resources to vigorously act, or at times fight, for the wishes of the patient is questionable [30]. Furthermore, accepting the responsibility to act as a surrogate decision-maker is not always readily accepted even by direct or indirect family members. The responsibility of deciding on treatment options, do-not-resuscitate orders, and funeral arrangements, for example, can become overwhelming. This is particularly the case if a patient suffers from a long term, debilitating illness in which the surrogate decision-maker is tasked with caring for the individual for a long period of time, even years, as is the case with many patients with major neurocognitive disorder. Despite good intentions, an exhausted or frustrated proxy at times may make surrogate decisions that deviate from the patient's wishes. The conflict in such decisions easily can be overlooked by clinicians when they are consistent with the treating team's biases, e.g., not to offer intensive-level care to a nonagenarian because of a diagnosis of Alzheimer disease-related neurocognitive disorder, when, if investigated more carefully, it would be learned that the patient had early Alzheimer disease and was socially interactive and independent in all activities of daily living except bathing. Potential red flags for conflicts of interest should be sought, such as the caregiver arguing for withdrawal of life support when that caregiver would be the beneficiary of an inheritance.

The most powerful surrogate decision-making mechanism is a guardian, whereby the court appoints a third party to make decisions for a person with a disability [32]. Guardianship is often done when a patient is deemed incapable and there is no next of kin available. This may also occur when family members of the patient are unable to come to a consensus regarding the patient's care, even after mediation. While some may argue that the legal rights and autonomy of the patient are stripped once a guardian is assigned, this may be the only method of caring for an older adult who is found incapable. Areas of the patient's life over which the guardian has control need to be explicitly stated so that conflicts do not occur. A guardian must be able to establish that he or she is using all information available to make a decision congruent with the patient's previously expressed capable wishes. In recent years, a new model of *supported decision-making* has surfaced that offers support to individuals with disabilities to make their own decision rather than relying exclusively on someone else to make decisions for them [32].

Shared decision-making often occurs within families, as different family members may try to influence a patient's or surrogate's healthcare decisions. Not uncommonly, the designated proxy may want to consult other family members or influential community leaders (e.g., priest rabbi, imam) before making a decision in order not to create a rift that could distance the proxy from the rest of the family or community, creating a potential conflict of interest with the patient's wishes. Although not formally part of the consulting psychiatrist's role, identifying potential familial, religious, or cultural conflicts that could interfere with the fiduciary responsibilities of the surrogate fall within the unique skill set of the psychiatrist.

9.1.8 Involuntary Commitment and Long-Term Care

Involuntary psychiatric commitment refers to the act of detaining an individual in a designated psychiatric facility against their will. As autonomy is a fundamental tenet of healthcare, involuntary commitment should be used only in circumstances warranted under law. In this sense, involuntary commitment laws are known as laws of exception. Generally, one can be committed involuntarily if they are deemed to be a danger to self and/or other(s) and/or are unable to care for themselves due to psychiatric illness. The law specifies the precise standard to be followed. Many medical and legal issues arise during the evaluation of patients. To what extent does one have to be a danger to self or others in order to pass the threshold of being involuntarily committed? When is the test of whether the individual constitutes a risk no longer a matter of public safety and a clinician is actually applying a best interest standard? How long an individual *can* be held against their will differs from how long one *should* be held. In cases where involuntary detention is being contested, patients should be provided all relevant information to appeal the finding of a clinician if requested.

The application of these rules and principles in mental health law can at times be difficult to apply in practice. Clinicians are not lawyers; lawyers are not clinicians. Most physicians would prefer not to appear before a court of law or tribunal where they must explain why they found someone needed to be involuntarily detained. Physicians often enter into negotiations with patients (and sometimes their lawyers), in a model of shared decision-making, to discover a suitable compromise that can achieve the twin goals of providing appropriate healthcare and ensuring public safety. The aim of clinicians should be to assist patients to reintegrate back into the community.

Who should bear the risk to care for older adults with psychiatric illness on a long-term basis? Long-term care is not only an ethical issue in terms of allocation of resources from a distributive justice perspective but also an ethical consideration in terms of what is the right action to take. There are often health policy and economic consequences in terms of offering or removing community resources but also consequences in terms of how governments legislate policy responses toward implementation [33]. When modern-day hospitals were first developed, it was never intended that individuals would reside indefinitely in them or for ultimate responsibility to fall upon healthcare providers to become de facto caregivers forever more. In some cases, this becomes unavoidable.

9.1.9 Elder Abuse

While elder abuse, neglect, or mistreatment occurs in all segments of the population, it may be more pronounced among individuals who suffer from psychiatric disorders. Such abuse can be in the form of emotional or physical abuse, financial exploitation, maltreatment, and neglect of care-taking, to mention a few [34]. Elder abuse often contains three elements: harm, a trust relationship, and intent [6]. It may not be surprising that the source of abuse frequently is from the older adult's own family members. As a clinician these issues require extreme sensitivity, particularly when one sees palpable signs of abuse, which are not always physical or tangible. Some victims may be particularly reluctant to come forward to address their valid concerns due to embarrassment, shame, lack of support, or an unwillingness to disrupt their current situation [34]. Clinicians may be the first to note such changes in their patients' demeanor, mood, or attitudes due to the confidential nature of their relationship, which may require further information from collateral sources. In most jurisdictions in the developed world, healthcare providers, including physicians, social workers, and nurses, are mandated to report a finding of elder abuse where they have reasonable cause to believe it has occurred.

