Ethics for the Elderly

Providing adequate health care to the elderly can be a maze of gray areas for medical professionals and the loved ones of the elderly person to navigate. Some of these dilemmas to address can include truth in disclosures, naming a caregiver (not to mention, determining and agreeing on the level of care needed), and care management strategies. The role each of these positions play has a varying degree of impact on the quality of life of the elderly person. For the ease of everyone involved, many people opt to have a plan in place before the need to make major decisions arises.

Advance Care Planning

Advance care planning is preemptively anticipating the potential needs of an aging person for the duration of their later years in life. Some of the easiest to foresee include:

- Do-Not-Resuscitate (DNR) requests. Many people are at peace with the idea of passing, and would rather do so than to risk any of the potential negative effects of a forced resuscitation (broken bones, brain damage, etc.). Other people want doctors to spare no effort at keeping them alive.
- Ventilator use. Should a person require mechanical assistance breathing, they may also wish to not engage. This is similar to the DNR in that it can be the individual's decision, but since it is not seen as resuscitation, it is not covered in a DNR.
- Artificial feeding and hydration. If a person is no longer able to consume foods, it may be necessary to intubate them for nutritional purposes. If a person is unconscious, this is one of the most famous ethical debates as it can extend a person's life almost indefinitely until someone later makes the decision to cease nutrition.
- Comfort care. Depending on an aging person's health, there may need to be a plan in place to help the end-of-life period minimize suffering. Comfort care manages oxygen needs, can limit frivolous testing, and can plan out medications for pain, anxiety, or digestive issues.

Advance care planning can address a range of "What if" scenarios, such as anticipating the needs after a stroke or heart attack should the elderly person be a high-risk factor of such. Having a health care directive in order can make it easier for a caregiver or healthcare provider to anticipate the needs and desires of a person, which will allow for everyone involved to offer the best possible care with the best quality of life. Advance care planning also negates the concerns of having to make decisions in the absence of the elderly person's ability to make them independently.

A healthcare provider is free to discuss options that are available, or of high-risk, with any caregiver directed by the elderly person. Working as a team can help all involved parties ensure that the elderly person is given the best possible care for any particular situation.

Capacity, Competence, and the Healthcare Difference

At its most basic, "Competence" is a legal category, not medical. Competence is used in law to determine the degree of mental availability to make a specific decision or carry out a particular act. Lacking competence is determined through functional deficiencies such as mental illness or impairment due to another mental condition (e.g. personality disorder). A court determines whether or not a person is competent by weighing the mental function of the person against the potential consequences to see if they were capable of understanding said consequences.

Capacity is an individual's ability to make an informed decision as determined by a licensed physician. Doctors assess a person's mental status to evaluate if the person is functional enough to make decisions of importance, particularly about their own healthcare.

Competence is much more issue-specific. Courts are often not involved unless it comes down to a determination of whether a specific incident in a case could have been addressed on a certain level by the individual.

Surrogate Decision-Making Process

Ideally, the elderly person will have a close next-of-kin who is willing to care for them with no others contesting this. Many times, this gets to be the case. For times when it isn't clear, there is a legal hierarchy that maintains the order of prevalence for the next-of-kin who is responsible for acting as a caregiver. This level of priority varies from state to state, but it is generally (in descending order):

1. Spouse
2. Adult child
3. Parent
4. Adult sibling

Some states go as far as including designations for aunts/uncles, nieces/nephews or adult grandchildren. Some states will allow it to go to any living adult relative. Some states will consider a "close friend" as an option, though they are usually given last priority and only accepted if no family members are available.

In the unfortunate situation of an elderly person with no next-of-kin or close friend to fill the caregiving role, it may be necessary for the state to appoint a conservator to step in and make decisions, with the treating physicians, in the interest of the elderly person.

Powers of Attorney and Conservatorship

When it comes to making healthcare decisions on behalf of others, the legal paths to acquire this authority vary based on the situation. In mild situations, the caregiver may only need to make basic decisions on behalf of the elderly due to the elderly's lack of mobility keeping them from running certain errands. In more severe situations, the caregiver may need to make decisions that the elderly is in no capacity to make.

Power of Attorney

A caregiver can be granted a power of attorney by an elderly person with the capacity to enter into such agreements. Powers of attorney can vary greatly in purpose, ranging from healthcare decisions to financial agreements. The person granted the power of attorney has the full legal authority to make decisions as though they were the person granting the power. For example, an elderly person can grant someone a caregiver a power of attorney over their financial matters which will grant authority to the caregiver to handle all of the bills and other accounting duties for the elderly.

