Comprehensive Assessments of Competence in the Elderly

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Three essentials:
- Presumption of competence (when the evidence is inconclusive)
- Segregation of competencies (competence is task or decision specific; must be assessed independently)
    - consent to treatment, refuse treatment, choose where to live
    - manage one's finances oneself; give a POA; give a mandate in case of incapacity; make a will
- Least restrictive intervention

Multidisciplinary: reports from:
social worker (financial status, sources of income, expenses, availability of family or friends who can help, risk for financial, physical, or emotional abuse)
occupational therapist (paying bills, banking, preparing meals, using transportation)
psychologist (indepth assessment of cognition, judgment)

Include information from relatives, friends, caregivers, business or work associates: eg, history of being abused or unduly influenced, history of exercising poor judgment

Information from patient charts (hospital, nursing home, CLSC home care): Manifestations of anxiety, paranoia, losing or misplacing things (wallets, money), overtrusting behaviour (not locking doors, leaving valuables lying around, revealing financial information to strangers), wandering or fugue, aggression

Patient to provide informed consent (court order may be necessary).

Considerations of safety:
- For the patient
- For dependents
- Differentiate between spouses, children, business partners

Ask the question: who could benefit from a finding of incompetence?

Our society permits people to exercise bad judgment, eg smoking, gambling, spending excessively. Why should we proscribe these behaviours in the cognitively impaired?

Physician assessors need to be aware of conflict of interest, between the interests of the patient and those of society.

An accurate medical diagnosis is essential.

The physician should defer giving an opinion on competence if:

- the underlying problem has not been definitively determined
- the problem can be treated
- the patient's condition is likely to fluctuate

Screening tools such as the MMSE have a limited role.

By their nature, mental or neurological conditions affecting competence are complicated and nuanced, and typically require specialized expertise to diagnose and treat. Should we then limit ourselves to a nonspecialist evaluation which can have such profound effects on the patient?

It is easier, faster, and safer for a physician to find someone globally incompetent than to take the time and effort required to determine what competencies exist and what their limitations are.

When to "red flag" a medical report on competence:

- a one-page report with checkboxes
- nonspecialist report for a complex medical problem
- a report done during an acute care hospitalization (when the patient was likely in worse condition than when not in hospital, or in chronic care).
- a diagnosis of dementia based on an MMSE score
- recent onset of cognitive impairment, fluctuations in performance, depression
- absence of involved family members (friends or informal caregivers may attempt to take advantage of the patient)
- conflict between relatives

Useful guidelines:
Financial and Personal Competence in the Elderly: The Position of the Canadian Psychiatric Association (published 1989; currently under review)
download link: http://publications.cpa-apc.org/media.php?mid=130