Editorial

Caring for the Elderly: Striking a Balance

by Barry R. Furrow, J.D.

In this issue, we publish a set of proposed guidelines for supportive care for nursing home residents, as drafted by a group of professionals in Minnesota concerned with the problems presented by the elderly, debilitated patient. The topic is timely, since the need for a framework for decisions has become increasingly apparent.[1] Physicians responsible for treating elderly patients have expressed considerable anguish over the difficulties of decisionmaking. As one doctor recently wrote:

> [T]he primary-care physician faces this complex dilemma alone. Because we have ignored the frequency with which such situations arise and their tremendous ethical importance, we force the physician into making profound ethical choices unprepared.[2]

The issue of providing only supportive care, rather than more aggressive medical intervention, is controversial. In speaking to a health law group this past April, Governor Richard Lamm of Colorado stated in effect that we have a duty to die and get out of our children's way, and a right to die without medical intervention.[3] A tremendous furor was created; some groups called for his impeachment, while others praised his forthrightness. Thus, we also present here the views of Jane Hoyt and James Davies, for the Nursing Home Action Group (NHAG), which objects to the *Supportive Care Plan* on the grounds that it is confusing and disregards the rights of the disabled. The NHAG concedes, however, the value of guidelines in dealing with difficult treatment decisions regarding elderly patients in nursing homes; the difference is one of emphasis.

Guidelines may ultimately serve several purposes. First, they will ease, if not resolve, the dilemmas facing the treating physician. Such guidelines offer helpful criteria for making supportive care decisions, developing a hierarchy of decisionmakers, and relying on the institutional ethics committee to evaluate choices. Second, guidelines may prevent staff slides down the slippery slope into thoughtless decisions to deny care—one of the worries expressed by Hoyt and Davies. Nursing homes have often been criticized as "geriatrics barracks;"[4] carefully drafted guidelines may offer protection for incompetent patients as well as help for decisionmakers. Third, where the patient is totally or partially competent, or a family member is available, such guidelines can promote patient and family decisionmaking autonomy. Fourth, guidelines can foster an environment in which patients and family members can articulate treatment desires in advance of a crisis. Frequently, both patients and their families fail to prepare for the crisis which arrives when an elderly patient begins to fail. Fifth, if such guidelines become generally accepted as a useful model, they will also provide a partial shield against legal liability, whether criminal or tortious, since they indicate a standard of professional practice. In the current uncertain legal climate which leaves many health care professionals worried about potential liability, guidelines provide some protection.

Shortly after I received these guidelines for review, I encountered a supportive care issue directly. A close personal friend had recently placed her elderly father in a nursing home, for she had trouble caring for him at home. One night, she received a call from the night nurse, who reported that the father had developed a very high fever. Would my friend like to have her father taken to the hospital for treatment? She was startled at suddenly being asked to decide between minimal care at the nursing home, with death probable, or active intervention at the hospital. She asked that he be treated. He was then rushed by ambulance to the emergency room of a major university hospital. She waited in the lobby, and after an hour, the physician on duty approached her, explained what they had discovered, and asked whether she wanted her father admitted to the intensive care unit. Again surprised at the choice, she asked that he be admitted.

In this situation, two health providers in different settings had offered a family member a choice as to aggressive treatment or supportive care. In neither case had the family member been prepared. She had not discussed the range of options with her father or with the medical staff. No living will or other document indicated her father's wishes. No ethics committee considered the issue. A set of guidelines would probably have better served the medical staffs, and my friend, in developing a plan in advance of the crisis. In the absence of any family member, and in caring for an incompetent patient, such guidelines would be even more valuable.

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References

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