

# Dental ethics case 26

## The incompetent geriatric patient

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### CASE SCENARIO

A longstanding patient whose family I have been treating for years brought in their aging mother who has recently been diagnosed with senile dementia. The patient was very co-operative and opened her mouth without a fuss. On examination she was found to have generalised periodontitis and numerous cavities. I suggested a simple restorative and preventive treatment plan for her especially in view of her being co-operative and calm but the daughter insisted that all her teeth be removed so that she has no problems in the future, as her dementia progressively worsens.

### COMMENTARY

The populations of most countries are ageing rapidly. By the year 2050 it is expected that an increase in the population aged 60 years or over will account for about half of the total growth of the world population.<sup>1</sup> However, although there is a higher life expectancy, the risk of developing at least one chronic disease increases with age.<sup>2</sup> The oral health needs of aging populations are having a large impact on dentistry.<sup>3</sup> Oral health problems, including periodontal disease, caries, xerostomia, edentulism and infrequent preventative care, become more prevalent with increasing age.<sup>4-5</sup> These oral diseases have negative impacts on daily life through reduced chewing performance, constrained food choice, weight loss, impaired communication, low self-esteem and well-being.<sup>5-7</sup>

Dementia is widespread in the elderly population and it is highly likely that dental professionals will encounter this illness at some point in their patients or their patients' families. A diagnosis of dementia has led to an increase in the use of drugs with psychotropic action that may impede cognitive functions.<sup>8-9</sup> Extensive use of drugs is common in the elderly, and in patients with dementia this further increases their vulnerability. The management of mild to moderate dementia presents complex and evolving challenges to the health professional. Dementia alters the patient's ability to accept conventional dental treatment and conflict situations arise that result in moral dilemmas in judgements and actions. Who should speak on behalf of them?

### OBTAINING VALID INFORMED CONSENT

Autonomy refers to the right of every individual to make decisions for him/herself and the obligation of obtaining informed consent is a mechanism for protecting patient autonomy in treatment decisions.<sup>10</sup> This is both an ethical and a legal requirement. A discussion between the patient and dentist needs to take place whereby the patient is informed about the nature of the oral health problem, the treatment options, the risks and benefits of those options (including costs and prognosis), and the consequences of not receiving treatment. However, for informed consent to be valid, the patient must have a free choice, and must be capable of making a decision.<sup>11</sup> A competent patient will be able to make a choice based on an understanding of the information given to him/her, an appreciation of the nature of the diagnosis, illness and/or procedure and its consequences and will be able to reason and weigh up the proposed treatment options.<sup>12</sup> While these elements may not be difficult to address for most older adults who are relatively healthy, significant problems can be anticipated for patients with dementia, stroke, psychiatric disorders, or sensory impairment, all of which may result in lack of perception, capacity to understand or to act upon choices. In situations where patients lack competence to consent, surrogate decision makers must be consulted – however, two important concepts – “competence” and “decision-making capacity” need to be understood. Competence is a legal designation that is determined exclusively within the legal system, while decision-making capacity is a clinical concept assessed within the healthcare system.<sup>13</sup>

Table 1 (adapted from Shuman, 1999)<sup>14</sup> summarises the role of patients, guardians, proxies, and clinicians under varying conditions of legal competence and decision making-capacity.

Patients with dementia often fall into the category of being legally competent patients but with impaired decision making-capacity and this can create a challenge to the practitioner. Competence is understood as relative to the type and complexity of the treatment decision at stake. Some impaired patients may show evidence of mental impairment that has affected memory, judgment, and reasoning, but often such deficits are not absolute, and some patient involvement in treatment decisions may be possible and should be encouraged. In addition, it has been suggested that thresholds for competence to make treatment decisions should be gauged on a “sliding scale”.<sup>15</sup> The threshold competence should become more demanding as the risks of the intervention and

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**Table 1:** Role of patient & clinician in the consent process

Patient	Example	Patient role	Clinician role
Competent with decision making-capacity	Most adults	Guides all decisions	Involves patient in all decisions.
Competent with no or questionable decision making-capacity.	Adults with late-onset mental impairment (e.g. dementias).	Guides decisions to extent permitted by diminished capacity.	<p>Involves patient to extent possible.</p> <p>Is sensitive to possible fluctuating capacity.</p> <p>Involves surrogates, family, loved ones.</p> <p>Solicits physician input if needed.</p> <p>Plans elective care according to patient values via "substituted judgment." In serious emergencies, provides care in the best interest of patient if other input is unavailable.</p> <p>Solicits input from Ethics Committee.</p> <p>Seeks recourse to the courts if serious lack of consensus exists over treatment.</p>
Incompetent	Adults with moderate to severe mental retardation, psychiatric disorders.	Participates in care to extent possible.	<p>Acknowledges the patient.</p> <p>Involves those patients for whom there is potential for return to independence (e.g., transient psychiatric disturbance).</p> <p>Confirms authorisation of all treatment decisions by legal guardian.</p> <p>In emergencies, provides care in the best interests of patient if guardian is unavailable.</p>

the uncertainty of its benefits increase. When decision making seems impaired but the patient has retained legal competence, it is important for the clinician to establish how surrogate decisions should be made and who should serve as the guardian or proxy decision maker.

