"Everyday Ethics" in the Care of Hospitalized Older Adults

Jennifer B. Seaman ▼ Judith A. Erlen

As the U.S. population ages, the proportion of hospitalized patients older than 65 years will continue to increase with a significant number likely to have some degree of cognitive impairment. Because of the high rate of falls-related traumatic injury among older adults, many will require orthopaedic services. These patients may have multiple comorbidities and are at increased risk for complications. Varying degrees of cognitive impairment in combination with possible postoperative complications including delirium places these patients at risk for decreased decisional capacity and can create ethical dilemmas during the provision of bedside care. This article explores some everyday ethical dilemmas that nurses face in their care of hospitalized older adults, and offers nurses strategies to preserve patient dignity and self-determination while providing high-quality, evidence-based nursing care.

As the U.S. population ages, an increasing number of older adults will sustain injuries or experience conditions that require orthopaedic care. Older adults comprise more than 13% of the nation's population (U.S. Department of Commerce, US Census Bureau, 2011) but make up more than 25% of patients who experience a trauma-related injury (American College of Surgeons, National Trauma Databank, 2012). More than half of these injuries are falls-related. Many of these older adults who experience traumatic injury will have multiple preexisting comorbid conditions and the distinct possibility of some level of cognitive impairment. Their risk for complications, including postoperative delirium, is significantly greater than that of their younger counterparts (Werman et al., 2011). In addition, numerous older adults are admitted for elective orthopaedic procedures and may experience similar complications. As older adults encounter increasing frailty and vulnerability, the preservation of dignity and self-determination becomes an important ethical concern for this patient population. The goal of this article is to illustrate some of the everyday ethical dilemmas that may arise as nurses provide care to hospitalized frail older adults and offer nurses strategies to preserve patient dignity and self-determination while providing high-quality, evidence-based nursing care.

The following hypothetical case illustrates several of the ethical issues that may occur when such a patient is admitted postoperatively to an orthopaedic unit.

> Mrs. Ellis is an 80-year-old community-dwelling older adult with a history of arthritis, congestive heart failure, mild cognitive impairment, and a bowel obstruction. She fell at home and has been admitted to your unit post–open reduction and internal fixation of a left hip fracture. Three days postoperatively she is experiencing abdominal distension and cannot tolerate clamping of her nasogastric tube. You are taking care of her for the first time today. The surgeon has ordered a computed tomography (CT) scan of her abdomen to rule out ileus. You prepare to send her to radiology, but when you bring the carrier in, she is adamant that she does not want to go.

One might reasonably question whether the situation described earlier represents an ethical dilemma. On the surface, having the test is in Mrs. Ellis' best interest. Yet, the nurse does not have explicit voluntary consent for the test from her; rather, the nurse is following the orders that have been written. Following the orders is the source of this everyday ethical dilemma.

Consent

Patient consent is necessary, even for minor tests such as a CT scan. For patients who undergo surgical procedures, there are well-established guidelines for the informed consent process. Assessments of capacity are made, and healthcare professionals determine if the individual has the capacity to consent to the surgical procedure being recommended. If it is decided that the patient lacks sufficient capacity to appreciate the risks and benefits of the procedure and make an informed, reasoned choice, a surrogate decision maker is identified (Buchanan & Brock, 1989). The surrogate then weighs the risks, benefits, and alternatives, considering the patient's values and preferences to arrive at a decision. Only when there is absolutely no one with knowledge of

Jennifer B. Seaman, BSN, RN, 2011–2013 Pre-doctoral Scholar, University of Pittsburgh, School of Nursing, John A. Hartford Foundation, Building Academic and Geriatric Nursing Capacity.

Judith A. Erlen, PhD, RN, FAAN, Professor & Chair, Department of Health and Community Systems, School of Nursing Professor, and Professor, Center for Bioethics and Health Law, University of Pittsburgh.

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the patient's values is it ethical to make a decision based simply on what a "reasonable person" in similar circumstances might choose (Beauchamp & Childress, 2009). This formalized process serves to maximize and preserve patient autonomy.

