

## Ethical Issues in Geriatrics: A Guide for Clinicians

PAUL S. MUELLER, MD; C. CHRISTOPHER HOOK, MD; AND KEVIN C. FLEMING, MD

Because of demographic trends, it is reasonable to expect that clinicians will care for an increasing number of elderly persons with challenging medical and psychosocial problems. These problems and issues, in turn, may lead to daunting ethical dilemmas. Therefore, clinicians should be familiar with ethical dilemmas commonly encountered when caring for elderly patients. We review some of these dilemmas, including ensuring informed consent and confidentiality, determining decision-making capacity, promoting advance care planning and the use of advance directives, surrogate decision making, withdrawing and withholding interventions, using cardiopulmonary resuscitation and do-not-resuscitate orders, responding to requests for interventions, allocating health care resources, and recommending nursing home care. Ethical dilemmas

may arise because of poor patient-clinician communication; therefore, we provide practical tips for effective communication. Nevertheless, even in the best circumstances, ethical dilemmas occur. We describe a case-based approach to ethical dilemmas used by the Mayo Clinic Ethics Consultation Service, which begins with a review of the medical indications, patient preferences, quality of life, and contextual features of a given case. This approach enables clinicians to identify and analyze the relevant facts of a case, define the ethical problem, and suggest a solution.

*Mayo Clin Proc.* 2004;79:554-562

AD = advance directive; CPR = cardiopulmonary resuscitation; ICD = implantable cardioverter-defibrillator; PAS = physician-assisted suicide; PSA = prostate-specific antigen

Because of public health measures and advances in medicine, Americans are living longer. By the year 2020, 53.7 million elderly persons (aged  $\geq 65$  years) will be living in America; by 2050, the number will be 82.0 million.<sup>1</sup> However, the elderly population is uniquely burdened with illnesses. An elderly person has, on average, 3 to 4 chronic illnesses and a nearly 20% annual risk of hospitalization. The elderly population accounts for most deaths.<sup>1,2</sup> Also, many older persons have impaired decision-making capacity and insufficient social support and economic resources.<sup>3</sup> Therefore, clinicians likely will care for an increasing number of elderly patients with challenging medical and psychosocial problems that, in turn, may precipitate daunting ethical dilemmas.<sup>4</sup> Because of these factors, clinicians should be familiar with the ethical dilemmas commonly encountered when caring for elderly patients. In this article, we review several of these dilemmas.

### ETHICAL PRINCIPLES

Clinical ethics is the identification, analysis, and resolution of moral problems that arise in the care of patients.<sup>5</sup> Four widely accepted *prima facie* principles that characterize the ethical concerns of clinical practice are autonomy, beneficence, nonmaleficence, and justice.<sup>6</sup> *Autonomy* refers to the

duty to respect persons and their rights of self-determination. *Beneficence* refers to the duty to do good, whereas *nonmaleficence* refers to the duty to prevent or do no harm. *Justice* refers to the duty to treat individuals fairly (free of bias and based on medical need). When caring for elderly individuals, clinicians may find these ethical principles at odds with each other. For example, respect for patient autonomy may be at odds with a clinician's desire to do good or prevent harm.

### COMMON ETHICAL DILEMMAS IN GERIATRICS Ensuring Informed Consent

*An 82-year-old woman presents with a palpable breast mass. Biopsy reveals breast cancer. The patient is seen by a surgeon who tells her that she needs surgery, hands her a consent form, asks her to read and sign it, and leaves the examination room. The surgeon's resident returns later to retrieve the signed form.*

Respect for patient autonomy is the ethical principle that underlies informed consent. For patients to be autonomous when making health care decisions, clinicians must adequately inform them about their illnesses and treatment options.

The legal duty to obtain consent for medical interventions was established in American law during the early 20th century.<sup>7</sup> However, the term *informed consent* was first used in 1957 in the case of *Salgo v Leland Stanford Jr Univ Bd of Trustees*.<sup>8</sup> The patient, who was paralyzed after an invasive procedure, claimed he was not informed fully about the risks of the procedure. The court agreed and

From the Division of General Internal Medicine (P.S.M., K.C.F.) and Division of Hematology and Internal Medicine (C.C.H.), Mayo Clinic College of Medicine, Rochester, Minn.

Individual reprints of this article are not available. The entire Symposium on Geriatrics will be available for purchase as a bound booklet from the *Proceedings* Editorial Office at a later date.

concluded that a clinician violates his or her duty to the patient if facts necessary to make an informed decision are withheld from the patient.<sup>8</sup> Later cases defined how much information should be given for consent to be considered informed. For example, the case of *Canterbury v Spence*<sup>9</sup> established the reasonable patient standard, ie, clinicians should provide the information that a "reasonable patient" would need to know to make an informed decision about the proposed intervention.<sup>7,9</sup>

The basic requirements of informed consent are that the physician conveys the necessary information to the patient (ie, the nature of the illness, the proposed intervention, and the risks and benefits of and alternatives to the proposed intervention) and has confirmation of the patient's decision-making capacity, understanding of the information, and voluntary agreement to the intervention.<sup>10</sup> A signed consent form is not a substitute for an in-depth and documented conversation with the patient about his or her illness and treatment options. In the case example, the patient may have signed the consent form but may not have understood it. Furthermore, it is unclear whether the patient understood her treatment options (including doing nothing). Thus, the surgeon did not necessarily obtain informed consent.

Informed consent should be obtained for most interventions. However, in certain circumstances, informed consent cannot be obtained. For example, when a patient lacks decision-making capacity, consent must be obtained from a surrogate. In emergencies, consent is presumed when an advance directive (AD) or a surrogate is unavailable.

It is ethically and legally permissible for patients with decision-making capacity to refuse unwanted medical interventions. Physicians have a duty to respect these decisions.<sup>11</sup> Not surprisingly, a patient's refusal of an intervention may be at odds with a clinician's desire to do good. Although refusal of an intervention may be regarded by the clinician as wrong, it is not necessarily irrational.<sup>12</sup> If the clinician determines that the patient is adequately informed about the proposed intervention and the risks of refusing it (informed refusal), the patient's decision should be respected.