Lawyers who represent the interests of older adults with psychiatric illness can be among the first to learn about potential elder abuse (particularly in financial matters); as such, they too may have a duty to report abuse, neglect, or exploitation [35]. Older adults may be willing to discuss legal matters, such as wills and estate planning, with healthcare providers. If an issue of elder abuse, neglect, or maltreatment arises in the context of a lawyer-client relationship, there will be an ethical conflict on the part of the lawyer on whether to protect the confidence of their client or to divulge the matter to authorities. In this regard, lawyers should be guided by their professional rules of conduct and other statutory obligations.

Psychiatrists may encounter victims of elder maltreatment when they are asked to consult on older adults for a possible depressive disorder, failure to thrive, or neuropsychiatric symptoms with a major neurocognitive disorder, particularly agitation or aggressiveness. The patient may not be able or willing to admit being abused because of cognitive impairment, a sense of humiliation, intimidation by the caregiver, fear of retribution, or fear of losing a caregiver who, in effect, is the perceived lifeline against institutionalization. When investigating these disorders in vulnerable, older adults, elder maltreatment should automatically be considered as a potential contributor. During the interview, discretely separating the patient and caregiver permits the psychiatrist to ask nonthreatening, leading questions, such as: "Do you feel safe at home?" and "Do you think you're getting the care you need?" When elder abuse is strongly suspected, the psychiatrist can ask more direct questions, such as "Do you get enough to eat?" "Do you ever feel that you're being punished at home?" "Do you ever get yelled at?" If marks or behaviors of possible physical abuse are present, such as unexplained ecchymoses, pattern bruises (a bruise resembling the object with which the patient was struck or a circumferential bruise around the arm from being grasped forcefully), or flinching when the patient is touched suddenly, the psychiatrist should request a consultation from an elder-abuse or forensic expert, if available. (See ► Chap. 34, ► section Screening for Elder Mistreatment and Neglect.)

9.1.10 Managing Risk of Violence in Older Adults with Psychiatric Disorders

An issue that often arises in psychiatry is the determination of risk for violence associated with individuals who suffer from psychiatric illness. Brain disease such as major neurocognitive disorder can contribute toward criminal behavior. (See ► Chap. 29.) Mental health and violence are key considerations for older adults, particularly in the context of domestic violence. Between 20–30% of older adults, the majority being women, experience or have experienced domestic violence [36]. Whereas physical abuse may decrease with age, rates of emotional abuse appear to be stable across the lifespan [36]. Managing risk of violence in older adults can be particularly challenging from an ethical position of balancing individual rights with societal interests. Older adults with psychiatric illness are vulnerable in part due to frailties associated with aging and from psychiatric illness. Some of the issues clinicians may be faced with include managing sexually disinhibited behaviors, delusional misidentification syndrome, homicide-suicide, sleep disorders, and the role of alcohol [37]. Physicians will be called upon to consider whether their patients should have access to firearms in their possession [38].

9.1.11 End-of-Life Discussions

The ethical debate around end of life has existed for years. End-of-life discussions with patients and family members can be extremely difficult, particularly in cases of late-stage major neurocognitive disorder and other degenerative diseases where no prior competent wish was made [7]. In 2016, the Canadian Government passed federal legislation [Bill C-14] supporting medical assistance in dying (MAID), the term adopted by the government rather than "physician-assisted death," based on a 2015 Supreme Court of Canada case of *Carter v. Canada* [39]. In *Carter*, the Supreme Court held that criminal laws prohibiting assistance in dying limited the rights to life, liberty, and security of the person under the *Canadian Charter of Rights and Freedom*. Under this legislation, MAID is available to persons in the following circumstances:

- Being an adult (at least 18 years old) who is mentally competent ("capable") to make healthcare decisions
- Having a grievous and irremediable medical condition
- Making a voluntary request for MAID which does not result from external pressure
- Giving informed consent to receive MAID after having been informed of the means that are available to relieve their suffering, including palliative care
- Being eligible for health services funded by a government

While the law does not define what constitutes a "grievous and irremediable medical condition," this has been left open to interpretation, and the law is likely to be challenged constitutionally. Another open question for Canadians will be how appellate courts will handle requests for MAID, particularly in those cases where there is serious psychiatric illness and an advance directive.

In the USA, as of 2016, five states (Oregon, Washington, Vermont, Colorado, and California) have enacted legislation permitting physician-assisted suicide, while Montana permits aid in dying through a court ruling. The remaining 44 states and the District of Colombia consider assisted suicide to be illegal. (See ► Chap. 33.)

