



CPME/AD/Brd/270304/111/EN/fr

At its Board meeting, Brussels, March 27th, 2004, the CPME adopted the following policy : Care and Consent in Elderly Patients (CPME 2003/111 Final EN/fr)

Care and Consent in Elderly Patients 2003

A fundamental principle of consent for medical treatment is that it should be fully informed, free from pressure and be given by patients with full capacity. In the context of the treatment of elderly patients, there may be a variety of reasons for this ideal not being realized. However, there is also good reason to believe that many doctors do not take sufficient care to fully assess the ability of elderly patients to make decisions about their care, or to make efforts to obtain consent in an adequate manner when caring for this patient group.

There is clear evidence that in many European healthcare systems elderly patients have inferior access to medical care, and poor treatment outcomes. It is unacceptable to ration care, or to make decisions to withhold or withdraw treatment, on the basis of age alone.

A major ethical difficulty in the care of elderly patients is that of assessment and recognition of capacity, and respect for autonomy. It is often assumed that an older patient necessarily has reduced capacity, simply as a result of age. This is a common mistake, and fails to give due respect to the patient's ability to make decisions for him or her self. Doctors should always assume that a patient has the capacity to make health care decisions, unless the opposite can be established. In addition, while there may not be full capacity for making decisions about complex medical treatment, or about difficult choices between treatment options, capacity may exist to reach decisions about more general issues, such as where the patient should be treated, food, clothing, etc.

Therefore, as a preliminary to discussing medical treatment, and obtaining consent, the doctor should assess the capacity of the patient to reach decisions, and whether this ability extends to complex choices about their care. Such issues, as the patient's overall clinical and mental state, the ability to retain and process information, and the capacity to express preference and to make choices, should all be addressed. The patient may, for various clinical reasons, exhibit variable states of capacity, and the doctor should be prepared to make an assessment on more than one occasion if necessary.

If full or partial capacity exists, then the patient's ascertainable wishes must be the main guide as to decisions about medical treatment. While it is important to communicate with relevant family members, only if there is concern about the patient's ability to make consistent and informed decisions about their care should other members of the patient's family be involved in making decisions about treatment. In some jurisdictions there is provision for relatives or friends to make proxy health care decisions on behalf of incapacitated patients. The ultimate responsibility rests with the doctor, but the doctor also has a duty to ensure that the proposed treatment, or on-treatment, is in the patient's best interest.

"Best interest" and "benefit" are terms much used in ethical discussions about treatment decisions. It is not acceptable for a doctor to act simply on the basis of his own assessment of what constitutes a correct or desirable line of treatment, based on

the somewhat narrow perspectives of physiological improvement or symptom relief. Such decisions can, and should, be based on an initial careful clinical assessment of all the potential harms and benefits of different treatment options, but it is the patient's own assessment of whether these options represent desirable alternatives that should be determinative. The clinical assessment, therefore, is one step, which must be followed by a discussion, with the patient if competent, or with relevant family members if not, that explores which treatment options may be desirable. Those family members who should be consulted when a patient lacks competence should be any close family member or friend who can be identified as having an informed view as to the patient's likely wishes. Such information may be helpful to the health care team, even if it may sometimes produce contradictory evidence, and it is the doctor's responsibility to consider it, and then reach a decision.

The presence of advanced statements setting out a patient's wishes in certain situations can be very helpful. Such documents may set out general statements of wishes, or more specific treatment directions or refusals. While patients cannot expect a doctor to undertake a specific treatment, in some jurisdictions an advance *refusal* of treatment, made while competent, and on the basis of full information, is legally binding on the doctor. In these circumstances it is important to ensure that the circumstances envisaged by the patient when making the advance refusal are similar to those now present. Any doubt about this will direct the doctor to seek clarification from those close to the patient.

If a patient demands a treatment that the doctor believes is clinically inappropriate, the patient may be advised that he/she is free to obtain a second opinion.

In summary, the following broad principles should be supported in treatment decisions applied to elderly patients:

- Age, in itself, should not be considered a barrier to access to treatment.
- Rationing of health care and decisions not to treat, on the basis of age, are unacceptable
- An elderly patient should be assumed to have full capacity to make decisions about his or her care unless the doctor can demonstrate to the contrary.

- If the patient is competent, then a decision about treatment is for the patient to make, and must be based on the principle of fully informed consent.
- While a patient cannot expect a doctor to provide treatment that is clinically inappropriate, a competent refusal of treatment must be respected.
- If the patient lacks competence for all or any part of a treatment decision, the assessment of best interest should rely on the views of those close to the patient, including close family and friends.
- Patients with partial capacity should be invited to take part in treatment decisions relative to their ability to participate.
- Family members cannot direct a doctor towards a specific treatment, and cannot refuse treatment on behalf of a patient. However, in some jurisdictions, proxy health care decisions can be made by legally appointed persons close to the patient.
- An advance directive can be helpful in assessing the best wishes of a patient who lacks capacity. An advance refusal, if relevant and competently made, must be respected.