The National Health Act 16 No 61 of 2003, Chapter 2 Section 7 indicates the following, if a patient is unable to consent:

1. Consent may be obtained from a person mandated by the patient in writing to grant consent on his/her behalf or by a person authorised to give consent in terms of any law or court order.
2. If no person is mandated or authorised to give consent, consent may be given by the spouse or partner of the patient, a parent, grandparent, adult child or brother or sister, in that specific order.
3. Provision of health service without informed consent may occur if it is authorised in terms of a law or court order.
4. If failure to treat the patient will result in a serious risk to public health, treatment must be provided.
5. If any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and the patient has not refused such treatment, treatment must be provided.

Patients whose decision making-capacity is significantly impaired and who have been formally declared by the courts as unable to manage their own affairs, are designated as "incompetent" and have a guardian appointed for them. They often include individuals with moderate-to-severe psychiatric disorders, with mental retardation, or those in persistent vegetative states. When a patient has been declared legally incompetent, the practitioner must obtain authorisation for treatment from the patient's legal guardian. In an emergency, health professionals need to act in the best interest of the patient.<sup>17</sup>

Not all treatment-related decisions may be incomprehensible to the patient even if the patient displays some limitation in decision making-capacity, since cognitive impairment may not affect all areas of intellectual function uniformly. For example, an individual who is unable to manage their finances may still be able to indicate whether he or she would prefer to save a tooth or have it extracted. When attempting to involve cognitively impaired patients in treatment decisions, it is usually necessary to allow extra time for the patient to fully comprehend the treatment plan and frequent reminders may be necessary. It is often beneficial to have the caregiver present during the consultation so that he/she can repeat and reinforce the information given.<sup>14</sup>

## **SURROGATE CONSENT – SUBSTITUTE JUDGEMENT OR BEST INTEREST**

Under normal circumstances and with competent patients, the dentist will guide patients through the proposed treatment plan and assist them with decisions as to what dental care is most appropriate for them, while taking into consideration the patients' stated preferences, health status and financial resources. However, matters become more complicated if the patient's preferences are unclear or unknown due to dementia and problems in cognition, communication, or other disabilities. In these instances, surrogate decision makers need to be engaged. Dentists need to be especially careful to ensure that their advice to patients promotes strategies that maximally protect patient autonomy and that they respect the two legal and ethical standards which govern surrogate decision making – namely: "substituted judgment" and "best interest."<sup>18</sup>

### **Substituted Judgment Standard**

In the substituted judgement – the surrogate decision-maker makes decisions that respect and are consistent with the patient's previous autonomous judgments – essentially what the patient would have chosen for themselves if he

or she could have expressed it directly.<sup>18</sup> The focus is on clarifying the patient's goals and values about oral health-care and making decisions consistent with them. Therefore, when there are several treatment options and patient preferences are unclear, those involved in decision making should attempt to make choices based on what the patient would have selected. To establish this, input from the patient's family, others in close, loving relationships with the patient, and from informal and formal caregivers, is helpful to understand patient goals and values concerning dental care.<sup>19</sup> Information can also be gathered from previous dental records and current oral findings. For example, a history of regular preventive dental visits and restorative or prosthodontic care will suggest that treatment decisions should be consistent with those values. On the other hand, a history of only emergency visits, missing teeth without replacement and lack of preventive care suggests that the person may have been neglectful of their oral health, which in turn might dictate a more basic approach to treatment planning.

### Best Interests Standard

On the other hand, "best interests" refers to situations where decisions made for the patient reflect what reasonable people would do under similar circumstances – and the values used in this case may not be those of the patient but of others in the same situation.<sup>20</sup> There has been concern that while the best interests standard has traditionally guided the thinking of health professionals, it creates the risk of paternalistic decision making, decisions that do not account well for differences in individual circumstances as well as in patient goals and values about healthcare. In recent years, the best interest standard has given way to more patient-centered approaches. In some instances when patient decision making is impaired, it may still be reasonable to approach care using the best interests standard, for example when emergency dental problems like acute pain or infection occur. However, it is still rarely justifiable in dentistry to initiate any treatment without some attempt to solicit input from others who have an interest in the patient's welfare when the patient him/herself cannot express a preference about care.<sup>14</sup>

### CONCLUDING REMARKS

The management of patients with dementia is complex and brings to the fore many challenging moral dilemmas. One of the most important is obtaining valid consent for treatment. Practitioners need to consider both the legal competence and the decision making-capacity of the patient. The National Health Act<sup>16</sup> sets out guidelines where a patient cannot provide consent. When decision-making is impaired, practitioners must involve others in the process of determining appropriate care. When faced with a choice of several treatment options and patient preferences are unclear or unknown, the principle of substituted judgment should be employed whenever possible to promote care in keeping with the patient's goals and values. In the current economic climate of restraint in public spending in healthcare, a discourse from the perspectives of ethics is essential to ensure respect for human integrity in society, a fundamental for all healthcare, including dental care of patients with dementia.

*Readers are invited to submit ethical queries or dilemmas to Prof. S Naidoo, Department of Community Dentistry, Private Bag X1, Tygerberg 7505 or email: suenaidoo@uwc.ac.za*

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See CPD  
Questionnaire  
on page 534