### Ensuring Patient Confidentiality

*An 81-year-old well-known public figure presents for a physical examination. During the interview, the patient shows substantial cognitive impairment. The patient's spouse, who is present during the interview, confirms that the patient's memory has been impaired for several years.*

The ethical principle of autonomy requires clinicians to maintain patient confidentiality. To be autonomous, patients must be able to control personal information. Furthermore, maintaining confidentiality is necessary for the

proper evaluation and treatment of patients.<sup>13</sup> In the case example, the clinician must be free to ask questions about potentially sensitive matters (eg, history of mental illness, substance abuse) to properly assess and treat the patient's cognitive impairment. In turn, the patient (and spouse) must be confident that the clinician will not divulge the patient's information to others.

However, statutory and case law duties may obligate clinicians to breach confidentiality to serve the best interests of others (eg, society). For example, most states have mandatory reporting laws for suspected abuse of elderly persons.<sup>14</sup> In this setting, the duty to protect the patient and others from the abuser overrides the duty to maintain confidentiality. Clinicians also may be obligated to breach confidentiality when an elderly patient with impaired decision-making capacity poses a risk of harm to himself or herself (ie, a vulnerable adult) or to others (eg, while driving an automobile).

### Determining Decision-Making Capacity

*A 79-year-old man with mild dementia has positive results on Hemocult testing of stool samples. His physician recommends colonoscopy. The patient understands and can repeat in simple terms the rationale for the procedure as well as its risks and benefits.*

Clinicians commonly care for elderly persons who have conditions (eg, dementia) that impair decision-making capacity. However, patients must have decision-making capacity to be autonomous and participate in informed consent. Decision-making capacity includes the ability to communicate a choice, understand the nature and consequences of the choice, manipulate rationally the information necessary to make the choice, and reason consistently with previously expressed values and goals.<sup>12</sup>

The level of decision-making capacity should be in accordance with the risks and benefits of the decision to be made.<sup>6</sup> For example, the physician should be absolutely certain that a patient who refuses a low-risk, yet life-saving, intervention has adequate decision-making capacity.

In many circumstances, patients with impaired cognition have sufficient decision-making capacity. The patient in the case example has sufficient decision-making capacity to consent to colonoscopy. He understands and can articulate the indications, risks, and benefits of the procedure.

At times, determining a patient's decision-making capacity can be difficult, especially if the patient or family disagree on the assessment, the patient has concerns unfamiliar to the clinician (eg, spiritual concerns), or the patient has a psychiatric illness that is difficult to treat. Colleagues who can help determine a patient's decision-making capacity include psychiatrists, geriatric specialists, chaplains, social workers, and ethics consultants.<sup>15</sup>

The clinician has a duty to protect patients without decision-making capacity from inappropriate health care decisions. In such cases, the clinician is not overriding patient autonomy because autonomous decisions by the patient are not possible. In these circumstances, clinicians should identify an appropriate surrogate decision maker (discussed subsequently).

### Promoting Advance Care Planning and Use of ADs

*An 86-year-old widow with 3 adult children is hospitalized with pneumonia. Despite antibiotics and supportive care, the patient's pneumonia progresses, and she develops hypoxemia and delirium. The patient's clinician recommends mechanical ventilation. Her AD identifies her youngest child, a nurse, as her surrogate decision maker.*

In emergencies, consent is presumed, and clinicians should endeavor to preserve life; however, most clinical situations are not emergencies. Clinical situations that involve patients who lack decision-making capacity require ways to facilitate decision making. Advance care planning allows a patient to identify health care preferences and surrogate decision makers in the event the patient cannot make health care decisions.<sup>11</sup> Advance care planning includes patient-clinician discussions of future and end-of-life care and the completion of an AD.

The AD promotes autonomy of patients who lack, but once possessed, decision-making capacity.<sup>16</sup> Clinicians should regard the AD as an extension of the fully autonomous patient. In general, there are 2 forms of ADs, the living will and the durable power of attorney for health care. The living will lists interventions and other actions that should or should not be taken in specific circumstances (usually when the patient is terminally ill). Living wills can be highly detailed or give vague instructions that make their interpretation difficult.<sup>17</sup> The durable power of attorney for health care identifies the surrogate decision maker in the event the patient lacks decision-making capacity. In the case example, the clinician should obtain informed consent for interventions from the child who is identified in the AD as the surrogate decision maker.

All 50 states recognize ADs as an extension of patient autonomy.<sup>18</sup> Furthermore, professional medical societies have endorsed wider use of ADs for end-of-life planning.<sup>11,19</sup> Most patients, whether young or old, and the general public endorse the use of ADs.<sup>20</sup> Finally, the Patient Self-Determination Act of 1990 requires health care institutions that participate in Medicare and Medicaid programs to ask patients whether they have an AD, inform patients of their right to complete an AD, and incorporate patient ADs into their medical records.<sup>21</sup>

Nevertheless, most people, including elderly persons, do not have ADs. One study<sup>22</sup> of a random sample of all US

deaths (N=13,883) found that only 9.8% of decedents had an AD. Patients with ADs, however, were less likely to undergo cardiopulmonary resuscitation (CPR) and more likely to use health care services (eg, physician visits) and hospice care. Other studies have found similar results.<sup>23</sup>

Many patients who complete an AD do not inform their clinicians that they have one.<sup>24,25</sup> Also, patients who have ADs often cannot produce them when they are needed (eg, when ADs are kept in safe-deposit boxes).<sup>17</sup> When ADs are in clinicians' possession, clinicians often place them into outpatient charts, not into hospital charts where the need for them may be greater.<sup>23</sup> One study<sup>16</sup> found that one quarter of ADs disappeared from nursing home charts within 2 years and that only one third were incorporated into the hospital chart when nursing home residents were hospitalized. In fact, most ADs are not incorporated explicitly into patient care.<sup>16,23,25,26</sup>

Few patients discuss end-of-life issues with their clinicians. However, most patients would welcome such discussions, and most want their clinicians to initiate them.<sup>24</sup> Unfortunately, informing clinicians of patient end-of-life preferences may not ensure that those preferences are granted or that end-of-life care is improved.<sup>27</sup> These facts suggest that clinicians must take more responsibility for actively discussing, documenting, and respecting their patients' future care and end-of-life preferences.