Older patients who have diminished capacity often rely on decision-makers including physicians, hospital committees, or public guardians to carry out their wishes [30]. While some patients may argue their values and wishes are well-known by their primary care physician, these patients are more likely to be admitted to an acute care setting as they near the end of life. As a result, situations may arise where someone has never met the physician tasked with caring for their health. Relying on acute care physicians for end-of-life decisions would lead to inconsistent practices as each physician would have their own personal values and beliefs which may unwittingly be imposed on the patient. Without advance directives in place, it is difficult to expect physicians to know the wishes and values of such patients. In other situations, clinicians or institutions may hold conscientious objections based on religious values to assisting patients in MAID. In these cases, clinicians may be asked to suspend their personal views and advocate for such individuals even where it is a referral of care.

9.1.12 Physicians' Roles and Responsibilities

The ethical values of clinicians will not always align squarely with those of their patients in terms of when something is perceived as paternalistic, interventionist, or beneficent [40].

In an effort to reduce ageism, some medical student and resident groups have developed a "Council of Elders" group to help them discern attitudes of older adult patients through a council of other older individuals [41]. Physicians need ongoing training and guidelines to assist in evaluating and making determinations that are not only legal, but also ethical so they are done in a fair and consistent manner. In many cases, involvement from family members/SDMs is welcome and endorsed by patients. In other cases, however, patients may choose to make decisions independently. Tensions between healthcare providers and patients' family members can heighten to the point that focus on what is best for the patient is lost. For patients lacking decisional capacity, clinicians need to remind family members that their role is not to do what the family or surrogate wants but what, in their best clinical judgment, is medically the most appropriate course of action within the context of what the patient would have wanted based on knowledge of the patient's beliefs and preference. Clinicians have an ethical duty first and foremost to their patient as the person receiving care.

While the older adult is the patient, concerned family members will often speak to physicians privately in an effort to develop a particular plan of action that is, according to them, in the best interests of the patient. In this context, physicians must be careful not to participate in decisions that create, or appear to create, an actual or perceived conflict of interest between the patient and others. Whether there is evidence of truth or dishonesty, financial gain or loss, or any other benefit or cost, what matters in the end is the patient's authentic decision that is made while decisionally capable.

In the years ahead, clinicians will need to grapple with ethical, legal, and professional implications of incorporating new technologies into clinical practice. Many older adults who will turn 65 years old in the years ahead will be computer literate, texting savvy, and familiar with electronic technologies for healthcare delivery [42]. Many clinicians have already been introducing technology-enabled services into their practice to interview patients for clinical purposes or have appeared before quasi-judicial tribunals to provide testimony. Advances in the field of "telehealth" have also been informing the development of an emerging area of "telelaw," whereby older adults with less mobility or those living in remote and rural areas are accessing legal services remotely [43]. There are ethical issues associated with the move toward technology-based services including access to healthcare, equity, and fairness. As the demographics of older adults change, there is likely to be an increasing willingness by them to adopt various technologies in an effort to maintain greater autonomy.

9.2 Case Studies

In the following below, two case studies are provided to address some of the issues related to clinical, ethical, and legal considerations for older adults suffering from psychiatric illness.

9.2.1 Case 1

Case 1 History

Ms. M., a widow and former smoker but otherwise in good health, prepared a living will at age 74 specifying that she did not want cardiopulmonary resuscitation, including emergency intubation. At the age of 81, she fell ill with influenza A despite annual vaccination and developed a severe viral pneumonia followed by a superimposed bacterial pneumonia associated with respiratory failure that did not respond to antibiotics and bilevel positive airway pressure. Her daughter stated that her mother was very active, loved to go on cruises, and enjoyed socializing with friends in her senior living community. Her medical record indicated that she was scheduled to undergo an elective lumpectomy for early breast cancer. The patient's oldest son and designated surrogate decision-maker, who lived 400 miles away, wished to honor his mother's advance directive. The on-call psychiatrist was asked to determine if the patient had decisional capacity and diagnosed the patient with delirium.

Case 1 Questions and Answers

Case 1 Questions

? Question 1. Ethically, what is the most appropriate course of action and accompanying reasoning?

? Question 2. What considerations for life-sustaining measures should be discussed with Ms. M. as soon as feasible?

Case 1 Answers

Case 1 Answer 1 (Question 1 – Ethically, what is the most appropriate course of action and accompanying reasoning?)

Many adults fear the devastating effects of functional dependence, of being in a persistent vegetative state, or indefinitely being hooked up to a ventilator in a nursing facility and therefore check the "do not resuscitate" box on pre-printed advance directive forms, such as the State of California's *Physician Order for Life-Sustaining Treatment*. However, most older adults adapt to changes in their health status and recognize that life can be enjoyed despite loss of some forms of independence. In this case, Ms. M. lifestyle and decision to undergo treatment for cancer clearly indicate that she wants to live. Her advance directive, presumably still legal, is 7 years old. The son may be an inappropriate surrogate decision-maker, despite his selection by the patient. He lives far away and apparently is unaware of or indifferent to her current lifestyle, as described by the daughter. If the clinician finds persuasive evidence that the surrogate decision-maker is not acting in the best interest of the patient or there is a strong likelihood that he or she is not honoring current stated or clearly inferred but undocumented preferences, it may be appropriate not to follow the surrogate's requests. That said, the son in this case is acting in a manner consistent with a document that is legally binding in many jurisdictions. In such cases, it may be necessary for individuals to obtain legal advice or representation in the matter.

