1.6 Elder abuse and neglect

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Educational Objectives

By the end of this case study, the physician will gain a better understanding of:

1. The professional duty to respond to cases of elder abuse and/or neglect in a comprehensive and timely manner.
2. The importance of determining capacity and assessing risk in cases of elder abuse and/or neglect.
3. The substantive and procedural ethics principles that can help guide decision making in cases of elder abuse and/or neglect.

Case

Mrs. C is an 84-year-old woman who was brought to the emergency department (ED) after her concerned landlord called the paramedics. The paramedics report finding Mrs. C seated in a recliner, unable to get up. Mrs. C is unable to give an account of how long she had been stuck in the chair; the paramedics estimate somewhere between 24-48 hours.

Mrs. C. is a widow who shares her apartment with her only child, Donald. Donald acts as Mrs. C’s primary caretaker and was not in the apartment when the paramedics arrived. According to the landlord, Mrs. C’s health has been in steady decline over the past year. Sometimes he hears her yelling at night, and on a few occasions he has found her in the building’s garbage room, eating from a can of discarded food. The landlord is very worried about Donald’s ability to care for Mrs. C; he cites multiple prolonged absences and sometimes seeing Donald “drunk.” The paramedics note that Mrs. C’s apartment is filthy, there is no food in the house, and Mrs. C’s medication bottles are either empty or expired. There are no mobility assist devices in the house.

Upon arrival at the emergency department (ED), Mrs. C is clinically stable though mildly hypotensive and tachycardic, and has a slight fever. She is somnolent but easily rousable and she is disoriented to place and time. She is moderately dehydrated and appears to be malnourished. Her arms and trunk are covered in excoriations, some of which are infected, and she has a stage II pressure ulcer on her buttocks. Her personal hygiene is extremely poor; her legs are covered in dried feces and she smells strongly of urine. Her past medical history includes a remote CVA with hemiparesis and mild aphasia, arthritis, and a history of multiple falls. She is diagnosed with a urinary tract infection and “failure to cope.” The plan is to admit her to the short stay unit of the hospital. Geriatrics and social work are consulted.

After 24 hours of hydration and antibiotics, Mrs. C’s vital signs have improved and she is more alert, though remains disoriented. She frequently repeats the word “home” to the nurses, though does not exhibit any exit seeking behavior. Her son Donald arrives and after visiting briefly with Mrs. C announces he would like to take Mrs. C home, believing she “will be more comfortable there and that is what she wants.” Multiple members of the treating team explain to Donald that Mrs. C requires medical care and that discharging her now would be against her medical best interest. Donald is adamant: he states that he acts as Mrs. C’s power of attorney (POA) for personal care and finances, and that he is taking her home.

Questions

1. Is this case an example of elder abuse? If so, what are the legal and ethical implications of this?
2. Why is assessing capacity important in this case? Who is responsible for assessing Mrs. C’s capacity?
3. If Mrs. C is found capable of making her own discharge decisions, to what extent should her desire to return home be balanced against a professional duty to promote her well-being? How might this be negotiated?
4. If Mrs. C is found incapable of making discharge decisions, does this change the decision-making process? Does an SDM who is also an alleged abuser continue to have the authority to make treatment decisions on a patient’s behalf? Are healthcare providers required to assess the SDM’s capacity as well?
5. Describe the ways in which agesism (both on an institutional and individual level) might play a role in the evolution and resolution of this sort of case?
Discussion

The World Health Organization (WHO) defines elder abuse and neglect as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person." Elder abuse includes physical abuse, emotional/psychological abuse, financial/material abuse, sexual abuse, and neglect. Ageism, broadly defined as negative social or individual attitudes towards older adults, may contribute to, or enable abuse and/or neglect. In the healthcare context, ageist attitudes may result in negative assumptions of patient capacity, removal of an older patient’s decision making power, ignoring a capable person’s wishes, or treating an older adult like a child. Healthcare providers should reflect on their assumptions about the elderly and ensure that they are not treating older adults in demeaning, discriminatory, or dismissive ways.