### When and How Surrogates Should Be Used for Decision Making

*A 68-year-old man with alcoholism is admitted to the hospital with hematemesis and encephalopathy. The patient's clinician recommends esophagogastroduodenoscopy. However, the patient lacks decision-making capacity and has no AD.*

When a patient lacks decision-making capacity, the clinician must rely on a surrogate to make decisions for the patient. If the patient has an AD that identifies a surrogate, this choice should be respected.<sup>11</sup> However, many patients without decision-making capacity do not have an AD. In these circumstances, clinicians must identify an appropriate surrogate.

The ideal surrogate is one who best understands the patient's health care values and goals.<sup>28</sup> Family members usually serve as surrogates; however, some states specify a hierarchy of surrogates (eg, court-appointed guardian, spouse, next of kin). In some cases, a patient's family and other interested persons may agree that a close friend may be the most appropriate surrogate.<sup>11</sup> In the case example, the clinician should determine the appropriate surrogate decision maker for the patient (while attempting to reverse the patient's encephalopathy and restore his decision-making capacity).

Surrogate decision makers should base their decisions on the patient's previously expressed values and goals (ie, "substituted judgment").<sup>28</sup> However, several studies have found that surrogates often are unaware of and cannot accurately predict patient health care values and goals.<sup>29,30</sup> Furthermore, other studies have found that surrogate review of elderly patients' ADs does not necessarily improve surrogate-substituted judgment.<sup>31,32</sup> These studies suggest that many surrogates do not understand patients' health care values and goals and base their decisions on what they regard as most appropriate for patients (ie, "best interest").<sup>28</sup>

### When Withdrawing and Withholding Life-Sustaining Interventions Is Appropriate

*A 72-year-old woman with metastatic colon cancer enrolls in a hospice program. She has an implantable cardioverter-defibrillator (ICD) for ventricular arrhythmias. While in hospice care, she asks her cardiologist to turn off the ICD.*

Both patients and clinicians see room for improving end-of-life care.<sup>33</sup> Patients say quality end-of-life care should include adequately managing pain and symptoms, avoiding a prolonged process of dying, achieving a sense of control, relieving burden, and strengthening relationships with loved ones.<sup>34</sup> Dying patients may refuse or request the withdrawal of any or all interventions. However, clinicians may be reluctant to grant such requests for fear of litigation or prosecution for unlawful death. Nevertheless, the right to refuse, or request the withdrawal of, medical interventions is ethical and legal.<sup>11,35,36</sup> Withdrawal of life-sustaining interventions (eg, mechanical ventilation, hemodialysis, and artificial nutrition) from patients with advanced medical conditions is practiced widely.<sup>37</sup>

The ethical principle of autonomy underlies the right to refuse, or request the withdrawal of, unwanted medical interventions. Patients also have the right to decline previously consented-to interventions if their health care values and goals have changed.<sup>37</sup> If a clinician begins or continues an intervention that a patient has refused, legally the clinician is committing battery, regardless of intent.<sup>11</sup>

Numerous American court decisions have clarified a patient's legal right to refuse, or request the withdrawal of, life-sustaining interventions. In the *Quinlan* case,<sup>38</sup> the New Jersey Supreme Court claimed that the right to privacy includes the right to refuse unwanted medical interventions, including life-sustaining treatments. In the case of *Cruzan v Director, Missouri Dept of Health*,<sup>39</sup> the US Supreme Court affirmed the right of competent patients to refuse unwanted medical interventions. The Supreme Court also affirmed the rights of incompetent persons to refuse treatments through ADs and surrogate decision makers. However, for situations involving patients who

never were competent or never completed an AD, the Supreme Court deferred to the states on how surrogates should exercise the right of patients to refuse medical interventions.<sup>40</sup> Notably, no American court has found a clinician liable for wrongful death after the physician granted a patient's or surrogate's refusal of, or request to withdraw, life-sustaining treatments.<sup>36</sup>

Granting a patient's refusal of, or request to withdraw, a medical intervention is not the same as physician-assisted suicide (PAS) or euthanasia. In PAS, the patient personally terminates his or her life by using an external means provided by a clinician (eg, lethal prescription). In euthanasia, the clinician directly terminates the patient's life (eg, by lethal injection). In PAS and euthanasia, a new intervention such as a drug is introduced, the sole intent of which is the patient's death. In contrast, when a patient dies after an intervention is refused or withdrawn, the underlying disease is the cause of death. The intent is freedom from interventions that are perceived as burdensome.<sup>11,41-43</sup> In the case example, the cardiologist should grant the patient's request to withdraw ICD support. Deprogramming the ICD is painless and would prevent uncomfortable cardioversions during the last days of the patient's life. The patient's disease, not deprogramming the ICD, is the cause of death.

Clinicians should be certain that patients who refuse or request the withdrawal of life-sustaining interventions have adequate decision-making capacity and are informed of the consequences of their request.<sup>37</sup> However, studies have found that many patients lack decision-making capacity when decisions to withhold or withdraw life-sustaining treatments are made (by surrogates).<sup>44,45</sup> Notably, life-sustaining treatments are more likely to be withheld from elderly persons and patients who lack decision-making capacity than from younger patients and patients who have decision-making capacity.<sup>46,47</sup> These studies highlight the importance of clinicians discussing end-of-life values and goals with elderly patients while the patients possess decision-making capacity. In addition, elderly patients should be encouraged to discuss these values and goals with their potential surrogates and explicitly express them in an AD.