Conservatorship

In the event that an individual is declared by a probate court to be incapable of fully making their own financial decisions, the court can appoint conservatorship to a caregiver of that individual. The caregiver, in this case, can now make financial decisions on behalf of the individual in addition to make decisions that the individual may not necessarily condone should the caretaker believe that it is in the best interest of the individual.

The Differences

A power of attorney is something that can be granted without having to get any outside parties involved. However, the elderly person must have the capacity to grant giving such authority in order for a power of attorney to be legal. The person granting a power of attorney can have the power be broad enough to cover a variety of issues or as specific as limiting it to finances or healthcare.

Conservatorships are granted only by a court decision. The court's primary focus is the capacity of the elderly person to make financial decisions. Only if the court feels that the individual is incapable of doing so independently will the court grant another conservatorship.

In the case of healthcare, the authority granted can be revoked by the elderly individual at any time for any reason. Conservatorships require court involvement to change. Powers of attorney do not supersede the wishes of the elderly individual; the elderly retains autonomy and full authority. A conservator can make decisions that the elderly individual can not override.

How These Impact Care

Providing care to an elderly person through someone who has a power of attorney or a conservatorship can be a process due to ensuring that proper care is delivered while respecting and maintaining the established chain of command. A financial power of attorney can make billing inquiries challenging due to a healthcare provider needing to maintain HIPAA compliance, particularly if the healthcare provider isn't holding a copy of the power of attorney. Also, the elderly person is more free to dispute billing with just a power of attorney than under conservatorship if the conservator sees no issue.

Making Ethical Healthcare Decisions for Those Who Can't

Given some of the issues addressed, above, it isn't difficult to notice that many of the situations that a caregiver or healthcare provider must address are matters of quality of life and death. Should an elderly person's capacity to make medical decisions be compromised without an advance care plan, the people who do make the decisions are in a limbo of what is in the desires of the elderly.

The American Society for Aging asserts that there are four practical ethical approaches towards elderly care:

- Autonomy - the right of an individual to make their own decisions.
- Beneficence - putting the elderly ahead of the caregivers or healthcare providers.
- Nonmaleficence - not causing harm through inaction.
- Justice - sharing benefits and burdens.

For patients to be fully autonomous of their own healthcare they must be sufficiently informed about their condition and situation, and have the capacity to make the decision. If their capacity is diminished in any way, it can be a conundrum to try to decide the best course of action should the caregiver or healthcare provider wish to implement a particular treatment against the desires of the elderly. The temptation to "white lie" to the elderly person to encourage voluntary participation in the best interest of the patient whether the patient would otherwise wish to, or not, can rise a lot with patients deemed "stubborn" against their well-being (e.g. using scare tactics to get a patient to admit themselves for testing).

Taking care of another person can be taxing. There are times that a caregiver or healthcare provider may wish to take a shortcut just to simplify a process or routine. However, this can lead to important care getting ignored. Though skipping one vitals check on an unruly patient may seem like losing a great burden, that may be the one check that could have indicated a sudden spike (or drop) in blood pressure. The elderly person should not be put at increased risk of complications for the sake of simplicity.

Deciding to administer a treatment is only one half of the coin, with deciding to not do something is also a choice. There is even a middle ground - ceasing a vital treatment at the request of the patient. For example, when a patient is receiving artificial nutrition requests to have that treatment stopped. This situation has been debated for decades. Arguments for and against granting this wish are layered.

- Healthcare providers may be hesitant to grant this request for fear of litigation or prosecution more than the ethical standpoint.
- Some argue that a person requesting anything that would accelerate their death is not in their right frame of mind, claiming the patient's capacity is compromised.

It can be a struggle to acknowledge that a patient is of sound mind and deliberately choose to shorten their life. However, prolonging another's suffering over personal conviction can also be argued as doing more harm than good. Often, a healthcare provider may choose to defer this request to another physician. Sometimes, being a caregiver or physician can require making the difficult decisions that are best for the patient.

CASES Method

The Department of Veterans Affairs' National Center for Ethics in Health Care developed a standardized approach to ethical dilemmas: CASES.

- **C**larify: Is there a concern? Is there a conflict?