Prevalence rates of elder abuse reported in international studies range from 3.2% to 27.5% depending on the definitions of abuse employed and the survey methods adopted. In Canada, it is estimated that 4% of non-institutionalized older adults have suffered some form of abuse/neglect. Populations who are especially vulnerable to abuse include the very old, those with limited functional capacity, women and the poor. Some of the consequences of elder abuse include physical trauma, loss of dignity and self-respect, and increased hospitalization. Elder abuse and neglect has also been associated with increased mortality in older adults. Since accounts of “granny battering” were first published in 1975, the WHO reports that the medical community has been slow to respond to the issue of elder abuse and neglect. Some research indicates that this may be precipitated by an overall lack of awareness and clarity on what constitutes abuse and neglect amongst health care professionals. Even when cases of elder abuse and/or neglect are identified, the lack of a legal framework may result in cases being inadequately addressed. In Canada, there is no specific crime of “elder abuse” though certain aspects of elder abuse and/or neglect may be classified as criminal acts under the Criminal Code (for instance: failing to provide the necessaries of life, s.215; theft, s.334; physical assault, s.265, amongst others.) Moreover, the legal guidance that does exist (mandatory reporting of elder abuse for example) varies according to provincial/territorial legislation, and is subject to additional considerations including whether the abused older adult is capable or incapable of making decisions, and whether the abuse took place in an institution/retirement home or in the community.

Recognizing and addressing elder abuse is fundamental to honouring the dignity and universal human rights of older adults and is a responsibility of all physicians.

Q1. Is this case an example of elder abuse? If so, what are the legal and ethical implications of this?

Mrs. C appears to be suffering from neglect, defined as “the intentional or unintentional failure to provide for the basic needs of an older adult.” Neglect is a form of elder abuse. The evidence suggests that Donald has failed to provide Mrs. C with the necessities of life, including adequate food, water, medication, social interaction, and personal hygiene. Mrs. C might also have suffered from abandonment – she has been left alone for long periods without the means to care for herself. The physician, in collaboration with the inter-professional team, should conduct an assessment investigating the suspicion of abuse.

Legal obligations surrounding elder abuse and neglect depend on a variety of factors. Although there is no specific crime of elder abuse in Canada, there are varied provincial/territorial laws that apply in these cases. For instance, some jurisdictions have laws that apply to older adults living at risk, while others have laws that only come into effect once elder abuse has occurred. Certain provinces/territories have legislation requiring mandatory reporting of elder abuse. Physicians should be familiar with elder abuse and neglect laws in their region. The Canadian Centre for Elder Law’s (2011) “A Practical Guide to Elder Abuse and Neglect Law in Canada” provides a helpful overview of provincial/territorial elder abuse and neglect law across Canada. (Available at http://www.bcli.org/project/practical-guide-elder-abuse-and-neglect-law-canada)

Cases of suspected or confirmed elder abuse often give rise to many ethical issues. Physicians caring for Mrs. C may experience uncertainty in deciding how to negotiate the dual obligations to respect patient autonomy and the professional duty to promote patient wellbeing. Physicians may struggle with whether or not it is right to permit an older adult to return to an abusive situation, despite the risk involved. In this case, negotiating the topic of elder abuse with Donald (the primary caretaker and alleged abuser) may be difficult for several reasons, not least of which is the fear that such discussion may potentially subject Mrs. C to greater risk of reprisals or future abuse. Furthermore, assessments of present and future risk of abuse/neglect may be complicated by a degree of uncertainty, or by disagreement within the care team about the degree of intervention required.

Q2. Why is assessing capacity important in this case? Who is responsible for assessing Mrs. C’s
Capacity assessments are particularly important in cases of elder abuse/neglect, because capable adults are entitled to make decisions that incapable patients are not. Capable patients can choose to live in risky situations, including with people who may be abusive. When patients are deemed incapable, there can be greater justification to limit their autonomy in favour of protecting the older adult from harm. This stems from the physician’s duty to protect a vulnerable patient who may lack the self-reliance and the ability to independently access support and assistance when needed.

The healthcare professional who is proposing a treatment or care plan is responsible for assessing whether Mrs. C is capable of making a treatment-related decision. The physician who is proposing admission to the Short Stay unit and continued intravenous therapy has a responsibility to assess whether Mrs. C has the ability to understand and appreciate the consequences of refusing antibiotic therapy/hydration and leaving against medical advice. The rule of thumb is that a person is considered capable unless a healthcare professional has “reasonable grounds” to suspect otherwise.13 Mrs. C’s confusion and disorientation may suggest incapacity but alone is insufficient evidence. The test for capacity varies depending on province/territory; however, three clusters of patient abilities are generally required for competence: 1) ability to formulate a preference, 2) ability to understand the information provided, and 3) ability to reason through the consequences of accepting or declining a recommended treatment or treatment plan.14 Mrs. C retains all decision-making authority until she lacks the abilities in at least one of these domains; as the POA for personal care, Donald can only make decisions on Mrs. C’s behalf once incapacity has been established.