Case 1 Answer 2 (Question 2 – What considerations for life-sustaining measures should be discussed with Ms. M. as soon as feasible?)

The psychiatrist may be called on in the future to reassess the patient's decisional capacity regarding life-sustaining measures in light of her fluctuating mental status. In such a determination, it is critical that she be educated about her status and prognosis first so that continuation or withdrawal of life support is done with informed consent. Although treatment for an anticipated reversible condition does reflect beneficence, medical standards do not support aggressive interventions that contradict a patient's prior competent wishes. Her recent behavior offers no evidence of impaired capacity, let alone 7 years ago. However, susceptibility to delirium may signal an undiagnosed major or mild neurocognitive disorder, and delirium is a risk factor for developing a major neurocognitive disorder.

Case 1 Analysis This case illustrates a situation that can arise when an individual's prior competent wish, as recorded in an advance directive, needs to be interpreted alongside a "current wish" that may have changed. A conflict can arise between what the individual originally requested in the advance directive and what the physician may perceive to be in the individual's best interests. This is particularly relevant in situations where it is no longer clear that the person in question would still agree with the decision previously made. Similar situations can pose a legal or ethical dilemma for the physician when an otherwise valid advance directive has not been updated, despite a significant change in the patient's health status. This case highlights the need to ensure that older adults revisit their advance directives regularly, perhaps annually, in the event that the document is triggered due to a finding of mental incapacity. When an advance directive appears to contradict the patient's current values, beliefs, and preferences (clearly expressed or inferred), the physician will need to explore the situation very closely. It does not necessarily mean that the physician must follow the patient's current values, beliefs, and preferences simply because it is the most recent expression. Similarly, if there is no reason to believe that the prior competent wishes documented in the advance directive have changed, and there exists ample corroborative evidence to that effect, then the physician may be expected to follow such wishes. Continuation or withdrawal of life-sustaining treatment is accomplished with the patient's full informed consent when capable.

9.2.2 Case 2

Case 2 History

You are the consultation-liaison psychiatrist on the psychosomatic medicine service being asked to see Mrs. B., a 76-year-old woman with a history of major depressive disorder, who was admitted with right hip fracture due to a fall in her home. She requires a preoperative evaluation for a hip fracture repair with replacement, but her admitting physician was unclear about Mrs. B.'s ability to clearly provide informed consent for that procedure and questioned whether she might be depressed. A ward social work assessment note indicated that Mr. B. was widowed and lived with her 47-year-old unemployed son in a house she owned. Of late, she was failing to attend scheduled appointments with her psychiatrist as she previously did, did not seem to be taking her antidepressant sertraline consistently, and was using excessive quantities of prescribed narcotic pain medication for her chronic lower back pain. You found that the social worker at the local community agency had recently visited Mrs. B. while at home and found it difficult to interview her alone without her son. Her house was in need of cleaning and minor repairs, and Mrs. B. was unkempt and unable to give a consistent history.

Today, you were unable to reach her son to obtain collateral information. You did obtain collateral information from her primary care physician who corroborated that Mrs. B. was failing to attend regular scheduled appointments as she previously did, focused on seeking more pain medication, and it was unclear if she adhered to her treatment with sertraline. Her last medical visit was 1 month previously. At that time, her Mini Mental State Examination (MMSE) score was 21 out of 30 points. Upon current examination, Mrs. B.'s mental status revealed significant depression and anxiety, but no psychotic symptoms. Her repeated MMSE was again 21 out of 30. She endorsed right hip and lower back pain, despite taking her pain medication. You ask her about her understanding of the risks and benefits of the treatment with sertraline and the planned hip surgical procedure. She tells you in a calm manner that sertraline will help with her "spirits" and the surgical procedure will "fix" her hip. When you provide her with information about risks and alternative treatment options, and query about her understanding, she replies, "It will be okay." You wonder whether she has the capacity to make the decision to restart treatment with sertraline and to proceed with the hip replacement surgery.

Case 2 Questions and Answers

Case 2 Questions

- ? Question 1. Why is the clinical examination important in Mrs. B.'s case?

- ? Question 2. What is the gold standard for capacity determination? What are the common instruments for assessing medical decision-making capacity?

- ? Question 3. What is the relationship between Mrs. B.'s cognitive abilities and incapacity?

- ? Question 4. What factors influence medical decision-making capacity? How would you address these factors in the capacity evaluation in this case?

Case 2 Answers

Case 2 Answer 1 (Question 1 – Why is the clinical examination important in Mrs. B.'s case?)

