

## Ethical considerations in the care of older people

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### Respecting older people as individuals

Older people share the full human and civil rights of all citizens. The Human Rights Act 1998 includes the right to be free of discrimination, and may be interpreted to include discrimination against citizens on the grounds of age. There is specific legislation in the UK prohibiting discrimination on the basis of sex, race or disability, but as yet no such legislation against ageism (eg in employment law). In *Your guide to the NHS*,<sup>1</sup> the government promises each patient that 'you will be treated fairly, according to your needs, regardless of your age'. Older people are particularly vulnerable to loss of dignity and privacy, as highlighted by Help the Aged in their report *Dignity on the ward*.<sup>2</sup>

The General Medical Council (GMC) instructs doctors that:

*You should not allow your views about a patient's lifestyle, culture, beliefs, race, colour, gender, sexuality, age, social status or perceived economic worth to prejudice the treatment you provide or arrange.*<sup>3</sup>

Complex patterns of discrimination may arise against some older people, for example female ethnic minority elders. The National Service Framework (NSF) for Older People begins with Standard 1: Rooting out Age Discrimination.<sup>2</sup> Age discrimination scrutiny groups now monitor NHS services, to identify areas of ageism and encourage the development of a non-ageist approach to the allocation of resources.

### Protecting vulnerable older people

Older people affected by physical disability may be more vulnerable to both physical and psychological injury, but those whose cognitive functions are waning are at most risk of injury and abuse. In many cases the abuser is also a carer, and potentially abusive situations may be avoided if carer strain is identified

early enough. There is no equivalent of the Children's Act to protect older people, but social services can activate their adult protection procedures if physical, sexual, psychological or financial abuse is suspected. Cases of institutional abuse still occur; these may demonstrate the fine line between precautions to protect the vulnerable and the abusive use of restraint, which may include the inappropriate prescribing of sedative medication.

The Law Society and the British Medical Association (BMA) have published a practical set of guidelines on the assessment of mental capacity.<sup>5</sup> The components of mental capacity are defined as being the understanding, retention, belief and consideration of information before a judgement and a choice are made. In 1999, the Lord Chancellor, having consulted on a paper entitled *Who decides?*, announced proposals for changing the law on mental incapacity in the policy statement *Making decisions*.<sup>6</sup> These include:

- the establishment of a new statutory test of mental capacity (based on comprehension of the specific decision at hand)
- a presumption of capacity unless proved otherwise, and
- a requirement to encourage and enable residual capacity where present.

A new continuing power of attorney would allow people to nominate friends or relatives to make health and welfare decisions on their behalf should they lose the capacity to do so. A doctor would be asked to certify that a patient is mentally capable of nominating an attorney, and a medical certificate would also be required later when the patient loses the capacity to take health and welfare decisions. New legislation would make it an offence wilfully to neglect a person without capacity.

The Scottish Parliament has already legislated on similar proposals, and the Adults with Incapacity (Scotland) Act was given Royal Assent in 2000. Scottish doctors are therefore already expected to consult the previously nominated attorneys of incapacitated patients about healthcare decisions.

### Key Points

Older people should be treated according to their needs regardless of age

Older people may be subject to abuse especially if they are cognitively impaired

No adult can give consent on behalf of another, incompetent adult

Older people are entitled to receive all the personal medical information they ask for or need

The mental capacity to perform a task is specific to the task in question

The sharing of confidential information with other care organisations should be subject to the specific consent of the patient

Competent patients have the right to refuse life-prolonging treatment, including refusal in advance of their loss of capacity

Competent patients should normally be included in discussions about their resuscitation status unless attempted resuscitation is physiologically futile

**KEY WORDS:** abuse, advance directive, ageism, capacity, confidentiality, consent, resuscitation

An alliance of 14 organisations concerned with older people, including Age Concern and the Stroke Association, has begun to campaign for new mental capacity legislation to be included in the next Queen's Speech.<sup>7</sup>

### Keeping older people informed

The GMC advises that all patients be given the medical information they ask for or need.<sup>3</sup> Older people may be particularly subject to misjudgement of their mental capacity to consent, either because of difficulties of communication (eg deafness) or because of delirium. Efforts should be made to restore and enhance competence before decisions are made about a patient's capacity to consent. The capacity to perform a task is specific to that task, and the capacity to consent to treatment does not imply that the person has testamentary capacity (the mental capacity to make a will). The BMA and the Law Society have published specific guidance on this (including advice to doctors who are asked to witness legal documents).<sup>5</sup>

Recent Department of Health (DH) guidance on consent has confirmed that even close members of the family cannot give consent on behalf of an incompetent patient. However, the new consent forms give them the option of countersigning a form which records procedures to be carried out in the best interests of the patient.<sup>8</sup> Should the Lord Chancellor's proposals become law, a relative with power of attorney for healthcare would be empowered to consent on the patient's behalf.

### Respecting the confidentiality of older people

Doctors should have the permission of their patients to discuss their diagnoses and treatments with friends or family members, and try to avoid the habit of routinely discussing confidential medical information with families before doing so with patients. It has been suggested that the taking of an 'ethical history' might include asking the patient if they wish to be informed of investigation

findings and who they would like to be with them when they are told.<sup>9</sup>

The NSF includes a 'single assessment process' for all agencies involved in the care of an older person. If assessment findings are to be shared with other agencies, then patients should be asked whether they consent to the sharing of that information. Even those whose capacity is impaired still have a right to expect healthcare workers to respect their confidentiality. Disclosure is permitted when it would be 'in the public interest.'