At times, a clinician may conscientiously object to a patient's request to withhold or withdraw life-sustaining treatments. Nevertheless, clinicians must acknowledge the patient's authority over his or her own body and right to refuse unwanted interventions. If the patient's decision to withhold or withdraw life-sustaining treatments remains unchanged after the patient carefully considers his or her health care goals and values and understands the consequences of the request, and if granting the request still violates the clinician's conscience, the clinician should transfer care of the patient to another physician.<sup>11</sup>

### Use of Cardiopulmonary Resuscitation and Do-Not-Resuscitate Orders

*An 82-year-old man is admitted for chest pain due to myocardial infarction. His clinician asks the patient if he desires CPR should he experience a cardiopulmonary arrest. The patient tells the clinician that he wants "everything done."*

In practice, consent to CPR is presumed, and clinicians must perform CPR unless a do-not-resuscitate order (to which the patient or surrogate has consented) exists. "Slow codes" (ie, incomplete CPR efforts) are morally indefensible.<sup>11</sup> Nevertheless, CPR is a low-yield procedure. A meta-analysis<sup>48</sup> of 10 studies of CPR in the hospital setting found that only 41% of patients who underwent CPR survived immediately, and only 13% survived to discharge. Notably, age was not a predictor of survival to discharge after CPR.

Among elderly persons, CPR outside of the hospital is less effective than CPR in the hospital. In 1 study,<sup>49</sup> 2 of 244 persons (0.8%) aged 70 years or older who underwent CPR outside of the hospital survived to discharge compared with 17 of 259 (6.6%) who underwent CPR in the hospital. Similarly, only 0% to 5% of nursing home residents who underwent CPR outside of the hospital survived to discharge.<sup>50</sup>

Adjusting for severity of illness, do-not-resuscitate order rates increase with age.<sup>51-53</sup> However, most elderly persons do not have an accurate understanding of what is meant by CPR, and most have not discussed CPR with their clinicians.<sup>54</sup> Furthermore, patients overestimate the success of CPR. However, after being informed of the actual efficacy of CPR, many elderly persons decline the procedure.<sup>55</sup> Also, studies have found that surrogates and clinicians often incorrectly predict elderly persons' preferences for CPR.<sup>56,57</sup> Furthermore, clinicians cannot infer an elderly patient's desire for CPR on the basis of whether the patient has an AD.<sup>17</sup> These studies emphasize the need for clinicians to explicitly discuss CPR and its efficacy with their elderly patients. In the case example, the patient's clinician should discuss with the patient the nature of CPR (ie, what is done), its risks and benefits, and the expected outcomes. In turn, the patient's decision regarding CPR should be respected.

### Responding to Requests for Interventions

*A healthy 77-year-old man requests serum prostate-specific antigen (PSA) screening for prostate cancer. Of note, one of his friends recently died of prostate cancer.*

Patients frequently make requests for medical interventions. Many requests are reasonable, and clinicians should honor requests if they are within the standard of care. However, clinicians are not obligated to grant requests for interventions that are clearly ineffective or requests that violate their conscience.<sup>58</sup>

Controversies related to patient requests for interventions frequently are due to requests of questionable efficacy (eg, PSA screening in elderly men) that support an uncontroversial end (eg, patient health).<sup>58</sup> These requests often reflect the gap between clinical evidence and clinical practice. Also, patients' values, goals, and experiences often prompt these requests. In the case example, the patient may have been prompted by the death of his friend to request PSA screening. However, because of insufficient evidence, his clinician cannot advise for or against screening. In situations such as this, clinicians are obligated to discuss with the patient their values, goals, and experiences that underlie the request and to inform the patient of the potential risks and benefits of the intervention.

Occasionally, patients also may request interventions that are effective yet support a controversial end.<sup>58</sup> A request that supports a controversial end reflects the gap between the patient's and the clinician's values of the desired end. For example, the surrogate decision maker for an elderly patient with multiorgan failure and impaired decision-making capacity may demand continued life-sustaining treatments (eg, ventilator and hemodialysis support) for the patient because the desired end is to keep the patient alive and the treatments are effective and necessary to achieve that end. However, the clinician may regard the treatments as futile or nonbeneficial because he or she believes the treatments will not result in a meaningful recovery for the patient (the clinician's desired end). In other words, what the clinician regards as futile may not be seen as futile by the patient or surrogate.

Medical futility is difficult to define.<sup>13,59</sup> Quantitative or qualitative assessments of futility are value-laden.<sup>60</sup> The *Wanglie* case<sup>61</sup> illustrates how patients (and their surrogates) and clinicians can have different views of the meaning of *futile*. Mrs Wanglie was an 86-year-old woman who was in a persistent vegetative state and was dependent on life-sustaining treatments for more than 1 year after an illness. The institution, claiming futility, did not want to continue life-sustaining interventions because they could not restore the patient to consciousness. However, to the Wanglie family, maintaining Mrs Wanglie's life in its current state was a valuable end, and maintaining the life-sustaining interventions was essential for achieving that end. The institution sought guardianship of Mrs Wanglie; the court refused and affirmed the rights of families to make decisions about life-sustaining treatments when patients cannot. Also, the court indicated that surrogates cannot be impeached if they differ with physician recommendations when there is reason to believe the surrogate is acting in accordance with the patient's wishes.<sup>62</sup>

When responding to requests for interventions that are effective yet support a controversial end, clinicians should

endeavor to discern the patient's health care values and goals. If the patient remains steadfast in his or her request and the intervention supports the patient's values and goals, the request should be granted. However, if implementation of the intervention violates the clinician's conscience, the clinician should arrange, if possible, to transfer care of the patient to another clinician or institution.<sup>11</sup>

### Allocating Health Care Resources

*An 80-year-old woman presents with exertion-induced chest pain. Coronary angiography reveals 3-vessel coronary artery disease and a 90% stenosis of the left main coronary artery. The patient's cardiologist recommends medical management rather than surgery.*

In 1997, health care spending accounted for 13.5% of the gross domestic product, and this figure is projected to increase.<sup>63</sup> The elderly population accounts for a disproportionately high percentage of health care spending.<sup>64</sup> Thus, it is not surprising that some have called for health care rationing based on age.<sup>4</sup> Clinicians are under increasing pressure from third parties (eg, health maintenance organizations) to control health care spending.<sup>65</sup>

Rationing occurs when a clinician withholds a medically beneficial intervention because of its cost to someone other than the patient.<sup>66</sup> Numerous arguments have been used to justify rationing based on age.<sup>4</sup> For example, some argue that elderly persons benefit less from medical interventions than do younger persons. Mounting evidence suggests that chronological age may not be as important in determining outcomes from medical interventions, including surgery, chemotherapy, and hemodialysis, as previously believed.<sup>67</sup> Instead, performance status, comorbid illnesses, and other factors are more important predictors of outcomes.<sup>65</sup> Some argue that society gains little from treating the nonworking elderly population. However, many young persons do not work (eg, those who are disabled). Furthermore, many nonworking elderly persons contribute to society in ways that are difficult to measure (eg, family relationships).<sup>4</sup> Similarly, some argue that, because older persons have lived most of their lives, health care resources should be diverted to younger persons. However, this approach would not ensure that health care resources would be used wisely. For example, many young persons have illnesses for which treatment is marginally beneficial, whereas many older persons have illnesses for which treatment is highly beneficial.<sup>4</sup> Overall, arguments that favor bedside rationing based on age are inherently value-laden and discriminatory.

