Bioethical Dilemmas in the Care of Older Adults

Nicholas R. Mercado, DrPH, MCHES, HEC-C

Assistant Professor of Health Humanities & Bioethics

Director, Bioethics Curriculum

University of Rochester School of Medicine & Dentistry

MEDICINE *of* THE HIGHEST ORDER

UNIVERSITY *of* ROCHESTER MEDICAL CENTER

Disclosures

I have nothing to disclose

Goal and Learning Objectives

Goal

❖Understand the foundation of bioethics and how it applies to clinical practice.

Learning Objectives

❖Define the four principles of bioethics.

❖Discuss bioethical dilemmas that arise in the care of older adults.

❖Describe a framework for analyzing common bioethical dilemmas in the care of older adults.

BIOETHICS

Arises from *dilemmas* or *conflicts* encountered in *moral choices* about *clinical* issues in patient care.

Sometimes involves a decision between *two (or more)* equally undesirable options.

Ethics in the care of older adults… not just end-of-life

Ethics in the care of older adults… not just end-of-life

- Decision-Making Capacity and Competency
  - Surrogate Decision-Making
  - Unbefriended Patients
- Discharge Issues
- Advance Directives (Living Will, DNR/DNI (MOLST), Health Care Proxy)
- Cross-Cultural and Diverse Belief Systems
- Quality of Life/Care
- Resource Stewardship

Case Study

JS is a 91-year-old male with a PMH of diabetes mellitus, s/p pacemaker (unknown cardiac hx), significant hearing loss who presented with LLE foot pain/injury, erythema and swelling, who was found to have cellulitis. Infection was treated with antibiotics with resolution. During hospitalization, ankle brachial index was performed, demonstrating poor arterial circulation to the lower extremities consistent with peripheral artery disease. JS has consistently refused angiography and vascular intervention. Discharge planning involved discussion of rehabilitation, which the patient adamantly refused, preferring to go home. JS is widowed and domiciled alone, without home assistance, and has lately refused help from family members.

Case Study con't

CL-Psychiatry was consulted to assess for capacity to refuse treatment and saw the patient twice. On assessment, JS was consistently AAOx3 and demonstrated full understanding of his medical hospitalization, as well as his own needs and limitations at home. As such, CL psychiatry has deemed JS with capacity to make decisions regarding discharge planning. JS endorses a need for help with ADLs, and states he is amenable to a discharge plan that would include a home health aide, home physical therapy or other interventions as long as he can go home.

Inpatient PT assessment recommended discharge to a rehab facility, but documented JS's refusal despite being informed of the risk/benefits. As per podiatry, he is cleared for discharge with weight bearing on the foot with a surgical boot, daily wound care with topical agents, and outpatient follow-up with podiatry in one week.

Purpose of Ethics Consultation

ETHICS CONSULT PURPOSE: **To assist the healthcare team in an ethical dilemma posed by a 91 year-old male with limited mobility whose desire to go home conflicts with the team's discharge recommendations.**

What is the role of an ethics consultant or ethics committee

Ethics Consultant - an expert in clinical ethics who either provides ethics consultations or serves as an educator.

Ethics Committee – a group made up of ethicists, physicians, RNs, ACPs, SWs, chaplains, community members (members without governance to the hospital or facility), etc. to discuss ethical issues.

- Retrospective committee (educational purposes)
- Ethics Review Committees (ERCs)
- Active committee*

**Sometimes the chair of the ethics committee will assign a subcommittee to handle a specific case.*

4 PRINCIPLES of Bioethics[1]
(analytic, operational)

(FOCUS = INDIVIDUALS)	APPLICATION
AUTONOMY (of individual)	➢Dignity ➢Controlling body's integrity ➢**Informed, voluntary** choice ➢Capacity for decisions.
NON-MALEFICENCE (by provider)	➢Avoid/reduce harm in treating (**primum non nocere**)
BENEFICENCE (by provider)	➢Prevent harm ➢Remediate harm ➢Promote best possible health or **quality** of living/dying
JUSTICE (by society's standards, applied by its agents – including health care providers)	➢Fairness (include vulnerable persons) ➢Equal/Equitable opportunity ➢Good of whole society and maximum number

1 Beauchamp, T. L., & Childress, J. F. (1994). *Principles of biomedical ethics*. Edicoes Loyola.

Informed Consent – Essential to Autonomy

"…permission granted, typically that which is given by a patient to a provider for treatment, with full knowledge of the possible risks and benefits…"

Why?

It is impossible to act autonomously without having all the information necessary to make an informed decision.

Elements of Informed Consent

Primary tool in medicine for the maintenance of a patient's autonomy and shared decision-making.[2]

3 Elements I – V – C[3]:

- INFORMATION is ***disclosed*** by clinician and ***understood*** by patient.
- Consent by patient is VOLUNTARY.
- Patient has CAPACITY to make ***this*** decision.
  - If the patient lacks capacity, then informed consent may be obtain by a surrogate decision-maker.

