

ETHICS AND GERIATRICS

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The Divine Comedy

-Dante Alighieri, 1315

Along the journey of our life half way
I found myself in a dark wood
Wherein the straight road no longer lay:
How hard it is to tell, make understand
What a wild place it was, so dense,
adverse
That fear returns in thinking on that
wood,
It is so bitter death is hardly worse.
But, for the good it was my chance to
gain,
The other things I saw there I'll
rehearse.



Objectives

- Overview Geriatric Medicine
- Principles of Geriatric Medical Ethics
- Models for Case Conferences
- Capacity and decision making
- Advance directives and the POLST



Purpose of Medical Geriatrics

Improve function

Physical

Psychological

Socioeconomic

Spiritual



Principles

- Aging is not a disease
- It occurs at different rates
- Aging increases susceptibility to illness
- Aging does not cause symptoms



Disease Characteristics

- Chronic and acute
- Multiple and co-existing
- Commonly present atypically
- Diseases, conditions, syndromes
- Diseases-heart, lung, stroke, cancer
- Conditions-diabetes, heart, arthritis, visual, hearing
- Frailty-syndromes multi-factorial



Syndromes are Critical

- Stroke
- Chronic illness
- Weakness
- Poor appetite
- Dehydration
- Weight loss
- Sensory loss
- Poverty
- Balance, gait, falling
- De-conditioning
- Confusion, delirium
- Dementia
- Depression
- Bed-rest, immobility
- Poly-pharmacy, drugs
- Pressure sores



Quality of Life – preferences and predictors

 Medical Care

 Medical health status

 Psychological

 Social support

 Financial

 Housing

 Food

 Family

 Spiritual

 Religious

 Autonomy

 Transportation

 Work



Goals of Care

- Improve or maintain function
- Quality of Life
- Care not cure



Special Concerns

- Do no harm
- Every issue is an Ethical issue
- Cascade effect- house of cards
- Small changes; big changes
- Caregiver and Family issues
- Multi-disciplinary work
- Aging in place requires a system in place
 - Needs and housing vary across a continuum



Suffering-Dr. Eric J.Cassell

“The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Physicians’ failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering but becomes a source of suffering itself.”



Support Study-J.Lynn, JAMA 1994, 272:1839-44

- 9000 patients, 10 most common ICU dx
- 4500 deaths in 6 mo
- 50% deaths within 2 wks predicted to live 6 mo
- 50% DNR were finished within 48 hr dying
- Patient preferences for site of death irrelevant
- 50% families perceived severe pain or had unwanted CPR



Barriers to accepting death for health professionals

- Training
- Fears
- Need to make diagnosis
- Technological imperative
- Death as the enemy
- We reward fixing things
- Unpredictable course of chronic illness



Co-morbidity and frailty

- Co-morbidity- common diseases
- Contributes to frailty but can be stabilized
- Frailty- syndromes predicts highest risk groups most vulnerable to decline
- Trajectory occurs but is unpredictable
 - Mild-reversible
 - Moderate-ongoing
 - Severe-irreversible, rapid decline



Eth-ic

Greek; ethike, ethikos

1. The discipline dealing with what is good and bad and with moral duty and obligation
2. A set of moral principles or values
3. A theory or system of moral values, governing conduct of an individual or group



Medical Ethics

- Morality in medical decision making
- Right or wrongness of human acts
- Affected by cultural, philosophical and public opinions, trends, and fashions
- politics



Medical moral dilemmas

- When rights of and wishes of patients conflict with obligations and values of providers, health care institutions and other family members
- Every aspect of geriatric medicine has a moral perspective



Major Ethical Issues in Geriatrics

- Life expectancy and intensity of treatment; futility of treatment
- Cognitive impairment and decision-making; capacity and competency
- Rationing, implicit and explicit; and disguised as morally just
- Advance directive conflicts; suffering and end of life care, assisted suicide
- Social justice, access, resources, cost



Principles of Medical Ethics in Geriatric Care

- Autonomy
- Beneficence
- Nonmaleficence
- Justice
- Other concerns
 - Cultural authenticity
 - Dignity
 - Community



Structure for Medical Ethics Discussion

- Medical Indications
- Quality of Life
- Patient Preferences
- Contextual Features



7 steps for Negotiating Care

- Create the right setting
- Determine what they know
- Ask how much they want to know
- Explore meaning, emotions and hope
- Suggest realistic goals
- Respond empathetically
- Plan and follow-through



Conference Guidelines

- Listen without judgment
- Explore their story-bodies have pain, people suffer
- Identify developmental life goals
 - Forgiving, closure, transmitting, transcending
- Build consensus
- Avoid false hope
- Avoid language with unintended consequences-reframing
- Stay Close and Do Nothing



Family conference objectives

- Listen to different goals before listing treatment options
- Negotiate different goals
- Identify reasonable hope
- Respect their story and diversity
- Communicate prognosis and uncertainty
- Limit unreasonable goals



Assessing Capacity

 Understanding

 Appreciation

 Reasoning

 Choosing



Understanding: tell me in your own words

- The nature of your condition
- The recommended treatment or test
- Risks and benefits
- Options to this treatment
- Risks and benefits to refusing this treatment



Appreciation

- What do you believe is wrong or the cause of your illness?
- What do you believe will happen if you do this?
- What do you believe will happen if you refuse this treatment?



Reasoning and choice

- How did you reach a decision?
- What was important to you in making this decision?
- What values did you use to balance or decide things?
- How did you make your choice?



The Oregon POLST

- The failure of the DNR
- The failure of the living will
- Ongoing conflict between all parties
 - Family, patient, facility, ambulance, ER, hospital staff
- a model that creates and opportunity for dialogue and investigation of ethics



Physician Order for Life Sustaining Treatment

- DNR/ full code- if actively dying
- Unstable but alive- comfort, to ER, to ICU
- Feeding tube and nutritional support
- Antibiotics
- Other issues- IV fluids, surgery



Barriers for families addressing medical ethics

- Diverse family values and religious conflict
- Denial, Anger and Resentment
- Hidden agendas-the favorite, the wisest, the designated leader
- Guilt and shame
- Fear and control
- Co-dependence



Co-dependence: "I love you so much I won't let you die."

- When ones self worth is defined by how much one is needed
- Ones self importance is derived from managing other peoples lives
- Making it about you instead of the dying patient
- Unable to be present without doing something distracting or harmful



Opportunities at the End of Life

- Goals determine choices not treatments
- Final developmental tasks
- Modeling and ceremony
- Gifts and transcendent insights
- Developing a contemplative practice
- Don't fix things; Stand there
- Practice fearless receptivity



