The editors of the *Revista del Hospital Italiano de Buenos Aires* would like to offer our readers the opportunity to reflect on topics currently under debate within the scientific community. To this end, we invited two distinguished experts with opposing perspectives to present their views on situations involving fluctuating decision-making capacity in the context of an academic debate based on a clinical scenario. Below, we present the reflections of Dr. Oscar Mazza* and Dr. Fabiana Giber, based on the following hypothetical case:

> *A 78-year-old man with a recent diagnosis of mild cognitive impairment lives with his daughter in Buenos Aires. After experiencing several episodes of abdominal pain, he is scheduled for an elective laparoscopic cholecystectomy. Although he understands the physician's explanation, he repeatedly asks the same questions, appears confused at times, and expresses fear about the surgery. His daughter believes that he is no longer capable of making decisions on his own and requests that the operation proceed. The treating team is therefore faced with a complex dilemma involving the limits of the patient's autonomy, the role of family members, and the physician's recommendation.*

Autonomy and Decision-Making Capacity in Older Adults with Mild Cognitive Impairment

Fabiana Giber
Servicio de Clínica Médica, Hospital Italiano. Buenos Aires, Argentina

In geriatric medicine, it is essential to distinguish between decision-making capacity (a clinical and dynamic concept) and competence (a legal concept). A diagnosis of mild cognitive impairment (MCI) does not negate a patient's capacity to provide informed consent. The fact that the patient repeats questions or appears confused suggests vulnerability in working memory, but not necessarily an inability to understand the risks and benefits of the proposed intervention. Decision-making capacity should be assessed in relation to this specific decision.

From a bioethical perspective, the principle of autonomy should prevail as long as the patient demonstrates preserved decisional capacity. Ethically, even the best intentions of a family member cannot override the patient's right to say "no" or "not yet," particularly when the procedure is elective rather than urgent.

To ensure that the patient's voice remains central, the treating team should assess the four functional components of decision-making capacity:

Understanding: Does the patient understand that he has gallstones and that the purpose of surgery is to remove the gallbladder?

Appreciation: Does he recognize that, if he does not undergo surgery, he may develop complications in the future?

Reasoning: Can he weigh the risks of surgery against the risks of continued observation?

Ability to express a choice: Is he able to communicate and maintain a consistent decision, even if that decision is to refuse surgery because of fear?

Fear of surgery is a rational human response, not a symptom of dementia. If the patient expresses fear, the ethical response is not to remove his decision-making authority, but rather to address that fear through clear information and appropriate support.

Because the Argentine Civil and Commercial Code protects the autonomy and legal capacity of older adults, the medical team should, in the present case:

Implement communication strategies by conducting brief interviews at times of the day when the patient is

*Commentary by Dr. Oscar M. Mazza "When Autonomy Conflicts with Harm Prevention " [link].

Corresponding author: fabiana.giber@hospitalitaliano.org.ar, Giber FN.

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most cognitively alert (avoiding sundowning), and, when appropriate, using visual aids.

Explain to the daughter that a diagnosis of MCI does not automatically confer legal decision-making authority. The role of the family is to support the patient's wishes, not to replace them, unless there is an imminent life-threatening situation, which is not the case here.

Use a staged consent process: if the patient is unable to make a decision today and the surgery is not urgent, the decision may be postponed for one week to reassess the consistency of his preferences and reasoning.

To help clarify the patient's decision-making ability, or to support the decision-making process, he may be referred for a Comprehensive Geriatric Assessment (CGA). This assessment can help determine whether the patient's confusion represents a stable feature of MCI or whether reversible factors are contributing to it. A CGA evaluates four domains:

1. Clinical and cognitive domain

Screening for superimposed delirium: It is essential to rule out the possibility that chronic abdominal pain or an asymptomatic urinary tract infection is causing fluctuations in the patient's mental status. A patient with acute delirium temporarily lacks decision-making capacity, whereas a patient with MCI may retain it.

2. Functional domain

Determine whether the patient remains independent in Instrumental Activities of Daily Living (IADLs). If he continues to manage his own finances or medications, invalidating his decision regarding surgery solely because he repeats questions would represent both a clinical inconsistency and a violation of his rights.

3. Emotional and social domain

Screening for depression: Fear of surgery may reflect depression developing in response to the diagnosis of MCI. Depression can impair appreciation of the potential benefits of treatment and, consequently, affect the validity of informed consent.

4. Family dynamics

A CGA also allows assessment of the daughter's caregiver burden. In many cases, the desire to proceed with surgery reflects the caregiver's anxiety about preventing a future emergency rather than an immediate clinical need.

Impact on the Limits of Autonomy

Once the Comprehensive Geriatric Assessment (CGA) has been completed, the medical team will have a clearer picture of the patient's condition:

If the CGA shows mild frailty and preserved executive function, the patient's wishes should be respected –even if he refuses surgery– while continuing to provide information through repeated discussions.

If the CGA reveals moderate cognitive impairment with impaired judgment, the patient's autonomy becomes more limited, and the daughter's role in decision-making becomes more relevant. However, any decisions should continue to be guided by the principle of the patient's best interests, rather than by convenience alone.

Conclusion: a CGA transforms a disagreement between the daughter and the physician into an evidence-based decision-making process. It restores the patient's right to be evaluated as a complex individual rather than simply as an older adult who appears confused. The autonomy of a person with MCI is vulnerable, but nonetheless real. Giving priority to the patient's voice means recognizing that he has the right to hesitate and to experience fear. As long as the patient can express a preference that is neither clearly irrational nor indicative of self-harm, his refusal or request for additional time should be respected, even if it conflicts with the family's or the healthcare system's desire for a more expedient course of action.

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