Capacity can fluctuate, and should be reassessed whenever (1) a patient’s condition materially changes – for instance, Mrs. C’s capacity to make decisions may improve as her dehydration and infection resolves, and (2) whenever a new treatment or service is proposed – that is, capacity assessments are specific; Mrs. C may be able to consent to one intervention and not another. In the event of uncertainty regarding determination of capacity, a second opinion should be sought.

O’Connor, Hall and Donnelly (2009) offer a discussion of assessing capacity in situations of elder abuse and neglect.

Q3. If Mrs. C is found capable of making her own discharge decisions, to what extent should her desire to return home be balanced against a professional duty to promote her well-being? How might this be negotiated?

Mrs. C. requires acute care and the physician and treating team should negotiate with her in an attempt to keep her in hospital until her condition has stabilized and a “safe” discharge can be ensured. Her son has indicated he wants to take her home but the patient needs to be engaged in this decision (preferably in private, at least for the initial conversation). Patients seldom want to be discharged against medical advice and persistent refusal of treatment in the face of a reversible serious or life threatening injury is rare and often suggests either a failure of communication, or a lack of capacity. Capable patients are legally entitled to leave AMA; however, any refusal of treatment or care should be carefully documented.

A more common scenario is that Mrs. C agrees to remain until she is stable (for instance, transitioned to PO antibiotics, IV hydration discontinued) but then insists on returning home, even though she will continue to face serious and ongoing harms. If Mrs. C can fully appreciate and understand the actual or potential risks and consequences associated with returning home (malnutrition, falls, isolation, increased risk of morbidity/mortality), then she has the right to choose to do so. Health professionals are often uncomfortable when patients make decisions to live at risk, voicing concerns about patient safety and wellbeing, professional responsibility, and organizational liability. However, these concerns do not override the right of capable older adults to make decisions about how they choose to live their own lives. If Mrs. C is capable and insists on returning home, then a risk mitigation and harm reduction approach may be helpful. The team should consider: what can be done to minimize the risks Mrs. C is facing?

A harm reduction approach to care would, amongst other things, explore the interventions Mrs. C believes are most useful, as well as develop an understanding of risks in the context of Mrs. C’s values, wishes and life experience.2 A comprehensive discharge plan might be put into place to support Mrs. C’s desire to return home and mitigate potential risk. This plan could include: Lifeline services, referral and follow up with home based community care organizations; Meals on Wheels programs; developing a Safety Plan; expanding the circle of care to include willing friends or neighbors; ongoing education, support and respite for Donald; and ensuring follow up with relevant care providers. The expectations and responsibilities for care held by both Mrs. C and the treating team should be clearly defined and documented.

Striking a mutually acceptable balance between patient autonomy and patient wellbeing may prove
challenging. Negotiating these cases takes time and inter-professional collaboration. The care team should hold a meeting to discuss the key issues at stake, consider different possible courses of action, and weigh the potential benefits and burdens associated with each course of action. Beaulieu and colleagues (2010) have developed an ethical decision making framework (available at http://www.nicenet.ca/files/In_Hands.pdf) to facilitate systematic discussion of elder abuse cases. In Mrs. C’s case, the physician may also want to consult the hospital ethicist and/or risk management for support. Decisions should be clearly documented in the patient’s health care record.

**Q4. If Mrs. C is found incapable of making discharge decisions, does this change the decision-making process? Does an SDM who is also an alleged abuser continue to have the authority to make treatment decisions on a patient’s behalf? Are healthcare providers required to assess the SDM’s capacity as well?**

If Mrs. C is found incapable, the decision becomes the responsibility of her SDM. The hierarchy of SDMs is provincially regulated, and physicians should be aware of the ranking of SDMs in their region. As the POA for personal care, Donald is legally entitled to make decisions on Mrs. C’s behalf if she is not capable of doing so. The POA document should be obtained and a copy placed in the patient’s chart.

With some exceptions, there are no hard and fast rules or laws prohibiting an SDM who is also an alleged abuser from acting as an SDM. One exception could include if there is a restraining order forbidding the SDM from interacting with the patient. In most cases, common sense and best judgment should prevail. SDMs must follow established criteria in making a decision on a patient’s behalf: (1) the SDM must honor any prior expressed wishes the patient has made, and (2) in the absence of any prior expressed wishes, act in the best interest of the patient (a standard which incorporates evaluation of the values and beliefs of a patient and the degree to which a patient’s condition is likely to improve or deteriorate with or without treatment). If Donald does not have sufficient evidence that Mrs. C had a clear prior expressed to remain at home, even at considerable risk to herself, then the best interest standard is likely to apply.