However, for many routine tests and treatments there is no formal process for obtaining consent. Patients are admitted to the hospital and sign blanket "consent to admission and treatment" agreements, which provide implicit consent to routine care. With the advent of evidence-based practice, much of this treatment has become protocol-driven to ensure that all patients receive the optimum treatment. Although most patients are likely to want this scientifically validated care, healthcare providers often forget the full definition of evidence-based practice: practice that incorporates the most relevant evidence, one's clinical expertise, *and the patient's preference and values* (Melnyk & Fineout-Overholt, 2005, italics mine). In addition, the American Nurses Association (ANA) Code of Ethics states that the nurse will uphold the patient's right to self-determination to the greatest extent possible and that the nurse's primary commitment is to the interests of the patient (ANA Code, 1.4, 2.1; ANA, 2001).

Clinical and ethical standards require that nurses inform patients about the care provided and recognize their right to question or refuse it, even if nurses do not necessarily agree with the patient's choice. This applies to venipuncture, diagnostic tests, and other treatments that are considered to be routine. Thus, consent is important for the "little things"—things that do not necessarily have signed consent forms, just as it is for major procedures. Involving patients in decisions about their ongoing, day-to-day care whenever possible demonstrates nursing's commitment to their dignity and self-determination.

With that in mind, how should the nurse address the situation with Mrs. Ellis? The nurse wants to maximize the patient's autonomy, but simply allowing Mrs. Ellis to refuse the test, while ostensibly supporting her autonomy, may not best serve her health interests. Nurses may be helped at this point by exploring the concept of autonomy, or self-determination, framing it in relationship to other bioethical ideals, and considering an alternative ethical paradigm.

Ethical Principles and Frameworks for Decision Making

Traditionally, a principles-based approach has been used to deliberate ethical dilemmas in clinical care, such as the one described previously. Healthcare professionals are encouraged to consider the four key principles—autonomy, beneficence, nonmaleficence, and justice—in relation to the case of Mrs. Ellis and strike a balance that maximizes good and minimizes harm to the patient. Autonomy refers to an action being freely chosen without coercive influence and is generally considered the most important principle in the equation. Beneficence or "doing good" requires that the action being contemplated will result in an actual benefit to the patient. Nonmaleficence demands that the risks of harm from an action are minimal or do not outweigh the potential benefits. Justice requires that benefits and burdens are borne as equally as possible across groups (Beauchamp & Childress, 2009).

But a principles-based approach alone may not be adequate to effectively deliberate ethical dilemmas. A number of bioethicists have questioned the artificiality of the principles-based approach. One of the major criticisms of this approach is its reliance on the concept of an individual as an autonomous decision-maker. The reality, these ethicists argue, is that individuals often require the input that family, close friends, clinicians, or clergy may offer when making decisions. In fact, in some ethnic or religious traditions, there are structured approaches to decision making that specifically do *not* place the patient at the center of the decision-making process (Kwak & Haley, 2005). Another criticism of the principles-based approach is that by viewing the dilemma and the individual as isolated from the clinical and social contexts of the community, healthcare providers may fail to see the impact the decision may have on those other critically important relationships and points of view (Wolf, 1996). The Feminist bioethical perspective offers an alternative approach to ethical dilemmas that may be a better fit for the everyday clinical context in which most nurses and other healthcare professionals practice.

A Feminist Perspective

There is not a single theory of Feminist bioethics; from the work of Feminist scholars in bioethics there are several key shared ideas. A major theme in the Feminist perspective is the value of relationship and the need to make decisions that preserve and reinforce relationships. Another important element of the Feminist perspective is the importance of caring. In the context of the healthcare setting, the nurse–patient relationship exemplifies both of these values. Bioethicists from the Feminist perspective would argue that in everyday decision making, nurses strive to find solutions that reinforce relationships and uphold values of caring, empathy, and integrity. This is not to say that the traditional principles are irrelevant in decision making. Rather, principles alone cannot address all dimensions within the larger context of the patient situation.