- **A**ssemble Information: Medical information, patient wants and interests, other involved parties' wants and interests, and ethics sources as applicable (codes of ethics, precedent, etc.).
- **S**ynthesize Information: Analyze different approaches, consider claims and counterclaims, and review justifiable options.
- **E**xplain Synthesis: Share the determination and relevant resources/information with involved parties.
- **S**upport the Process: Integrate systems to implement the decision, if action is necessary.

Applied to a scenario such as smoking while using oxygen:

- **C**larify: Is there a concern? Is there a conflict?
    - Patient believes it is his/her right to smoke. Physician believes it is his/her responsibility to discourage smoking for health and fire safety. Ethics dilemma: If a patient wishes to smoke, but the doctor is concerned for the health and safety of the patient, what are the best options available for prescribing oxygen?
- **A**ssemble Information: Medical information, patient wants and interests, other involved parties' wants and interests, and ethics sources as applicable (codes of ethics, precedent, etc.).
    - Review the severity of the patient's lung disease and the necessity of prescribed oxygen. Ensure patient has been informed of the potential risks of smoking while on oxygen, as well as relevant facts and figures. Evaluate the patient's living conditions, such as alone in a single-family home or an apartment. Consider patient's capacity to make important medical decisions.
- **S**ynthesize Information: Analyze different approaches, consider claims and counterclaims, and review justifiable options.
    - Possible options and their results:
        - Withhold oxygen:
            - Disregards patient's wishes
            - Patient could die
            - Prevents risks to others
        - Prescribing oxygen:
            - Honors patient's wishes
            - Patient continues to live
            - Small risk to patient and others

- **E**xplain Synthesis: Present the information to the patient and involved parties, including likely scenarios of each possible decision. Be prepared to answer questions on the subject.
- **S**upport the Process: Follow through on the decision made.

Approaching Ethical Dilemmas

The Mayo Clinic Ethics Consultation Service recommends a case-by-case approach that is detailed in the Jonsen et al. case. It assesses four categories: Medical indications, patient preferences, quality of life and contextual features. A table offered provides guidance on many of the frequent situations that are faced. When unique situations present themselves with no clear answer, mediation can be particularly helpful in getting an objective perspective. In any and all cases, it is the best interest of the patient that should be considered the top priority.

Case Study

Good Death, or Assisted Suicide? The Case of Mr. Perry and his Pacemaker

The following is a summary of the above-titled case study by Tarris Rosell, PhD, DMin. The full study can be reviewed at the website of the Center for Practical Bioethics.

Mr. Perry (pseudonym) was an 83-year-old man with many health problems. Until recently, he lived independently. Though widowed, he has been seeing a lady friend in the area. He has five adult children and several grandchildren. The last several months have been spent in and out of hospitals and rehab centers. Per Mr. Perry:

> *“My body is all worn out. I’m worn out. Don’t want to do this anymore, Doc. They say I can’t go home and be safe. And I’m NOT going to a nursing home. No way! Just stop that little gadget that shocks me and the part that keeps my heart going. I want them stopped. Yes, the pacemaker, too. A magnet will stop it, right? Just do it. Please.”*

A few years prior, Mr. Perry had a cardiac resynchronization therapy defibrillator (CRT-D) implanted. He was 100% dependent on the defibrillator regulation. However, the device has shocked him on many occasions, including the night of the event that brought him to the hospital. He had decided that he wanted no more shocks, medications, hospitals, or other care.

It was immediately determined that the cardiologist was fine with the deactivation of the defibrillator. She explained that if he didn’t want the machine to stop to keep from being shocked, it would be torture to keep the device going.

A DNR was placed.

Mr. Perry asked that the pacemaker also be stopped. Would this be respectful of the patient’s autonomy, or physician-assisted suicide? Mr. Perry was informed that his passing would be within a few minutes, to which he was fine.

Findings From the Situation

Most ethicists and cardiologists agreed that to stop the pacemaker is not unethical, and is permissible, but there is a significant dissent. One survey of cardiologists found that while 77.6% have done a pacemaker deactivation, only 34.4% reported being comfortable with the decision.

Cardiovascular implant devices often lack a full informed consent process. Of 91 patient implant forms reviewed, only one suggested an end-of-life discussion which may have involved deactivation.

Case Study Conclusion

A hospital ethics consultation determined that this was a permissible request to grant out of respect for the patient’s capacity and autonomy. Mr. Perry’s pacemaker was deactivated, and he passed with loved ones by his side. His lady friend expressed appreciation for good years together, but that he’s suffered enough and that she let him go. Mr. Perry’s last words were “Thank you.”