3

Geriatric Populations

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Aging is not a disease; it does not necessarily imply physical and intellectual deterioration. Simply being older in no way implies that a new, or looser, code of ethics is applicable. The principles of medical ethics that apply to younger patients also apply to those patients in older age groups. However, many medical problems—dementing illnesses in particular—are much more common with advancing age, and that, together with an often associated decline in social and economic conditions, may lead to an increase in ethical issues for the psychiatrist who treats older patients.

While some ethical and value issues are unique to the psychiatric care of the elderly, many are shared with other age groups in psychiatric practice. For example, efforts at cost containment and the rationing of medical services are impinging deeply on psychiatric patients, many of them elderly. Psychiatric consultants at nursing homes are more frequently asked by nursing staff to evaluate patients, only to find that the patients' insurance will not cover psychiatric care. At this stage, psychiatrists are left with the ethical dilemma of either providing care for which they will not be reimbursed but for which they are liable, or letting the patient's psychiatric problem go untreated. If this happened with just a few patients, it would not cause much difficulty; but when such patients begin to constitute a significant number of consultation referrals, it becomes more of a problem. Working with older patients, we are faced with ethical quandaries on a daily basis. Some are more straightforward than others; some seem insurmountable—but with a clear understanding that we must do the best for our patients, be

thoughtful of ethical issues at all times, and try to do the right thing, most issues can be resolved to a comfortable extent.

Confidentiality

Confidentiality is a cornerstone of psychiatric practice. With older psychiatric patients, there is often the ethical dilemma of the need to share important medical and psychiatric information with third parties (other physicians, family members, caregivers, and insurance companies). A conflict may arise between preserving the patient's autonomy and avoiding potential harm to the patient or society. Although one's primary duty to the patient may be to preserve confidentiality, in the interest of patient or societal safety, sometimes the best course of action involves divulging information. This should always be done on a case-by-case basis, with confidential consultation with an ethics expert if necessary. Because a patient is elderly does not imply that the usual need for confidentiality no longer exists.

Competence and Consent

Psychiatrists are often asked to make judgments about a cognitively impaired patient's capacity to make decisions about his or her medical care. Again, a dilemma arises from preserving the patient's autonomy and avoiding harm. Discussions about the patient's decision-making capacity need to focus on the medical issues at hand and not on the patient's global abilities. This often needs to be carefully explained to the patient's family and other treating physicians, since the patient may be capable of making decisions about medical care but not about financial dealings. The psychiatrist also should try to identify and decrease factors that may diminish the patient's decision-making capacity. These could include factors such as depression, sleep deprivation, metabolic imbalance, and medication side effects. The ethical issue in determining competence involves obtaining all information available and using that information to determine the balance between exercising paternalism and encouraging autonomy—and between coercion (forcing patients into treatment or financial decisions against their will) and neglect (allowing patients to refuse treatment or financial help despite a great known risk attached to this).

Quality of Life

Often with the combination of advanced age, medical illnesses, and cognitive impairment, the patient's family and physicians may see little quality in the patient's life, and therefore little value in continuing it. The patient may also voice wishes to end his or her life. The ethical difficulty that the psychiatrist faces in this situation is the need to look at the situation from the patient's perspective, rather than from the desires of the psychiatrist, the family, and other physicians. The psychiatrist should also look at ways of maximizing the patient's quality of life given the medical, economic, and time constraints. Often, small changes in the patient's environment, treatment regimen, or caregiver can improve the patient's quality of life. When the psychiatrist helps to identify these factors, alterations can frequently be made; these can significantly improve the patient's outlook.

Abuse and Neglect

Physicians have the ethical and legal obligation to ascertain and report cases of elder abuse and neglect. In many cases, this clearly benefits the patient, but often reporting abuse and neglect is a difficult issue. Patients often depend on the abusers for support and may prefer to risk further abuse, rather than be forced to move from their home of many years into a nursing home. Together with the psychiatrist's legal obligation in these matters comes the ethical obligation to determine whether the patient's own desires can be met by working with the family, legal system, social service agencies, and other involved health care professionals. The risks, benefits, and alternatives to institutionalization and legal action against caregivers need to be carefully examined in light of the patient's expressed wishes and needs.

Use of Restraints

The greatest predictor of the use of restraints in acute and long-term care facilities is cognitive impairment. Ethical dilemmas can develop

from decisions that limit patients' freedom of movement against their wishes or in situations where patients cannot make their wishes known. Federal guidelines prohibit the use of restraints for staff convenience, but they are still widely used for the protection of the patient or those around the patient. The decision to use restraints over the patient's objections always requires careful consideration of the risks and benefits and should never be an automatic decision, since it always decreases the patient's autonomy. Whenever possible, ethically working toward environmental and behavioral interventions should always be considered before ordering restraints. Creating a safe environment for patients has been shown to significantly decrease the prevalence of injuries, when compared with an environment where restraint is used regularly.

Research

While there has been a definite need to test the safety and effectiveness of psychiatric treatments in the elderly, the ethics of research on this population continues to need monitoring. Issues related to informed consent in cognitively impaired patients, the use of double-blind studies when approved treatment alternatives are available, the risk of coercion, and the involvement of nursing home populations all present ethical dilemmas. Working closely with patients' families and nursing home staff—and with primary care physicians, institutional review boards, and ethics committees, if available—helps to clarify these issues. However, the final ethical responsibility still lies with the psychiatric researcher, who must ensure that the benefits always outweigh the risks.

Conclusions

Despite the myriad ethical dilemmas encountered on an almost daily basis, working with older patients is very rewarding. Seldom are the issues straightforward or clear-cut, and many will involve consultation with family members, other treating physicians, social service agencies, and the legal system. However, as psychiatrists, we are uniquely qualified to be true patient advocates, trying to maximize our patients' autonomy while protecting them from harm, intent on doing the right thing at all times.