According to the Feminist bioethical perspective, organizational structures, especially those that have been traditionally male-dominated, tend to reinforce power imbalances that result in poorer healthcare for members of marginalized groups such as women, minorities, older adults, those with disabilities, and those in poverty. Therefore, applying the classic bioethical principles across the board, as if all are working from a "level playing field," may be detrimental or too simplistic to address the issue. Feminist theorists would argue that there is a need to acknowledge these imbalances and strive to promote decision making based on relationships, caring, and recognition of the unique needs of the individual. Hospitalized older adults, especially those who are disabled cognitively, operate from a position of extreme disadvantage. From this perspective, the obligation of nurses and other healthcare professionals to promote the dignity and well-being of frail older adults

becomes even more compelling. Hence, the Feminist approach more accurately mirrors the world of patients, where decisions are made collectively; the world of nurses, where the ethic of caring is of central importance; and the larger social context, where the preservation of relationships is perhaps more highly valued than individual bioethical principles in isolation.

In returning to the dilemma of Mrs. Ellis, applying elements of the Feminist bioethical perspective to the situation allows one to arrive at strategies that move beyond the principles-based approach. The first strategy should be to ensure that Mrs. Ellis has adequate information by offering a thorough explanation of the test that was ordered. The nurse needs to take the time to explain and assess that Mrs. Ellis understands why the CT is recommended and identify and address any misconceptions. Hearing and visual deficits may be barriers to understanding; therefore, making use of hearing aids and glasses can help minimize any communication difficulties. Another possible reason for the refusal may be fears and/or anxiety about symptom exacerbation. So, instead of directly proceeding to deliberate Mrs. Ellis' superficially autonomous choice such as the benefits of the CT scan and the possible risks of refusing it, the nurse also needs to understand the *context* of Mrs. Ellis' refusal.

> After explaining the CT scan process to Mrs. Ellis in simple, concrete language, you also explain the specific reasons it has been ordered. You then ask her if she has any concerns about the test. She reveals that her back is bothering her; she is worried about it getting worse, especially if she has to remain on her back in the scanner. You offer to call the doctor to discuss options for pain medication. You obtain an order to give an analgesic now and arrange to have the test rescheduled for 1 hour later. You share this information with Mrs. Ellis. After about 45 minutes, she is feeling much better, and agrees to proceed with the CT scan.

By considering the dilemma in the context of the patient situation, along with the nurse's desire to maintain an empathetic, caring relationship, a higher level of patient self-determination is actually achieved. Furthermore, the trust relationship between the patient and the nurse has been upheld and strengthened.

A Final Thought on Autonomy and Decision Making

Facilitating autonomous decision making for patients would be very straightforward if healthcare professionals could simply designate patients as competent or incompetent to make healthcare decisions. However, in reality, decision making is more nuanced. Capacity to make decisions is not a fixed determination but is instead assessed in proportion to the risk inherent in a particular decision. For example, a patient with mild cognitive impairment may have the capacity to decide about a p.r.n. (as-needed) medication—"I'd like to try one pain pill first, and if that doesn't work, I'll take the second one." Given the minimal risks involved in the decision, the patient meets the threshold to make an autonomous choice. So although some patients may not have capacity to make high-risk decisions (i.e., for surgery or chemotherapy), they have not "checked their autonomy at the door" and should be involved in decision making about their care to the extent to which they are able.

Conflicts Around Goals of Care

Another area where every day ethical conflicts frequently arise is clarification of goals of care. Quite possibly a Feminist approach to an ethical dilemma may offer a better solution than the classic principles-based approach. Consider the following clinical situation.

> Mr. Charles is a 78-year-old widower with three very concerned and supportive daughters. He was admitted after his leg "gave out" while he was walking. Mr. Charles suffers from multiple conditions including chronic obstructive pulmonary disease (COPD), severe osteoarthritis, and chronic renal failure, which requires hemodialysis. Over the past two years his health has been in decline. Last year he experienced acute cholelithiasis and required long-term care for several months following surgery. The orthopedic surgeon has just told him that he recommends hip replacement surgery. Mr. Charles' daughters are optimistic and encouraging; they're sure he will be so much better after his hip replacement. However, he tells you, his nurse, that he really doesn't want to have surgery again—he just wants to go home.

