



# Advanced age and decisional capacity: The effect of age on the ability to make health care decisions



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## ABSTRACT

**Objective:** Cognitive disorders, including dementia, have been shown to be predictors of decisional incapacity, even more than psychotic or substance use disorders. Nonetheless, the impact of advanced age on decisional capacity remains understudied.

**Method:** Out of more than 2500 consecutive psychiatric consultations performed by the Consultation-Liaison service at Bellevue Hospital Center in New York City, 266 completed decisional capacity assessments were identified and analyzed with respect to the indications for referral and the impact of age and other sociodemographic, medical and psychiatric variables on decisional capacity.

**Results:** By itself, in this sample advanced age was not associated with impaired medical decision-making. In individuals  $\geq 65$  years old, among whom only 27% were deemed to have decisional incapacity, cognitive disorders including dementia remained the strongest association with this incapacity; meanwhile, in patients  $< 65$ , decisional impairment was evident in 62%, and delirium, psychosis and neurological disorders caused more decisional impairment. The main indications for referral were placement refusals in those  $\geq 65$ , while young patients were largely seen due to their desire to leave the hospital against medical advice.

**Conclusion:** Advanced age by itself failed to be associated with decisional incapacity in this sample. In those  $\geq 65$ , cognitive disorders remained the main association with such incapacity, versus psychosis, substance use and neurological disorders in younger patients.

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## 1. Introduction

Assessing decisional capacity is critical to providing the necessary level of care to those who lack the ability to make appropriate health care decisions on their own. In the United States of America, decisional capacity – as a central concept in health care laws and ethics – is defined as an individual's ability to make their own, appropriate health care decisions. This law generally presumes that adults have this ability (Cruzan, 1990). The concept of decisional capacity is based on the doctrine of informed consent, which intends to promote and protect the autonomy of health care subjects. The standard approach to assessing decisional capacity is to evaluate four individual components of this capacity: understanding, appreciation, reasoning, and choice (Appelbaum, 2007; Appelbaum & Grisso, 1988).

Two essential assumptions underlie decisional capacity, both derived from the requirements of informed consent. For one

assumption, decisional capacity is a decision-related concept, meaning that it is assessed relative to a specific decision, at a particular time, in a particular context. For the second assumption, decision-making capacity is a threshold concept, meaning that it is bivalent. As such, individuals either have it or lack it. The indications for a decisional capacity assessment can vary from minor healthcare decisions, like consenting to a blood test or radiological scan, to major decisions like living independently versus in some assisted-living arrangement. With each assessment, decisional capacity is often considered relative to the decision to be made. As such, whereas a patient might be considered capable of making a minor or simple decision, that same patient might be deemed incapable of making a more major or complex decision (Buchanan & Brock, 1989).

In different jurisdictions, such as the England, Wales or Scotland the definitions of decisional or mental capacity and incapacity are determined by specific laws such as the mental capacity act from 2005 (HMSO, 2005) in England and Wales or the adults with Incapacity Act (HMSO, 2000) in Scotland. Similarly, in both acts, key elements of the assessment of capacity base on the understanding of the proposed treatment, their purpose and

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nature, benefits, risks and alternatives, as well as consequences of not receiving the treatment, and the ability to retain the information sufficiently to arrive at a decision (HMSO, 2005; HMSO, 2000).

Psychiatric disorders and medical conditions are known to influence decisional capacity. The majority of studies described decisional incapacity in the elderly and those with cognitive disorders, primarily some form of dementia (Burton et al., 2012; Dymek, Atchison, Harrell, & Marson, 2001; EtcHELLS et al., 1999; GAVIRIA, Pliskin, & Kney, 2011; Griffith, Dymek, Atchison, Harrell, & Marson, 2005; Karlawish, 2008; Marson, Schmitt, Ingram, & Harrell, 1994; Marson, Cody, Ingram, & Harrell, 1995; Moye, Karel, Gurrera, & Azar, 2006; Raymont et al., 2004a; Rodin & Mohile, 2008; Weiss, Berman, Howe, & Fleming, 2012). Mild and moderate dementia does not necessarily prevent someone from making informed treatment decisions (Rodin and Mohile, 2008). Still, in such patients the rate of incapacitated decision-making remains high (Karlawish, 2008). Overall, cognitive impairment has been shown to contribute to decisional incapacity in up to two thirds of inpatients (Kahn, Bourgeois, Klein, & Iosif, 2009). Beyond dementia, another contributor to decisional incapacity is the presence of delirium (Auerswald, Charpentier, & Inouye, 1997; Ganzini, Mansoor, Socherman, & Duckart, 2012; Rodin & Mohile, 2008; Young & Inouye, 2007), as well as neurological and infectious disorders (Raymont et al., 2004b). Whereas, psychotic disorders (14%), mood disorders (12%), and substance use disorders (9%) were found to influence decisional capacity to a much lesser extent (Kahn et al., 2009). In previous studies, rates of decisional incapacity ranged from 31 to 88% (Auerswald et al., 1997; Ganzini et al., 2012; Kahn et al., 2009; Raymont et al., 2004b; Young & Inouye, 2007).