The ethical principle of justice refers to the duty to treat individuals fairly (ie, free of bias and based on medical need).<sup>6</sup> Injustice occurs when health care decisions are based on irrelevant patient-specific factors (eg, age) rather than on medical need.<sup>13,65</sup> The case example illustrates possible bed-

side rationing based on age. If the standard treatment for her coronary artery disease is surgery and relevant contraindications do not exist, the patient should be offered surgery.

### Recommending Nursing Home Care

*A 79-year-old widow is admitted to the hospital after a stroke. She has a dense left hemiplegia and requires skilled nursing care. Her clinician recommends long-term care in a nursing home. However, the patient wants to be discharged to her home.*

Most nursing home residents are elderly,<sup>1</sup> poor, physically disabled, and cognitively impaired, and many have experienced losses of social support (eg, death of a spouse).<sup>28</sup> Furthermore, autonomy of nursing home residents may be limited by government regulations, restrictions on activities, and congregate living.<sup>14,28</sup> Finally, the quality of care and sufficiency of staffing in nursing homes long have been of concern.<sup>68</sup> Not surprisingly, many seriously ill people would rather die than live in a nursing home.<sup>69</sup>

Nevertheless, safety is a frequently cited reason for offering nursing home care. The ethical dilemma of autonomy vs safety commonly affects nursing home residents.<sup>70</sup> In the case example, the clinician regards the benefits of nursing home care (eg, safety and skilled nursing care) as greater than the harms (eg, limited autonomy). If discharging the patient to her home is clearly dangerous, then the clinician has an ethical and possibly a legal duty (eg, vulnerable adult statute) to protect the patient with appropriate institutional care. If the risk of harm is ambiguous, then discharging the patient to her home with appropriate monitoring on a trial basis could be attempted and may be necessary for the patient's acceptance of future nursing home care.

For nursing home residents, clinicians should endeavor to maximize autonomy while ensuring the patient's (and others') safety. Maximizing autonomy can be achieved, in part, by respecting the resident's values and goals and involving them in the decisions (eg, treatments, personal care, communications). When feasible, requests for privacy should be honored. Physical restraints should be avoided, not only because they severely restrict autonomy but also because they cause more harm than good.<sup>71</sup>

### AVOIDING ETHICAL DILEMMAS THROUGH EFFECTIVE PATIENT-CLINICIAN COMMUNICATION

Effective patient-clinician communication maximizes patient autonomy. However, effective communication goes beyond informed consent and maintaining confidentiality. Clinicians have an ethical duty to treat patients in a dignified, courteous, and respectful manner.<sup>13</sup>

Research studies have found major problems with patient-clinician communication. Clinicians frequently fail to elicit patients' concerns.<sup>72</sup> Clinicians interrupt patients, on

Table 1. Practical Tips for Effective Patient-Clinician Communication

Opening the interview	<p>"Before we begin, I'd like to take a few moments to get to know you."            "Did you make it to the office OK?"            "Tell me about yourself."</p>
Information gathering	<p>Allow the patient to describe his or her concerns without interruption, and then ask, "What else?" until the patient finishes.            Jointly prioritize concerns.</p>
Relationship building	<p>PEARLS mnemonic  <i>Partnership</i>: "We are going to solve this problem together."  <i>Empathy</i>: "It sounds like you are experiencing a lot of pain."  <i>Apology</i>: "I'm sorry I've kept you waiting."  <i>Respect</i>: "I admire your strength and courage."  <i>Legitimization</i>: "Many people with this illness experience similar symptoms."  <i>Support</i>: "I will be here for you throughout your treatment."</p>
Conveying information (eg, test results, treatment plans)	<p>Ask the patient about his or her understanding of the problem, the tests done, etc  <i>Tell</i> (slowly and jargon-free) the patient his or her test results, diagnosis, etc            Ask about his or her understanding and feelings</p>

Data from Barrier et al.<sup>79</sup>

average, 18 seconds after patients begin to describe their reasons for the consultation.<sup>73</sup> Furthermore, advance care planning and end-of-life discussions between clinicians and patients are sparse.<sup>24,74</sup> Thus, it is not surprising that ethical dilemmas may arise because of poor communication between clinicians and their patients (or surrogates).<sup>74</sup>

Nevertheless, research studies, including randomized trials, have found that effective patient-clinician communication is associated with greater patient satisfaction and compliance and better health outcomes.<sup>72,75</sup> Also, effective communication is associated with fewer malpractice claims<sup>76,77</sup> and may prevent ethical dilemmas.<sup>78</sup>

Fortunately, clinicians can learn skills to improve communication with patients related to opening the interview, information gathering, relationship building, and conveying medical information (eg, results of tests, diagnoses).<sup>79</sup> When opening the interview, clinicians should endeavor to learn about the patient as a person (who they are, their values and goals, etc).<sup>80</sup> The patient should be allowed to describe his or her reasons for the consultation without interruption. Physicians should elicit the patient's entire agenda by asking questions such as, "What else concerns you?"<sup>79</sup> Notably, the average time for a patient to articulate his or her list of concerns is 60 seconds.<sup>73</sup> After all the patient's concerns have been aired, the clinician and patient should jointly prioritize them. In the course of the interview, relationship-building statements should be used (Table 1).<sup>79</sup> When conveying medical information (eg, test results or

treatment plans), clinicians should use jargon-free language and frequently assess patient comprehension (eg, by asking "Am I making sense?"). Additional practical tips for effective patient-clinician communication are listed in Table 1. Patient-centered interviewing requires little time and effort.<sup>81-83</sup> Other factors and conditions may inhibit effective communication between elderly patients and their clinicians including sensory impairment (eg, hearing loss), cognitive impairment, and social isolation. To fully discern the needs and maximize the autonomy of their patients, clinicians are obligated to address these conditions and factors.

