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Elizabeth Niven
UNITEC Institute of Technology

ETHICAL ISSUES WITH THE ELDERLY

Ethical issues in relation to elderly people are many and complex. Resource issues, competency, treatment issues are all problematic. In this short time, I need to focus my information, and so I have chosen three issues. The first two I will merely introduce, and the third I will spend a little more time discussing.

The first two issues are notions that I found thought provoking when I first met them, and I have continued to be challenged by them since.

The issues are:
1 The technological imperative and Death as a moral evil.
2 Mercy versus Justice
3 Autonomy as Abandonment.

The Technological Imperative
This term will be familiar to many of you. It encompasses a notion that if we can do it, if we have the knowledge, expertise, the technology to do something, then somehow this flows directly into the belief that we ought to do it. There is a sense of moral obligation -- why would we deny someone a treatment which exists? For many in the general public transplanting of organs would fit into this category. They do not always of course understand that the transplant may be inappropriate in many circumstances.

Daniel Callahan, in his book, The Troubled Dream of Life, suggests that in the past death was a 'social' evil. In older times, the loss of a human being was experienced at a social level. We lost a person to our society, to our relationships. Death was inevitable, and sorrowful, and as a society we experience sadness and grief. Now, he suggests, death has become a moral evil. As medicine has developed the capacity to meet the challenge of much of our illness, an expectation that sickness can be cured has arisen. Now death can be pushed away, and he argues this has lead to a conception that death is a moral evil — something ought to be able to be done about it. As persons, we feel moral outrage at death, instead of corporate and individual sadness. It seems that this notion of that death should somehow be prevented is having an insidious effect on us as a
society. I heard just this week that there have been two assaults this year on medical personnel who refused to attempt resuscitation on terminally ill patients who died.

**Justice vs Mercy.**
Per Nortvedt, a Norwegian nurse philosopher, struggled with the issues of caring in his doctoral work. He wondered how it was we could respond differently to issues of caring in general, from how we responded to issues of caring in a personal relationship.
He hypothesised that we operate from an *abstract sense of justice* when we think about issues of resource and how to act when we consider people in general. That is, faceless people, people in number, populations, or even people not presently in our direct care.
He suggests that when we care for people face to face we operate from a standpoint of *mercy*, which requires us to act for *that person* as a priority.
He noted that we put the person who has come into our caring duty ahead of others. He argues that we have a moral duty to do this, and that it arises from a sense of *mercy*. This differentiation allows us to defend to ourselves and to others why and how it is that we give more of our resource of caring and all that it encompasses, to the person in our care.

I don't have time here to discuss these two concepts further, but I hope they have given you something to take home and ponder.

**Autonomy as Abandonment.**
This is the issue I want to put more time into, as for most of you in care of the elderly it is a continuous challenge.

Can autonomy be abandonment?
It seems to me that we have idealised the legal notion of autonomy as singular, separate, individual, alone decision making, without questioning whether this is the legal view, and indeed whether it is what is intended.
We have a strange notion in our society that a person already compromised by ill health, or pain, or confusion, or distress, should have the additional burden of making often momentous decisions about their life, or well being. Some other cultures do not place this heavy burden on people experiencing these stresses. Some even consider us barbaric to do so.

My neighbour, an 80 year old woman had had several rounds of chemotherapy. It was unclear whether it was effective. The tumour had not shrunk, but it had not grown. The treatment was distressing. The medical team summarised the position for her, and said they would give her time to consider whether she wanted to continue treatment or not. They would come back after lunch to hear her decision, which would be entirely hers.
Poor Miss A was confused. Who was she to make an expert judgement about continuing? She did not understand the cellular level effect of the drugs. She did not know how other patients fared. She did not know what was ahead of her if she decided this way or that. She was confused, frightened, anxious, and distressed. She felt abandoned.

I would like to suggest that the whole field of decision making needs review. I wonder if it would be useful to consider where the decision to be made properly lies on the continuum I offer. I think we could as nurses, document our assessment of

- the patient's present and past personal context
- the social & family context
- the institutional reality
- the type of decision required (urgent/non-urgent; reversible/irreversible)

This would help us judge where on the continuum the decision should lie.

In this model, I show the proportion of the decision which is taken by the patient, and the proportion taken by the health professional(s).

At one end we have the patient making 99% of the decision, assisted 1% by the health professional. (number 1)

At the other, we have the health professional, possibly assisted by the kin, making 99% of the decision. The 1% left for the patient is the knowledge of what this patient would have wanted, or even less, any similar person could reasonably be expected to want. (number 10)

In between we have

2 - Patient gets full information, pros & cons, decides.
3 - Patient makes a central choice, but leaves some peripheral or flow on decisions to be logically derived or assumed.
4 - There is a shared decision with all participants in consensus and full discussion
5 - The kin & health professional discuss all the factors and make a recommendation to the patient. The patient agrees, or doesn't agree. The
recommendation may highlight a pathway to a patient that they didn't know they didn't want!
6 - The group of kin & health professional as above make a decision and inform the patient. The patient agrees, or doesn't refuse.
7 - The patient acquiesces or assents.
8 - The patient allows the decision
9 - The patient is informed.

On the model, the wriggly line is the kin – family, friends, significant people. They may be present in time and space or not present in time and space. Family traditions and expectations may retain their influence even though individuals who expressed them have died. Kin may be more and less involved in decisions.

We need, I think to remember that, like our patients state of hydration, the readiness to participate in decisions varies from time to time, short or long. We assess hydration, respond accordingly and document both our assessment and response. I would argue that we should as readily have confidence in our expertise to judge a person’s readiness to participate in decisions.

We can document an event, perhaps as follows:

Mrs A was exhausted today, following the recent chest infection and being up all night with diarrhoea. She was unable to decide whether she would like to go on the unit outing to the local playhouse this coming Saturday. As she has enjoyed such outings in the past, her name has provisionally been put on the list, subject to her confirmation when she feels able to decide for herself.

Mr B was shocked, in pain and appeared unable to articulate his thoughts. A fractured neck of femur was diagnosed and consent for surgery was sought. He seemed too bewildered to take full responsibility of consent, so his kin and the staff of the Home discussed the information and made a recommendation to Mr B. He agreed to surgery, and appeared pleased to share the weight of this decision with others.

Now, it may be strictly legal to keep everyone else out, and to require Mr B to decide alone, but I would argue, and I believe our legal system would support me, that the moral duty to care asks us to go further. I would say that by doing such an action we are carrying out our duty of care, as described by Marie Burgess, in providing the best care we know how to do, based on expert knowledge and experience, and fully accountable for our actions.

I ask you to think about sharing decisions, according to the context of the moment, to base these decisions on your expert nursing knowledge, to document your actions, and to be proudly accountable for your nursing practice.