Using a principles-based approach would likely result in escalating family conflict. Considering that Mr. Charles has the capacity to make the decision about the hip surgery, the logical conclusion would be to honor his autonomous choice. However, if his daughters are excluded from the discussion, they are likely to become angry and distrustful, believing that the staff does not recognize that they have their father's best interests at heart. A Feminist approach, however, would consider patient preferences in the context of the clinical situation and the relationships involved.

When approaching Mr. Charles' situation, the nurse considers that he lost his wife within the last 18 months and has had multiple hospitalizations; there is a reasonable likelihood that Mr. Charles may be suffering from depression. Therefore, the nurse needs to recognize the importance of evaluating his psychological state, as depression can affect decision making. A geriatric or psychiatric consultation could provide such an assessment. Also, Mr. Charles' pain is not well controlled; an ideal group to address this issue is the palliative care (PC) consultation service. In fact, the PC service can likely address his possible depression and pain control issues, as well as explore the values and preference that may be underlying his decision to refuse surgery.

> You approach the primary care physician (PCP) with your dilemma. You want to support Mr. Charles' decision, yet you believe that there is more to the picture and are concerned how his daughters may react. You suggest a consult to the PC service; the PCP agrees. A physician from the PC service comes, reviews the records, and has a long discussion with Mr. Charles.

The PC physician tells him she would like to have a family meeting to discuss his options, and Mr. Charles agrees. In the family meeting, the PC consultant is aware of the family dynamics and is able to help depict Mr. Charles' perspective. She explains that Mr. Charles has experienced multiple losses over the past 2 years and is experiencing some grief as a consequence. She also identifies poor pain control as another major source of stress to him. All-in-all, the prospect of surgery and rehabilitation is overwhelming at this time. She proposes that Mr. Charles begin a regimen including an antidepressant and daily pain medication and return home on these medications. After the medications are adjusted, he will then consider returning for hip replacement surgery. The daughters are disappointed that he will not have the surgery immediately, but they recognize his need to gain some strength and have better pain control.

By involving the PC service, Mr. Charles has gained not only the benefit of the physician's clinical expertise but also her skill in advocating for his wishes. By using a Feminist approach, the patient's interests remained central to the decision-making process; however, the interests of the daughters, the other key players, were also included in the decision making.

Conclusion

The combination of an aging population, continued increasing life expectancy, and high rates of traumatic injury and chronic illness has resulted in a growing number of older adults requiring inpatient hospitalization. The prevalence of chronic illness and cognitive impairment for this population increases the complexity of care required and leads to new ethical issues. This demographic shift and the resulting challenges demand new discussion and exploration of strategies to address the inevitable ethical dilemmas that arise.

While a principles-based approach to ethical dilemmas addresses basic elements to be considered in decision making, the artificiality of a single decision-maker isolated from the context of the family and care environment can lead to decisions that are suboptimal. A Feminist bioethical perspective, however, takes into consideration the limitations of cognitive impairment, care needs, and ongoing relationships with family and caregivers.

The goal of this article is not to imply that this work is easy or that these approaches will result in easily identified solutions for the ethical dilemmas nurses will face. Instead, these ideas and clinical scenarios are offered with the utmost respect and appreciation for the difficulties nurses face in daily practice, where the lines are not so clearly drawn creating the need for nurses to address multiple competing interests. The hope is that these ideas will help nurses frame difficult decisions in ways that reflect the complexity of contemporary nursing practice.

Readers may find it useful to put themselves in the role of the nurse caring for Mrs. Ellis and Mr. Charles and ask the question, "What would I have done? Would I have considered these other contextual factors? In my healthcare setting, would there have been barriers to my acting as a professional nurse?"

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