### APPROACHING ETHICAL DILEMMAS

Even in the best circumstances, many clinicians will face ethical dilemmas that they cannot resolve quickly. The Mayo Clinic Ethics Consultation Service uses a case-based approach to ethical dilemmas described by Jonsen et al.<sup>5</sup> This approach to ethical dilemmas begins with a review of 4 topics: medical indications, patient preferences, quality of life, and contextual features (Table 2). This order of review does not imply ethical priority. Rather, it allows for proper exposition, organization, and analysis of all the ethically relevant facts (ie, the facts related to the 4 *prima facie* ethical principles) of a given case. Answering the questions in Table 2 is a convenient approach to the 4 topics. Reviewed together, the answers to the questions not only usually define the ethical problem but also suggest a solution.

Occasionally, despite this approach, ethical dilemmas remain unresolved; third-party mediation can be helpful to break the impasse. Most health care institutions have some form of ethics consultation process to help resolve these dilemmas. Clinicians should be familiar with the ethics consultation process at their institutions and use it when needed.

### CONCLUSIONS

It is reasonable to expect that clinicians will care for an increasing number of elderly persons with challenging medical and psychosocial problems. These problems and issues may lead to daunting ethical dilemmas. We reviewed ethical dilemmas commonly encountered when caring for elderly persons but recognize that this group is by no means exhaustive.

Many ethical dilemmas arise because of inadequate patient-clinician communication. Effective communication is not only a clinician's duty; it is an important feature of the art of medicine and may prevent many ethical dilemmas. Nevertheless, even in the best of circumstances, ethical dilemmas occur. A useful approach to ethical dilemmas begins with a review of the medical indications, patient preferences, quality of life, and contextual features of a given case. This approach enables clinicians to identify and analyze the relevant facts of a case, define the ethical problem, and suggest a solution.

**Table 2. Topics for Proper Analysis of the Ethically Relevant Facts of a Given Case**

**Medical indications**

- Ethical principles: beneficence and nonmaleficence  
 What is the patient's medical problem? History? Diagnosis? Prognosis?  
 Is the problem acute? Chronic? Critical? Emergent? Reversible?  
 What are the clinician's goals of treatment?  
 What are the patient's goals of treatment?  
 What are the probabilities of success?  
 What are the plans in case of therapeutic failure?  
 In sum, how can this patient benefit from medical and nursing care, and how can harm be avoided?

**Patient preferences**

- Ethical principle: respect for patient autonomy  
 Does the patient have decision-making capacity?  
 If the patient has decision-making capacity, what are his or her preferences for treatment?  
 Has the patient been informed of the benefits and risks of the treatment, understood this information, and given consent?  
 If the patient lacks decision-making capacity, who is the appropriate surrogate?  
 Has the patient expressed preferences previously (eg, advance directive)?  
 Is the patient unwilling or unable to cooperate with treatment? If so, why?  
 In sum, is the patient's right to choose being respected to the extent possible in ethics and law?

**Quality of life**

- Ethical principles: beneficence, nonmaleficence, and respect for patient autonomy  
 What are the prospects, with or without treatment, for a return to normal life?  
 What physical, mental, and social deficits is the patient likely to experience if treatment succeeds?  
 Are there biases that might prejudice the clinician's evaluation of the patient's quality of life?  
 Is the patient's present or future condition such that his or her continued life might be judged undesirable?  
 Is there any plan and rationale to forgo treatment?  
 Are there plans for comfort and palliative care?

**Contextual features**

- Ethical principles: loyalty and fairness (justice)  
 Are there family issues that might influence treatment decisions?  
 Are there clinician issues that might influence treatment decisions?  
 Are there financial and economic factors?  
 Are there religious or cultural factors?  
 Are there limits on confidentiality?  
 Are there problems of allocation of resources?  
 How does the law affect treatment decisions?  
 Is clinical research or teaching involved?  
 Is there any conflict of interest on the part of clinicians or the institution?

Adapted from Jonsen et al,<sup>5</sup> with permission from McGraw-Hill.