Because decisional capacity for medical decisions is always presumed unless proven otherwise, clinicians may fail to recognize incapacity and generally question a patient's capacity only when the medical decision to be made is complex with significant risk, as is the case presented herein, or if the patient disagrees with the physician's recommendation [44]. As previously stated in this chapter, the criteria for obtaining valid informed consent to medical treatment have three elements [45]; therefore, Mrs. B. must:

1. Be given adequate information regarding the nature and purpose of proposed treatment with sertraline and the surgical procedure, as well as the risks, benefits, and alternatives to the proposed treatment, including no treatment
2. Be free from any coercion
3. Have the ability for medical decision-making capacity

The element of medical decision-making capacity is generally met based on evaluating the four abilities cited earlier in this chapter [46]. Mrs. B. must have the ability to:

1. Understand the relevant information about proposed diagnostic investigations or treatment.
2. Appreciate her situation (including her current medical situation and underlying values).
3. Reason using her thought processes to make a decision.
4. Communicate her choice.

As in Mrs. B.'s case, probing is often required in assessing a patient's understanding of the proposed medical treatment and her medical decision. The patient's decision must be based on her values. She must show the ability to reason effectively (i.e., the process of being able to manipulate the information provided). In Mrs. B.'s case, her failure to answer specifically your questions about risks and alternative treatments raised concern about her capacity and should result in a formal capacity assessment. As stated previously in this chapter, a patient's capacity is both situational and temporal, and capacity evaluations should occur in the context of a specific medical decision that needs to be made. Some patients may lack capacity for circumscribed periods of time (e.g., patient with delirium); some are permanently incapacitated (e.g., patient with advanced major neurocognitive disorder) or may have limited capacity. As in Mrs. B.'s case, those with limited medical decisional capacity may be able to make some diagnostic and treatment decisions (generally less risky decisions such as restarting treatment with sertraline in this case) but not others (riskier medical decisions such as hip surgical procedure in this case). As evidenced in this case, physicians commonly hold patients to higher standards when judging capacity for higher risk situations [47].

Case 2 Answer 2 (Question 2 – What is the gold standard for capacity determination? What are the common instruments for assessing medical decision-making capacity?)

Any physician can make a determination of incapacity, not just a psychiatrist. In general, the physician proposing the respective treatment should assess the patient's capacity. The gold standard for capacity determination is a clinical examination by a physician. A physician may choose to evaluate a patient's decisional capacity using a combination of clinical judgment and standardized capacity assessment instruments. A number of instruments have been developed for assessing capacity to make medical decisions. Capacity assessment instruments that can be performed in an office visit and that have robust likelihood ratios and moderate to strong levels of evidence include the Aid to Capacity Evaluation, Hopkins Competency Assessment Tool, and Understanding Treatment Disclosure [48]. The MacArthur Competence Assessment Tool for Treatment and the Mini Mental State Examination (MMSE), which has been found to correlate with clinical judgments of decisional incapacity, have also been used to aid in the capacity assessment [25, 48]. ▪ Table 9.4 includes some commonly used instruments to assist in assessing mental capacity that have moderate to strong levels of evidence of support [48]. There are many others, but among these the Aid to Capacity Evaluation was validated in one of the largest research studies, is free, and available online for which training materials are provided.

Case 2 Answer 3 (Question 3 – What is the relationship between Mrs. B.'s cognitive abilities and incapacity?)

Physicians frequently assess a patient's cognition by using cognitive screening tests such as the Mini Mental State Examination (MMSE) or Montreal Cognitive Assessment (MoCA) and may use these tools as a proxy for capacity. However, their usefulness in assessing patient's capacity has been under debate. Some studies found evidence of a strong relationship between capacity and MMSE scores. MMSE scores less than 20 were found to increase the likelihood of incapacity, and scores less than 16 further increased the likelihood. Scores between 20 and 24 were found to have no effect on the likelihood of incapacity, and scores greater than 24 significantly lowered the likelihood of incapacity [48]. Mrs. B.'s MMSE score of 21 would generally suggest no effect on the likelihood of incapacity. The MMSE does not test executive functioning like reasoning and judgment. For this reason, the MoCA may be a better screening instrument.

Case 2 Answer 4 (Question 4 – What factors influence medical decision-making capacity? How would you address these factors in the capacity evaluation in this case?)

Mrs. B.'s capacity is potentially influenced by a variety of factors, including situational (e.g., reduced social support, isolation), psychosocial (e.g., parent-child relational problem, possible elder maltreatment), medical status (e.g., poor health, poor adherence to medical treatment, history of falls), and neuropsychiatric disorders (e.g., depressive disorder, neurocognitive disorder). The physician performing the capacity assessment should do so in the context of a specific decision, so that the physician must be fully knowledgeable about the proposed decision including the potential risks and benefits. In Mrs. B.'s case, the psychiatrist proposing treatment with sertraline could also assist in the opinion on the hip surgery provided that he or she observed Mrs. B.'s orthopedic

Table 9.4 Common capacity instruments [48]