According to the best interests standard, Donald must demonstrate that returning home is consistent with Mrs. C’s values and interests and that in returning home her condition is likely to remain the same or improve. If Donald makes no concessions to the importance of improving Mrs. C’s living conditions – for instance, to provide adequate nutrition, mobility assists devices, and/or to allow community homecare providers to assist with medication and personal hygiene – it is arguable that he is not making decisions in Mrs. C’s best interest. In the event that Donald does not seem to be adhering to SDM decision making standards, he can be challenged in court and compelled to act in the patient’s best interests.

All decision makers, including SDMs, must have the capacity to make decisions. If a physician has reason to suspect that an SDM does not have the ability to appreciate or understand the nature of a choice that is being faced, provincial guidelines should be consulted. For example, in Ontario, if a physician believes an SDM is incapable, they must document the reasons for the finding of incapacity, inform the SDM of the finding, and inform the SDM that the next highest rank decision maker becomes the SDM.13 The SDM who is found to be incapable can always appeal the decision in court.

**Q5. Describe the ways in which agesism (both on an institutional and individual level) might play a role in the evolution and resolution of this sort of case?**

Some argue that ageism is prevalent in western medicine. For instance, evidence suggests that older adults are less likely than young people to receive a similar range of medical interventions for vascular disease and transient ischemic attacks.15 In emergency rooms across the country, older adults like Mrs. C with multiple comorbidities and no clearly identifiable chief complaint are routinely referred to as “gen dets” (for general deterioration) or are given a diagnosis of “failure to cope.” Many institutions view these older adults as “social problems” and outside the traditional scope of medicine. In a recent commentary, one medical student describes a “hidden curriculum” which encourages students to turn their attention to younger, more “medical” patients, 16 instead of learning to engage with the complex medical and psychosocial problems of a patient like Mrs. C. This may not be surprising given that only 5 out of 17 medical schools in Canada have a geriatrics rotation, in spite of the increasing size of the Canadian population over the age of 65.16

Ageism may also result in a tendency amongst healthcare providers to view older adults as weak, frail or incapable.3 This bias (whether explicit or implicit) may manifest itself as a lack of respect for an older adult’s values, goals, lifestyles and choices. In Mrs. C’s case, ageist assumptions may result in an approach that devalues or ignores Mrs. C’s wishes and desires, ultimately seeing her only as a vulnerable adult in need of protection. At a minimum, healthcare professionals should be self-reflective
about how their values and beliefs about age, risk and wellbeing inform their approaches to care and decision making.

**Ethical issues/principles addressed in this case**

"Preventing and treating elder abuse means encountering ethical issues at nearly every juncture." 9

**Autonomy:** All patients who have decision-making capacity, including older adults, have the right to make free and informed choices about their health care. Capacity can be thought of as a person’s ability to understand the information being given to them and their ability to appreciate the consequences of either acting or not acting on the information. Assessing capacity is extremely important in cases of suspected or confirmed elder abuse and neglect: if capable, informed consent is required for supportive interventions. A patient who has capacity has the freedom to make a decision to remain in an abusive situation, or take risks, that an incapable patient may not. Capacity may also have implications for an older adult’s ability to access support and assistance.

**Beneficence and non-maleficence:** Physicians have a duty to consider the well-being of their patients and to abstain from causing harm to their patients. Elder abuse cases may be especially concerning when a capable patient chooses to expose themselves to a degree of risk that the treating team is uncomfortable with, or when an SDM maker for an incapable patient makes decisions that do not align with what is perceived to be in the patient’s best interests. When a capable patient chooses to live at risk, there will be a conflict between the ethical principles of autonomy and beneficence. Physicians may struggle with their own values and biases with regards to violence, neglect and the elderly.10 Deliberating about the right course of action in elder abuse cases often involves complicated risk/benefit assessment, especially with respect to discharge planning.

**Confidentiality:** There is general consensus that properly addressing elder abuse requires inter-professional and multi-sector commitment. Community care agencies, hospitals, police departments, emergency medical services, shelters and advocacy groups, are just a few agencies that may be involved in a single case. Deciding when and how to share confidential personal health information among multiple parties should be made with due consideration of the patient’s right to privacy and confidentiality. There may also be concern about who in the treating-team should be informed of suspected abuse for fear of creating prejudice towards the alleged abuser before the claim is substantiated.2

**Justice:** Elder abuse disproportionately affects vulnerable groups including women, the socially isolated and dependent, and the poor. In today’s healthcare context, wait-lists for long-term care facilities or retirement homes may be long or prohibitively expensive, and community services may be inadequately resourced to provide for the medical and psycho-social needs of elderly patients. Examining ethical issues surrounding elder abuse from a macro-level perspective may include contemplating how systemic factors, including resource allocation, impact instances of elder abuse and or neglect.

**References**