Whether age by itself has an effect on someone's ability to make appropriate health care decisions has not been studied to date. For this reason, the current study aimed to explore the impact of a patient's age on their decisional capacity versus incapacity, while assessing numerous other potential confounders for their possible contributions.

## 2. Methods

### 2.1. Patients and procedures

As a hospital serving a large city, a level-one trauma center, and the major teaching site for the New York University School of Medicine with 450 medical and surgical beds, 120,000 patients visit adult emergency services, and 26,000 inpatients receive their medical care every year. As part of the psychiatric service, the Consultation-Liaison service performs more than 2000 initial consultations among medical, surgical and emergency care patients, and approximately double this number of follow-up patient assessments.

The Consultation-Liaison service records and tracks initial consultations and manages re-consultations for acute events in already-seen patients within a clinical database. This database was reviewed and all referrals for a decisional capacity assessment (for signing out AMA, for refusing work-up and/or treatment, and for placement issues) extracted by hand, and then the patient's records individually reviewed in the computer-based patient record system: Misys CPR™ by Misys Healthcare Systems in order to eventually extract the required sociodemographic, medical and psychiatric, as well as decisional capacity assessment variables. Data review and extraction was performed by the research team.

A number of patient factors were recorded. These included sociodemographic variables like the patient's age and gender; medical and psychiatric diagnoses; indications for the capacity and psychiatric assessments; and the standard treatment approach

used. Medical diagnoses were categorized into: cardiovascular, gastrointestinal, endocrine, neurologic, pulmonary, genitourinary, infectious diseases, oncology, trauma, dermatology, or other; multiple recordings were possible. All psychiatric diagnoses were determined by the C-L staff as per DSM-IV TR criteria (American Psychiatric Association, 2000). For simplification purposes, psychiatric diagnoses were categorized into psychotic, mood and cognitive disorders, substance use disorders, other disorders, or none.

Among cognitive disorders, delirium and dementia were recorded when the given information sufficed. Conversely, when the available information or clinical impression did not allow for a definite diagnosis of delirium and/or dementia, patients were given the allocation of 'cognitive disorder not otherwise specified (nos)'. The diagnosis of substance use disorder included active substance use prior to hospitalization (mostly alcohol, opiates and benzodiazepines); detoxification, which was primarily managed on a medical floor; and stable substance use disorder, which included patients on methadone maintenance.

Generally, decisional capacity assessments were requested by the medical and surgical team when treatment recommendations were not followed and the suspicion of an underlying psychiatric diagnosis and improper judgment were assumed. Due to the availability of the C-L psychiatry service, the majority of decisional capacity assessments were referred to this service.

All patients had been assessed in person by either a psychiatry service resident or attending physician. Decisional capacity was assessed by face-to-face interview using the four Applebaum criteria: understanding, appreciation, reasoning, and choice (Appelbaum, 2007; Appelbaum & Grisso, 1988). To describe specific aspects of decisional capacity, requests were classified as (a) signing out against medical advice (AMA); (b) refusing a work-up or (c) treatment; or (d) a placement issue. When the patient refused the interview, the assessment was repeated at a later time and collateral information from the medical and surgical services utilized. Assessments of decisional capacity were recorded in a bivalent manner as: decisional capacity existed (yes) or decisional capacity did not exist (no). For this analysis, all completed decisional capacity assessments were included.

Repeat decisional capacity assessments were allowed, as well as for multiple admissions and various assessments over the period in which cases were reviewed. Recording multiple psychiatric and/or medical diagnoses was possible, as per the patient profile. Particularly within the cognitive disorder domain, multiple recordings occurred.

These cases were previously published with respect to the general sample with respect to medical and psychiatric as well as decisional capacity characteristics (Boettger, Bergman, Jenewein, & Boettger, 2014).

This chart review was approved by the Institutional Review Board (IRB, S-12-02375, Status Exempt on May 2nd 2012) and the Bellevue Central Office for data collection and publication.

### 2.2. Statistical analysis

All data analysis was performed using the IBM Statistical Package for the Social Sciences (SPSS) version 20 for Windows. For the purpose of analysis, the patient sample was subdivided into elderly patients age 65 years or older and younger patients under age 65. Decisional capacity also was set as a dichotomous variable: yes versus no. Within this sample, prevalence rates for psychiatric co-morbidities were calculated among those in each age bracket with versus without decisional capacity. Comparisons between age brackets were conducted using Student's *t*-tests for independent samples for continuous variables (e.g., age) and Pearson's

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