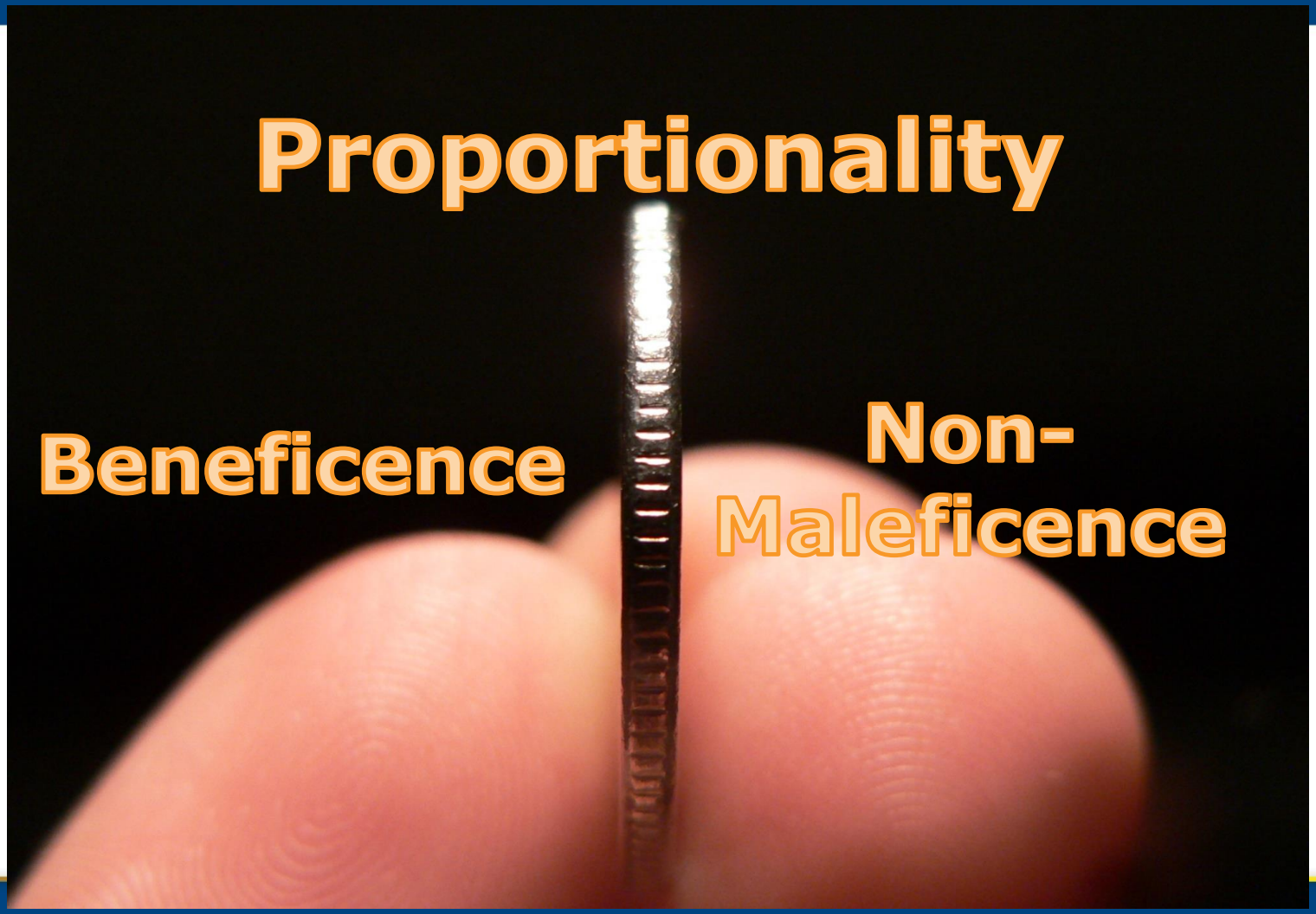
2 Devon KM, Lerner-Ellis JP, Ganai S, Angelos P. Ethics and Genomic Medicine , How To Navigate Decisions in Surgical Oncology. *J. Surg. Oncol*. 2015;111:18–23.
3 Terry PB. Informed consent in clinical medicine. Chest. 2007 Feb 1;131(2):563-8.

What is Decisional Capacity? How is it assessed?

The ability to rationally evaluate a question and provide an answer.[4]

Communicate a choice.
Understand the information.
Appreciate the facts and gravity of the situation.
Reason through the decision

4. Appelbaum, P. S. (2007). Assessment of patients' competence to consent to treatment. *New England Journal of Medicine*, *357*(18), 1834-1840.