**REFERENCES**

- US Bureau of the Census. *Statistical Abstract of the United States: 2000*. 120th ed. Washington, DC: US Bureau of the Census; 2000.
- Jahnigen DW, Schrier RW. The doctor/patient relationship in geriatric care. *Clin Geriatr Med*. 1986;2:457-464.
- Thomasma DC. Freedom, dependency, and the care of the very old. *J Am Geriatr Soc*. 1984;32:906-914.
- Rivlin MM. Protecting elderly people: flaws in ageist arguments. *BMJ*. 1995;310:1179-1182.
- Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. 5th ed. New York, NY: McGraw-Hill; 2002.
- Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 4th ed. New York, NY: Oxford University Press; 1994.
- Meisel A, Kuczewski M. Legal and ethical myths about informed consent. *Arch Intern Med*. 1996;156:2521-2526.
- Salgo v Leland Stanford Jr Univ Bd of Trustees*, 154 CalApp2d 560, 317 P2d 170, 181 (1957).
- Canterbury v Spence*, 464 F2d 772 (DC Cir 1972).
- Marsh FH. Informed consent and the elderly patient. *Clin Geriatr Med*. 1986;2:501-510.
- American College of Physicians. Ethics manual. 4th ed. *Ann Intern Med*. 1998;128:576-594.
- Pellegrino ED. Decisions to withdraw life-sustaining treatment: a moral algorithm. *JAMA*. 2000;283:1065-1067.
- American Medical Association, Council on Ethical and Judicial Affairs. *Code of Medical Ethics: Current Opinions With Annotations*. 2000-2001 ed. Chicago, Ill: American Medical Association; 2000.
- Kane RA. Ethics and long-term care: everyday considerations. *Clin Geriatr Med*. 1994;10:489-499.
- Karlawish JHT, Casarett D. Competency and decision-making capacity. In: Sugarman J, ed. *20 Common Problems: Ethics in Primary Care*. New York, NY: McGraw-Hill; 2000:225-237.
- Danis M, Southerland LI, Garrett JM, et al. A prospective study of advance directives for life-sustaining care. *N Engl J Med*. 1991;324:882-888.
- Walker RM, Schonwetter RS, Kramer DR, Robinson BE. Living wills and resuscitation preferences in the elderly population. *Arch Intern Med*. 1995;155:171-175.
- Prendergast TJ. Advance care planning: pitfalls, progress, promise. *Crit Care Med*. 2001;29(2, suppl):N34-N39.
- Orentlicher D. Advance medical directives [published correction appears in *JAMA*. 1990;264:1661]. *JAMA*. 1990;263:2365-2367.
- Emanuel LL, Barry MJ, Stoeckle JD, Ettlson LM, Emanuel EJ. Advance directives for medical care—a case for greater use. *N Engl J Med*. 1991;324:889-895.
- Wolf SM, Boyle P, Callahan D, et al. Sources of concern about the Patient Self-Determination Act. *N Engl J Med*. 1991;325:1666-1671.
- Hanson LC, Rodgman E. The use of living wills at the end of life: a national study. *Arch Intern Med*. 1996;156:1018-1022.
- Miles SH, Koepf R, Weber EP. Advance end-of-life treatment planning: a research review. *Arch Intern Med*. 1996;156:1062-1068.
- Layson RT, Adelman HM, Wallach PM, Pfeifer MP, Johnston S, McNutt RA, End of Life Study Group. Discussions about the use of life-sustaining treatments: a literature review of physicians' and patients' attitudes and practices. *J Clin Ethics*. 1994;5:195-203.
- Teno J, Lynn J, Wenger N, et al. SUPPORT Investigators. Advance directives for seriously ill hospitalized patients: effectiveness with the patient self-determination act and the SUPPORT intervention. *J Am Geriatr Soc*. 1997;45:500-507.
- Teno JM, Licks S, Lynn J, et al. SUPPORT Investigators. Do advance directives provide instructions that direct care? *J Am Geriatr Soc*. 1997;45:508-512.
- SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients: the study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT) [published correction appears in *JAMA*. 1996;275:1232]. *JAMA*. 1995;274:1591-1598.
- Hayley DC, Cassel CK, Snyder L, Rudberg MA. Ethical and legal issues in nursing home care. *Arch Intern Med*. 1996;156:249-256.
- Morris BA. Surrogate decision making: only one piece of the puzzle [editorial]. *Arch Fam Med*. 1995;4:503-504.
- Layde PM, Beam CA, Broste SK, et al. Surrogates' predictions of seriously ill patients' resuscitation preferences. *Arch Fam Med*. 1995;4:518-523.
- Ditto PH, Danks JH, Smucker WD, et al. Advance directives as acts of communication: a randomized controlled trial. *Arch Intern Med*. 2001;161:421-430.
- Coppola KM, Ditto PH, Danks JH, Smucker WD. Accuracy of primary care and hospital-based physicians' predictions of elderly outpatients' treatment preferences with and without advance directives. *Arch Intern Med*. 2001;161:431-440.