Test	Abbreviation	Time to complete (minutes)	Comments
Aid to Capacity Evaluation	ACE	10–20	Freely available; uses the patient's own medical situation and diagnosis or treatment decision; an eight-question tool that assesses understanding of the problem, proposed treatment/alternatives, option to refuse treatment, foreseeable consequences of the decision, and the effect of an underlying psychiatric disorder on decision; it provides objective criteria for scoring responses
Hopkins Competency Assessment Tool	HCAT	10	Freely available; a four-paragraph essay tool written at three reading levels of 6th grade, 8th grade, and 13th grade (completed high school); the examiner reads aloud, while the patient reads the same material, starting with the 13th-grade example, followed by six questions; if score < 3 on higher-level essay, the 8th-grade and then 6th-grade level essays are used. Scores < 3 suggest incapacity
MacArthur Competency Assessment Tool for Treatment	MacCAT-T	20–25	Available from Professional Resource Press
Understanding Treatment Disclosure	UTD	< 30	The tool provides three subscale scores; the tool has a scoring manual that provides objective criteria for scoring responses

surgeon explaining the surgical procedure to Mrs. B. Since direct observation of another physician's informed consent process is rare, and documentation often limited, the psychiatrist performing the capacity evaluation may need to contact the surgeon directly to review the surgeon's explanation and his or her impression of the patient's understanding. If doubt remains regarding the patient's capacity to have provided consent for the procedure, the psychiatrist is ethically bound to challenge its validity, even if willingly given by the patient.

Because capacity exists on a continuum, it can be transient. Language barriers and educational level of the patient should be taken into consideration. The nature of the decision should be explained in plain language, using the patient's own words if possible, and reviewing the information as needed. The physician should consider whether the patient's capacity can be optimized or capacity reassessed at a later time (e.g., optimizing hearing and vision function by providing hearing and vision aids; patient with moderately severe Parkinson disease whose ability to communicate could be improved with antiparkinsonian medication adjustment). Problematic relationships, as well as linguistic, cultural, and educational barriers, can preclude reliable capacity assessments and should result in referral of the patient to a clinician with expertise in cognitive capacity assessments. Undiagnosed depressive and/or anxiety disorder or other neuropsychiatric disorders can confound a capacity assessment. Therefore, the psychiatrist must determine whether the psychiatric disorder is affecting Mrs. B.'s decision-making. A patient can feel unworthy of medical treatment and refuse therapy, or nihilistic thinking in the context of major depression could lead to a patient's claim of being an unworthy surgical candidate. It is important to note that a diagnosis of psychiatric disorder alone does not per se render a patient incapable of medical decision-making. Referral of a medical patient (as in Mrs. B.'s situation) to a psychiatrist may be required for confirmation of incapacity or when there is psychiatric diagnostic uncertainty.

As stated previously, Mrs. B.'s physician relied on standardized measures of cognition to aid in her capacity assessment. In her case, MMSE score provided support for further performing a formal capacity assessment because her score was bordering between low and the gray area score of 20–24. However, physicians should not rely solely on the MMSE score for determining incapacity, but rather patients with a low MMSE score should be given relevant information about a healthcare decision and have their capacity for that medical decision explicitly addressed. Because capacity is decision specific and is transient, Mrs. B. was found to have capacity for one medical decision and not for another, and she should be retested when future medical decisions arise.

Case 2 Analysis You decide to evaluate her capacity for medical decision-making using the Aid to Capacity Evaluation, which is based on making decisions about her actual problem; you ask the questions based on the decision about whether to have sertraline restarted and the hip replaced. She is clearly able to communicate her choice, and you find that she appreciates and understands her medical problems of major depressive disorder and hip fracture ("I am depressed and I have hip pain from the broken bone") and the proposed treatment ("I need to take an antidepressant, and they are planning on fixing my hip") and that she can refuse the proposed treatment ("It's up to me to have the antidepressant started, and the surgery, or not"). Although she is found to be able to answer questions about the risk, benefit, and the foreseeable consequences of accepting or declining the treatment for major depressive disorder, she is unable to answer questions about the risk of surgical complications including death and the rehabilitation required after hip surgery. You decide that Mrs. B. does appreciate the foreseeable consequences of accepting or declining the treatment with sertraline but does not so for the treatment of her hip problem. Weighing the moderate risk of the hip surgery and her responses to the Aid to Capacity Evaluation, you decide that she lacks capacity to make the decision about the proposed hip surgery.

You eventually discuss the situation with her son and agree that he will make the decision as her surrogate decision-maker under her previously implemented healthcare power of attorney. You inform him that capacity decision is treatment specific, and while she has now capacity for treatment with sertraline, she might also have capacity for future, less risky decisions. Her son eventually makes the decision that her pain due to hip fracture is significant and urgent to merit the risks and decides to proceed with the hip replacement procedure. A social worker followed up at her home to explore if there were any concerns of maltreatment after discharge from the hospital. At 6-month follow-up, Mrs. B. is fully remitted from her depressive symptoms, is ambulating well, and is happy that she "decided" to have the surgery.

9.3 Key Points: Ethics, Mental Health Law, and Aging

- As a result of advances in medical treatment, clinicians are likely to see an increase in the number of older individuals with psychiatric illness including major neurocognitive disorders.
- It is important for clinicians to be aware of their own cognitive biases in terms of ethical values and principles adopted in clinical practice. There are various ethical theories clinicians can adopt in reasoning through complex dilemmas arising in practice.
- Advance care planning can play a critical role in assisting patients to achieve their own health outcomes in a manner that complies with prior capable wishes, preferences, and values. Older adults with psychiatric illness should be assisted in advance care planning and provided resources for doing so.
- Among the myriad of issues related to ethics, mental health law, and aging, neither does age nor mental health constitute, in and of itself, incapability. Every effort should be made to ensure that older patients with psychiatric illness are allowed to voice their decisions, goals, and concerns.