Proportionality
Beneficence
Non-
Maleficence

Justice
(Social Justice, Distributive Justice)

Equitable care

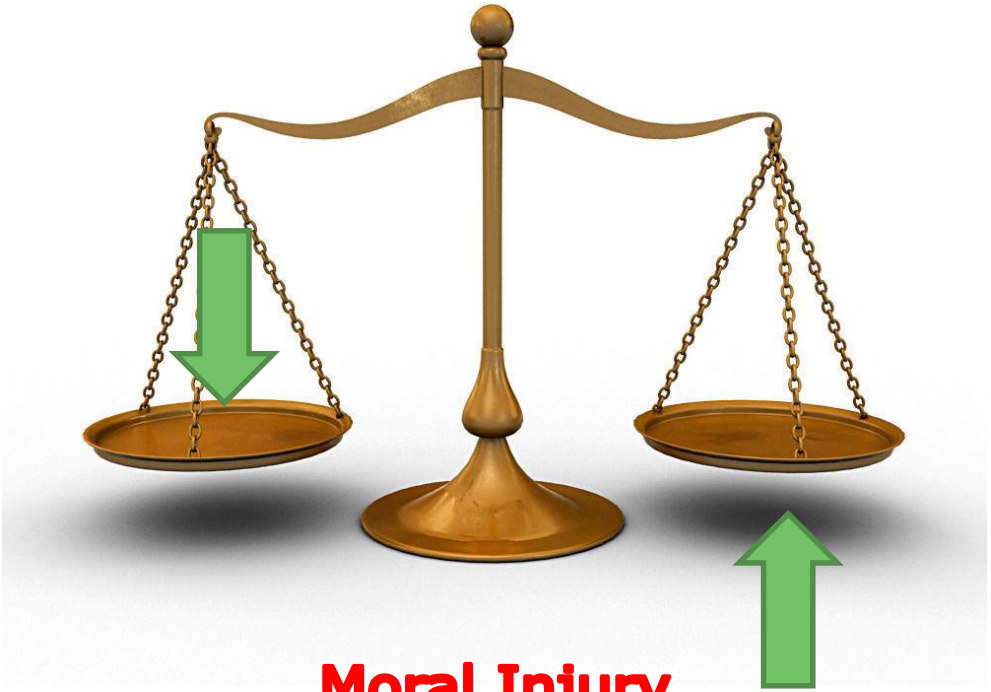
Resource stewardship (allocation, gatekeeping, triage)

- Organ Transplant
- ICU Beds
- Clinician Time

Vulnerable populations

Note: It is very difficult to make justice-based arguments on an individual basis.

Balancing issues between principles



Principles Analysis in the case of JS

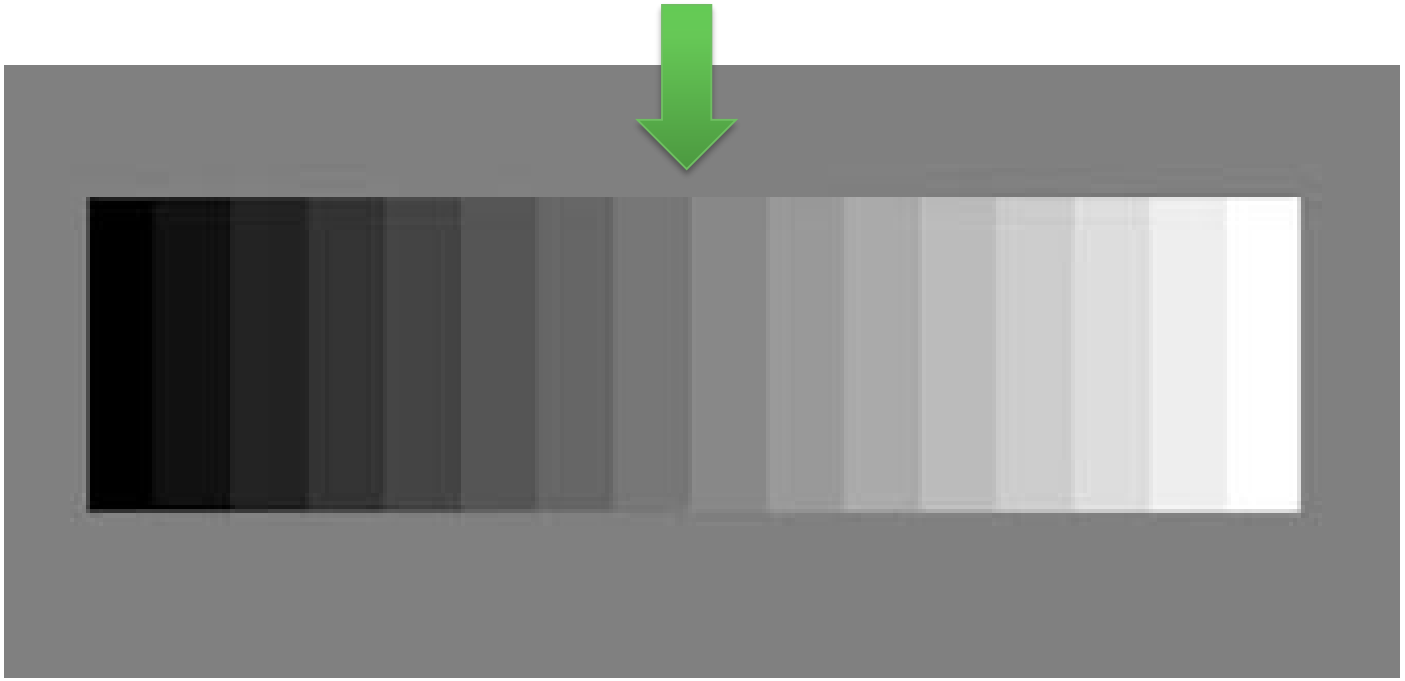
Autonomy	Beneficence	Non-Maleficence	Justice