33. Council on Scientific Affairs, American Medical Association. Good care of the dying patient. *JAMA*. 1996;275:474-478.
34. Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspectives. *JAMA*. 1999;281:163-168.
35. Fairman RP. Withdrawing life-sustaining treatment: lessons from Nancy Cruzan. *Arch Intern Med*. 1992;152:25-27.
36. Gostin LO. Deciding life and death in the courtroom: from *Quinlan* to *Cruzan*, *Glucksberg*, and *Vacco*—a brief history and analysis of constitutional protection of the "right to die." *JAMA*. 1997;278:1523-1528.
37. Quill TE, Barold S, Sussman BL. Discontinuing an implantable cardioverter defibrillator as a life-sustaining treatment. *Am J Cardiol*. 1994;74:205-207.
38. *In re Quinlan*, 355 A2d 647 (NJ 1976).
39. *Cruzan v Director, Missouri Dept of Health*, 497 US 261 (1990).
40. Emanuel EJ. Securing patients' right to refuse medical care: in praise of the Cruzan decision. *Am J Med*. 1992;92:307-312.
41. Rhymes JA, McCullough LB, Luchi RJ, Teasdale TA, Wilson N. Withdrawing very low-burden interventions in chronically ill patients. *JAMA*. 2000;283:1061-1063.
42. Meisel A, Snyder L, Quill T, American College of Physicians—American Society of Internal Medicine End-of-Life Care Consensus Panel. Seven legal barriers to end-of-life care: myths, realities, and grains of truth. *JAMA*. 2000;284:2495-2501.
43. Winter B, Cohen S. ABC of intensive care: withdrawal of treatment. *BMJ*. 1999;319:306-308.
44. Bedell SE, Pelle D, Maher PL, Cleary PD. Do-not-resuscitate orders for critically ill patients in the hospital: how are they used and what is their impact? *JAMA*. 1986;256:233-237.
45. Faber-Langendoen K. A multi-institutional study of care given to patients dying in hospitals: ethical and practice implications. *Arch Intern Med*. 1996;156:2130-2136.
46. Hanson LC, Danis M, Mutran E, Keenan NL. Impact of patient incompetence on decisions to use or withhold life-sustaining treatment. *Am J Med*. 1994;97:235-241.
47. Hamel MB, Teno JM, Goldman L, et al. SUPPORT Investigators. Patient age and decisions to withhold life-sustaining treatments from seriously ill, hospitalized adults. *Ann Intern Med*. 1999;130:116-125.
48. Ebell MH, Becker LA, Barry HC, Hagen M. Survival after in-hospital cardiopulmonary resuscitation: a meta-analysis. *J Gen Intern Med*. 1998;13:805-816.
49. Murphy DJ, Murray AM, Robinson BE, Campion EW. Outcomes of cardiopulmonary resuscitation in the elderly. *Ann Intern Med*. 1989;111:199-205.
50. Zweig SC. Cardiopulmonary resuscitation and do-not-resuscitate orders in the nursing home. *Arch Fam Med*. 1997;6:424-429.
51. Boyd K, Teres D, Rapoport J, Lemeshow S. The relationship between age and the use of DNR orders in critical care patients: evidence for age discrimination. *Arch Intern Med*. 1996;156:1821-1826.
52. Wenger NS, Pearson ML, Desmond KA, et al. Epidemiology of do-not-resuscitate orders: disparity by age, diagnosis, gender, race, and functional impairment. *Arch Intern Med*. 1995;155:2056-2062.
53. Goodlin SJ, Zhong Z, Lynn J, et al. Factors associated with use of cardiopulmonary resuscitation in seriously ill hospitalized adults. *JAMA*. 1999;282:2333-2339.
54. Shmerlin RH, Bedell SE, Lilienfeld A, Debanco TL. Discussing cardiopulmonary resuscitation: a study of elderly outpatients. *J Gen Intern Med*. 1988;3:317-321.
55. Murphy DJ, Burrows D, Santilli S, et al. The influence of the probability of survival on patients' preferences regarding cardiopulmonary resuscitation. *N Engl J Med*. 1994;330:545-549.
56. Uhlmann RF, Pearlman RA, Cain KC. Physicians' and spouses' predictions of elderly patients' resuscitation preferences. *J Gerontol*. 1988;43:M115-M121.
57. Zweibel NR, Cassel CK. Treatment choices at the end of life: a comparison of decisions by older patients and their physician-selected proxies. *Gerontologist*. 1989;29:615-621.
58. Weijer C, Singer PA, Dickens BM, Workman S. Bioethics for clinicians, 16: dealing with demands for inappropriate treatment. *CMAJ*. 1998;159:817-821.
59. Truog RD, Brett AS, Frader J. The problem with futility. *N Engl J Med*. 1992;326:1560-1564.
60. Veatch RM. Why physicians cannot determine if care is futile. *J Am Geriatr Soc*. 1994;42:871-874.
61. *In re Helga Wanglie*, Fourth Judicial District (Dist Ct Probate Ct Div) PX-91-283, Minnesota, Hennepin County.
62. Angell M. The case of Helga Wanglie: a new kind of "right to die" case [editorial]. *N Engl J Med*. 1991;325:511-512.
63. Smith S, Heffler SK, Calfo S, et al. National health projections through 2008. *Health Care Financ Rev*. Winter 1999;21:211-237.
64. Pawlson LG, Glover JJ, Murphy DJ. An overview of allocation and rationing: implications for geriatrics. *J Am Geriatr Soc*. 1992;40:628-634.
65. Hébert PC. *Doing Right: A Practical Guide to Ethics for Medical Trainees and Physicians*. New York, NY: Oxford University Press; 1996.
66. Ubel PA, Goold S. Recognizing bedside rationing: clear cases and tough calls. *Ann Intern Med*. 1997;126:74-80.
67. Jecker NS, Schneiderman LJ. Futility and rationing. *Am J Med*. 1992;92:189-196.
68. Centers for Medicare and Medicaid Services. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Executive Summary: Phase II Report*. December 2001. Available at: [www.cms.hhs.gov/medicaid/reports/rp1201es.pdf](http://www.cms.hhs.gov/medicaid/reports/rp1201es.pdf). Accessibility verified March 8, 2004.
69. Wallace SP, Abel ER, Stefanowicz P. Long-term care and the elderly population. In: *Changing the U.S. Health Care System: Key Issues in Health Services, Policy, and Management*. 2nd ed. San Francisco, Calif: Jossey-Bass; 2001:205-217.
70. Agich GJ. Respecting the autonomy of elders in nursing homes. In: Monagle F, Thomasma DC, eds. *Health Care Ethics: Critical Issues for the 21st Century*. Gaithersburg, Md: Aspen Publishers, Inc; 1998:200-211.
71. Castle NG, Mor V. Physical restraints in nursing homes: a review of the literature since the Nursing Home Quality Reform Act of 1987. *Med Care Res Rev*. 1998;55:139-170.
72. Rosenberg EE, Lussier MT, Beaudoin C. Lessons for clinicians from physician-patient communication literature. *Arch Fam Med*. 1997;6:279-283.
73. Beckman HB, Frankel RM. The effect of physician behavior on the collection of data. *Ann Intern Med*. 1984;101:692-696.
74. Loewy EH, Carlson RW. Talking, advance directives, and medical practice [editorial]. *Arch Intern Med*. 1994;154:2265-2267.
75. Stewart MA. Effective physician-patient communication and health outcomes: a review. *CMAJ*. 1995;152:1423-1433.
76. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice: lessons from plaintiff depositions. *Arch Intern Med*. 1994;154:1365-1370.
77. Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. *JAMA*. 1997;277:553-559.
78. Orr RD, Marshall PA, Osborn J. Cross-cultural considerations in clinical ethics consultations. *Arch Fam Med*. 1995;4:159-164.
79. Barrier PA, Li JT-C, Jensen NM. Two words to improve physician-patient communication: what else? *Mayo Clin Proc*. 2003;78:211-214.
80. Platt FW, Gaspar DL, Coulehan JL, et al. "Tell me about yourself": the patient-centered interview. *Ann Intern Med*. 2001;134:1079-1085.
81. Frankel RM, Morse DS, Suchman A, Beckman HB. Can I really improve my listening skills with only 15 minutes to see my patients? *HMO Pract*. 1991;5:114-120.
82. Fogarty LA, Curbow BA, Wingard JR, McDonnell K, Somerfield MR. Can 40 seconds of compassion reduce patient anxiety? *J Clin Oncol*. 1999;17:371-379.
83. Beckman H, Markakis K, Suchman A, Frankel R. Getting the most from a 20-minute visit. *Am J Gastroenterol*. 1994;89:662-664.

End of the Symposium on Geriatrics.