The GMC gives specific advice on the disclosure of medical concern about fitness to drive. Disclosure may be made directly to the Driver and Vehicle Licensing Agency (DVLA) if attempts to achieve voluntary reporting have been unsuccessful.<sup>10</sup> Medical recommendations should be based on clinical assessment, not on the patient's age.

### Advance directives and treatment refusal

According to the DH guidance on consent:

*Case law is now clear ... An advance refusal of treatment which is valid and applicable to subsequent circumstances in which the patient lacks capacity is legally binding.<sup>8</sup>*

If a directive appears to be directed against a patient's best interests, further ethical and legal advice should be sought.

There have been several cases in which courts have referred to the legal position of advance directives, although the validity of a formal written advance directive has yet to be examined in an English court. The recent case of Ms B, whose artificial ventilation was discontinued following a judgement by the High Court, was consistent with the established legal position of competent patients, that a person is at liberty to decline treatment in advance, 'including artificial feeding, designed to keep him alive'.<sup>11,12</sup>

In the case of incompetent patients, the BMA and the GMC recommend a second medical opinion if artificial hydration and nutrition are to be withheld or withdrawn.<sup>13</sup> A recent article

describes the ethical issues involved in feeding by gastrostomy.<sup>14</sup>

### Making resuscitation decisions

A competent patient is usually in the best position to judge whether post-arrest complications would be worth risking for a chance of prolonging his or her life, but detailed discussions are required for this decision to be properly informed. Sayers *et al* found evidence of the distress and confusion that may result from isolated resuscitation discussions. They proposed that ethical issues could be routinely included in a patient's medical history to allow resuscitation decisions to be made in the context of the patient's general life views.<sup>9</sup> In the case of an incapacitated patient, doctors are expected to take such a decision in the best interests of the patient after consulting the family. According to the BMA:

*our duty to protect life must be balanced with our obligation not to subject our patients to inhuman or degrading treatment.<sup>15</sup>*

Article 14 of the Human Rights Act is the right to be free of discrimination. Discrimination on the basis of age is unethical and, according to Article 14, would now be regarded as unlawful. Although old age has been identified as a prognostic factor in studies of cardiopulmonary resuscitation outcomes, it by no means precludes successful resuscitation. The outcome is more favourable if the arrest is witnessed, and this may be referred to in discussions about resuscitation.<sup>16</sup> Many older people would like to have the opportunity to discuss resuscitation with their doctors, some expressing a preference to keep such discussions confidential even from members of their family.<sup>17</sup> If consultation is to be handled with the necessary sensitivity, the close involvement of senior medical staff in making these decisions will require a considerable investment in time with each patient.

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## How far to investigate older people?

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When assessing older people, clinicians are often faced with difficult decisions in deciding how far to investigate them. There are now guidelines for the investigation of most common clinical problems, but these often fail to address common situations of comorbidity, disability and cognitive impairment in older people.

The principle of assessing potential benefits and risks before embarking upon a medical investigation is important for patients of all ages and all medical specialties. However, decisions in older patients can involve many different factors; this complexity poses a considerable challenge. This article examines key issues that should be considered when deciding how far investigation should be pursued in an older patient, illustrating these processes of assessment and decision-making with common clinical problems in three different patient case scenarios.

### Identifying key factors that may influence a decision to investigate

#### Major physical comorbidity

Multiple pathology becomes increasingly common with advancing age, with an increase in many chronic diseases.<sup>1</sup> When assessing an older patient it is therefore more appropriate to use a process of identification of problems and problem solving rather than to seek a single unifying diagnosis to explain all the patient's symptoms and clinical

signs. People over 70 years have an average of five medical complaints.<sup>2</sup> Conditions that become particularly common include:

- ischaemic vascular disease
- hypertension
- diabetes mellitus
- osteoarthritis
- visual impairment, and
- deafness.

Symptoms of ischaemic heart disease (angina or previous myocardial infarction) are present in 20–30% of people over 65 years of age and 5–10% have a history of stroke.<sup>1</sup> Faced with an older patient with multiple comorbidities, the clinician has to make a judgement as to which of these are most likely to be adversely affecting quality of life (QoL) and which will be the limiting factor in determining life expectancy. Effective prioritisation ensures that investigations are selected that are most likely to give useful prognostic information or lead to a change in management.

#### Cognitive impairment

The prevalence of chronic cognitive impairment increases with advancing age. This includes mild problems (present in ca 16% of those over 65 years) which do not fulfil standard criteria for diagnosis of dementia.<sup>2</sup> This syndrome is now known as 'mild cognitive impairment'. Such subjects are at high risk of progressive cognitive decline.

About 8% of over 65s have dementia, rising to 40% in people over 90.<sup>3</sup> Dementia is associated with a high mortality, with a mean survival of approximately seven years from the time of diagnosis in Alzheimer's disease patients.<sup>4</sup> It is also a major cause of impaired QoL. However, the boundary between minimal cognitive impairment and dementia is somewhat arbitrary and difficult to define. Different diagnostic criteria for dementia mean that the proportion of patients given the label of dementia varies up to tenfold.<sup>5</sup> Great caution should therefore be exerted in the use of the term 'dementia' and it is often preferable to use the label of 'chronic cognitive impairment'.