Principles Analysis in the case of JS

Autonomy	Beneficence	Non-Maleficence	Justice
• Patient has capacity – own autonomous agent • Making a decision based on information presented	• Providing inpatient therapies as indicated • Recommending rehabilitation for maximal success following discharge	• Refraining from unnecessary therapies • Harm reduction methods to align with patient's preferred discharge plan	• Patient is an older adult • Significant hearing loss (disability?)

Ethics is Gray

Yes
Good
Right



No
Bad
Wrong

Case Study 2

MK is a 90-year-old female with past medical history of dementia (baseline AAO x0-1), chronic obstructive pulmonary disease, depression, heart failure with preserved ejection fraction (EF 65%), severe aortic stenosis, T2DM, afib on Eliquis, chronic kidney disease, hypothyroidism, and GERD. MK was sent from nursing for acute hypoxemic and hypercapnic respiratory failure, found to have acute metabolic encephalopathy in the setting of sepsis secondary to multifocal pneumonia and UTI, as well as anemia, hyperkalemia and acute kidney injury (Cr downtrending from 5.07 on admission to 1.74). Patient was placed on BiPAP for management of respiratory failure.

MK's only known living family (son and daughter-in-law) are choosing not to be contacted for healthcare decisions. MK is in the Palliative Care Unit for symptom management, but is under the Medicine service. Patient is on a dysphagia diet.

- Patient came from a residential facility where she has resided for over 10 years.
- Residential facility staff is concerned that MK's symptoms are going to worsen and that she cannot return to the facility.
- Medical team in hospital feel patient is hospice appropriate, but the surrogate decision-makers are unwilling to be involved.

Question: Who can make decisions on behalf of MK?

Who makes medical decisions for a patient lacking decisional capacity?

The NYS Family Health Care Decisions Act (PHL 29-CC) – Surrogate Decision-Making Hierarchy

1. **Court Appointed MHL-81 Guardian**
2. **Spouse or Domestic Partner**
3. **Adult Child** ←
4. **Parent**
5. **Sibling**
6. **Close Friend** ←
7. **Two Physicians**

Family Health Care Decisions Act – Decisions Regarding Hospice

- **5-a.** Decisions regarding hospice care (for adult patients without capacity and without a reasonably available surrogate decision-maker). An attending practitioner shall be authorized to make decisions regarding hospice care and execute appropriate documents for such decisions (including a hospice election form) for an adult patient under this section who is hospice eligible in accordance with the following requirements (summarized).
    - The attending physician sets forth the recommendation (whether the patient is hospice appropriate).
    - A concurring opinion from a practitioner independent from the case depending on where the patient is located or resides.
    - The **Ethics Review Committee** must review the decision in accordance with the surrogate decision-making standards.

Ethics Review Committee - NYS

- Needs at least 5 members including one physician, one nurse, and one member from the community with *no governance to the hospital or residential facility.*
- Ethics Review Committee meeting determinations are documented in the patient's chart.
- Documentation is sent with the appropriate materials to any county or state agencies required to know (i.e. Mental Hygiene Legal Services, Office of Mental Health, or Office for Persons with Developmental Disabilities).
- Patient is enrolled in hospice provided no objections arise.

Summary

- The principles-based framework is useful in analyzing bioethical dilemmas in patient care.
  - Respect for Patient Autonomy
  - Beneficence
  - Non-Maleficence
  - Justice

- Bioethical dilemmas arise from questions with no clear answer or if the answers available present moral injury.

- In addition to end-of-life issues, there are several bioethical dilemmas that care arise when caring for older adults. Some have nuances that an ethics consultant or ethics committee can help resolve.

Thank you!

Questions?