9.4 Comprehension Multiple Choice Question (MCQ) Test and Answers

? **MCQ 1.** Which of the following statements is correct?

A. Autonomy refers to the fiduciary duty.
B. Nonmaleficence balances benefits against risks when making decision.
C. Beneficence refers to the obligation of a physician to avoid harm.
D. Justice refers to fair distribution of psychiatric services or resources.

✓ Answer: D

Fiduciary duty refers to the duty that a physician must act in the patient's best interests, whereas autonomy refers to the obligation of a physician to respect a patient's rights to make his or her informed choices without being coerced. Thus, statement A is incorrect. Nonmaleficence is a central guiding principle of the ethical practice of medicine, first expressed by Hippocrates, and translated into Latin as *primum non nocere*, "first do no harm." Beneficence refers to the fundamental commitment of a physician to provide benefits to patients and to balance benefits against risks when making decisions, whereas nonmaleficence refers to the obligation of a physician to avoid harm. As many treatments involve some degree of harm, the principle of nonmaleficence would imply that the harm should not be disproportionate to the benefit of the treatment. Therefore, statements B and C are incorrect. Justice refers to fair distribution of psychiatric services or resources; thus, statement D is correct.

? **MCQ 2.** Mr. C. was a university educated single man in his mid-seventies who resided in the community. He had a lengthy history of schizoaffective disorder, substance abuse, and antisocial personality traits. Many of the shelters in the city barred him from entering because he was aggressive and manifested disruptive behavior. When he was brought to hospital on the most recent occasion, he was declared incapable to consent to treatment by a clinician who based his finding in part on results from the MacArthur Competence Assessment Tool. The psychiatrist proposed several treatments but then decided to start Mr. C. on an antipsychotic medication, olanzapine, which he had taken in the past but refused on this admission. The psychiatrist asked Mr. C. numerous questions, including: How have you reached your decision about the proposed treatment? What things were important to you in making this decision? Which one of the following criteria best align with these questions?

A. Ability to communicate a choice
B. Ability to understand the relevant information
C. Ability to appreciate the situation and its consequences
D. Ability to reason about treatment options

✓ Answer: D

The ability to communicate a choice relates to whether Mr. C. would have been able to make a decision about which treatment he might want based on his expressed beliefs and values or previous decisions. This ability can often be preserved even where there may be impairments in other decision-making abilities. The ability to understand refers to one's ability to comprehend basic information about a problem and the risks and benefits associated. One might explore Mr. C.'s level of education and intelligence as to whether he could understand the relevant information. The ability to appreciate the situation and consequences refers to whether Mr. C. is able to recognize the reasonably foreseeable consequences of not taking the medication and whether he has the ability to see how the problem applies to his own situation if he decided not to take the medication. The ability to reason refers to Mr. C.'s ability to describe how a solution would affect his everyday life and demonstrate an ability to rationally and logically think through the process of how he determined his choice not to take this medication.

References

1. United Nations Department of Economic and Social Affairs, Population Division. World Population Ageing. New York; 2015. Contract No.: ST/ESA/SER.A/390.
2. Nolan L. Dimensions of aging and belonging for the older person and the effects of ageism. BYU J Public Law. 2011;25:317–39.
3. Canada Statistics. Canada year book. Ottawa: Government of Canada; 2012.
4. Jeste D, Alexopoulos G, Bartels S, Cummings J, Gallo J, Gottlieb G, et al. Consensus statement on the upcoming crisis in geriatric mental health – research agenda for the next 2 decades. Arch Gen Psychiatry. 1999;56(9):848–53.
5. Welsh S, Deahl MP. Modern psychiatric ethics. Lancet. 2002;359(9302):253–5.
6. Rabins P, Black B. Ethical issues in geriatric psychiatry. Int Rev Psychiatry. 2010;22(3):267–73.
7. Walaszek A. Clinical ethics issues in geriatric psychiatry. Psychiatr Clin North Am. 2009;32(2):343–59.
8. Robertson M, Walter GA. Critical reflection on utilitarianism as the basis for psychiatric ethics. J Ethics Mental Health. 2007;2(1):1–4.
9. Beauchamp T. Principlism and its alleged competitors. Kennedy Inst Ethic J. 1995;5(3):181–98.
10. Beauchamp T. Making principlism practical: a commentary on Gordon, Rauprich, and Vollman. Bioethics. 2011;25(6):301–3.
11. Kapp M. Legal interventions for persons with dementia in the USA: ethical, policy and practical aspects. Aging Ment Health. 2001;5(4):312–5.
12. Bynum J. The long reach of Alzheimer's disease: patients, practice, and policy. Health Affair. 2014;33(4):534–40.
13. Baldwin C. Narrative, ethics and people with severe mental illness. Aust NZ J Psychiat. 2005;39(11–12):1022–9.
14. Parikh R, Montgomery A, Lynn J. The older Americans act at 50 – community-based care in a value-driven era. New Eng J Med. 2015;373(5):399–401.
15. *Older Americans Act*, (1965) (Pub. L. 89–73, 79 Stat. 218).
16. Birke MG. Elder law, medicare, and legal issues in older patients. Semin Oncol. 2004;31(2):282–92.
17. Alford D. The elder justice act. J Gerontol Nurs. 2011;37(8):14–6.
18. *Criminal Code of Canada*, (1985) (R.S.C. c. C-46).
19. Doron I, Meenan H. Time for geriatric jurisprudence. Gerontology. 2012;58(3):193–6.
20. Winick BJ. The right to refuse mental health treatment: a therapeutic jurisprudence analysis. Int J Law Psychiat. 1994;17(1):99–117.
21. Sabatino C. Warning: this legislation may cause nausea – and headaches. J Am Geriat Soc. 2005;52:2136–7.
22. Mintzer J, Steinberg E. Elder courts: transforming a crisis into a therapeutic opportunity. Am J of Geriat Psychiat. 2014;22(3):S143.
23. Shah K, Shah N. The ethical intersection of elder law and elder care practices. J Am Geriat Soc. 2013;61(12):2265–6.
24. Roberts LW. Informed consent and the capacity for voluntarism. Am J Psychiatry. 2002;159(5):705–12.
25. Appelbaum P. Assessment of patients' competence to consent to treatment. New Eng J Med. 2007;357(18):1834–40.
26. Moye J, Marson DC. Assessment of decision-making capacity in older adults: an emerging area of practice and research. J Gerontol B Psychol Sci Soc Sci. 2007;62(1):P3–P11.
27. Pinsker D, Pachana N, Wilson J, Tilse C, Byrne G. Financial capacity in older adults: a review of clinical assessment approaches and considerations. Clin Gerontologist. 2010;33(4):332–46.
28. Moye J. Theoretical frameworks for competency in cognitively impaired elderly adults. J Aging Stud. 1996;10(1):27–42.
29. Cole M. Clinical assessment of the mental capacity of the older adult. McGill Journal of Law & Health. 2011;5(2):273–7.
30. Weiss B, Berman E, Howe C, Fleming R. Medical decision-making for older adults without family. J Am Geriat Soc. 2012;60(11):2144–50.
31. Effiong A, Harman S. Patients who lack capacity and lack surrogates: can they enroll in hospice? J Pain Symptom Manag. 2014;48(4):745–50.
32. Kohn N, Blumenthal J, Campbell A. Supported decision-making: a viable alternative to guardianship. Penn State Law Review. 2013;117(4):1113–57.
33. Hoffman A. Reimagining the risk of long-term care. Yale J Health Policy Law Ethics. 2016;16(2):147–232.
34. Moskowitz S. Saving granny from the wolf: elder abuse and neglect – the legal framework. Conneticut Law Review. 1998;31(31):77–204.
35. Schimer M. Elder abuse: the attorney's perspective. Clin Gerontologist. 2005;28(1/2):55–82.
36. Knight L, Hester M. Domestic violence and mental health in older adults. Int Rev Psychiatr. 2016;28(5):464–74.
37. Cipriani G, Lucetti C, Danti S, Carlesi C, Nuti A. Violent and criminal manifestations in dementia patients. Geriatr Gerontol Int. 2016;16(5):541–9.
38. Kapp M. The physician's reesponsibility concerning firearms and older patients. Kansas J Law Public Policy. 2016;25(2):159–86.
39. *Carter v. Canada [Attorney General]*. (2015) 1 SCR 331, Supreme Court of Canada.
40. MacCourt P, Tuokko H. Marginal competence, risk assessment, and care decisions: a comparison of values of health care professionals and older adults. Can J Aging. 2010;29(2):173–83.
41. Westmoreland G, Counsell S, Sennour Y, Schubert C, Frank K, Wu J, et al. Improving medical student attitudes toward older patients through a "council of elders" and reflective writing experience. J Am Geriat Soc. 2009;57(2):315–20.
42. Karel M, Gatz M, Smyer M. Aging and mental health in the decade ahead what psychologists need to know. Am Psychol. 2012;67(3):184–98.
43. Ries N, Johnston B, McCarthy S. Technology-enabled legal service delivery for older adults: what can law learn from telehealth? Findings from an international review of literature. Elder Law Rev. 2016;10:1–14.
44. Barton CD Jr, Mallik HS, Orr WB, Janofsky JS. Clinicians' judgement of capacity of nursing home patients to give informed consent. Psychiatr Serv. 1996;47(9):956–60.
45. Appelbaum PS, Grisso T. The MacArthur treatment competence study. 1: mental illness and competence to consent to treatment. Law Human Behav. 1995;19(2):105–26.
46. Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. N Engl J Med. 1988;319(25):1635–8.
47. Kim SYH, Caine ED, Swan JG, Appelbaum PS. Do clinicians follow a risk-sensitive model of capacity determination? An experimental video survey. Psychosomatics. 2006;47(4):325–9.
48. Sessums LL, Zembrzuska H, Jackson JL. Does this patient have medical decision-making capacity? JAMA. 2011;306(4):420–7.