ETHICAL CONSIDERATIONS IN THE CARE OF THE DYING ELDERLY PATIENT

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IN confronting the problem of the care for the aged and particularly the right of the aged to die in peace and dignity, mature, responsible medical judgment is of the greatest importance. Nonetheless, even the best medical insight must be subject to ethical considerations that weigh heavily in the ultimate decisions to be reached by those immediately concerned and by those who wish to formulate general principles. One must enter a *caveat* in using the term: "elderly," for there is no dictionary definition which would tell us when old age begins nor is old age synonymous with either physical or mental deterioration. There is no reliable measure to indicate the age, if any, at which senility or advanced arterio-sclerosis and so forth will incapacitate a person. Mental agility and physical dexterity are not necessary functions of age. A similar caution is indicated in hypothesizing lack of recuperative powers in the "elderly." While it is generally assumed that old age brings about a diminishing potential for cellular resilience and reformation, the radically and rapidly changing science of medicine is on the threshold of fundamental changes in concepts and treatment.

"Conventional" notions of a half a century ago are of course outmoded. But by the same token even the most recent medical insights are no longer infallible and there can no longer be any "medical convention" either in diagnosis or in treatment.

Therefore, a formulation of an ethical guide on the subject of the treatment of the elderly and the dying is put forth with the caution that it too must be subject to change, corresponding with the change in medical sciences. With such reservation, the following point of view appears to be pertinent:

I. Hospitalization of the Elderly

If medical views of the psychological and physical hazards in hospitalization are as real as projected; if for some elderly patients, hospitalization appears either to shorten their lives or to prolong an ultimately futile clinical treatment, then in those instances, hospitalization seems *eo ipso* immoral.

What are the factors that enter into the moral judgment and into the moral decision regarding hospitalization of the aged?

The reasons for hospitalization of the aged may be summed up as follows:

A. *Convenience of the Attending Physician*

Obviously, where the hospitalization of the aged results from such considera-

tions as the attending physician's convenience, either to relieve him from tedious chores or from the sense of inadequacy, and last but not least when it is dictated by the physician's prudence, one cannot but refer to the spirit of the Hippocratic Oath.

In such deliberations, the individual physician must examine his own sense of responsibility and medical ethics. No doubt, the physician lives under many pressures and stresses, much more so today than even before. Similarly, the physician-patient relations have undergone considerable changes in that we now have a professional rather than a personal relationship between members of the medical profession and patients. Under his many pressures and in the absence of personal involvement, a physician might be inclined to resort to the accommodating solution of sending his patient to a home or hospital. These mitigating circumstances, however, do not obviate a high sense of dedication that physicians must bring to their practice.

B. *Training of the Attending Physician*

One advances with a great deal of trepidation and hesitation the possibility that some physicians, practicing medicine for many, many years, resort to routine treatment and diagnosis. For whatever reason, there will be found physicians who do not keep up with the advance of medicine, who do not read professional literature or who do not benefit from professional meetings, lectures, etc., and who therefore are oblivious of the most recent medical-scientific insights. The routine physician, relying on his training decades ago, will unwittingly counsel treatment deemed deleterious in the light of the newest knowledge and, with the highest sense of dedication, will act contrary to the interest of his patient.

Along the same lines, it ought to be mentioned that many well-meaning people resort to the hospitalization of the elderly by reason of an unawareness of its debilitating effects. Lay people do not know that what appears to be a good deed actually is fraught with harm. In such cases, once more, one has to refer to the sense of responsibility of the attending physician, who should attempt to explain fully the possible results and consequences of such course of action.

Ultimately then, the factors in the decision of what to do with the elderly involve individual and professional ethics. Rarely will a single consideration decide whether or not an elderly person be hospitalized. Only when factors for hospitalization indicated below are also present will the physician's recommendation for hospitalization—highly respected as it might be—be followed or rejected.

C. *Decision of the Children*

The main burden for the decision as to what to do with the elderly lies, of course, with the children, where there are any. Of course, the spouse of the patient has a primary say in deciding how the elderly should be treated. It might make interesting reading to study the statistics of how spouses react to the problem of hospitalizing a mate in poor physical—or mental—condition. The trauma of having a spouse hospitalized and thus breaking up a home after many years of living together weighs heavily in such instances. There is evidence to indicate that spouses react negatively to suggestions of separation. (Those living as a couple in homes for the aged are not in the purview of this discussion.)

In guiding the decision of the children, we have a very definite religious-moral point-of-view based on Jewish religion. Accordingly, children are responsible

for the welfare of their parents: they are bidden to provide for all their needs including that of health. This is a *personal* duty not to be vicariously fulfilled. Therefore, as long as there is any choice, it is the obligation of the children to exercise it in whatever care their parents may require.

Resorting, for convenience sake, to substitutes in our days cannot be condoned except in the light of the most pressing circumstances. Obviously, when parents are able to care for themselves, the honor due to them may be expressed in a variety of suitable ways. But when parents become "burdens" because of their physical condition, that is, when filial love and patience are most needed, dispensation cannot be given lightly.

The Code of Jewish Law states: "If one's father or mother becomes demented, the son (child) should make an endeavor to deal with them in accordance with their understanding until the Lord has mercy upon them. However, if he be unable to bear it any longer *because their condition is grave,* he may abandon them and delegate others to give the proper treatment."[1]

The exception indicated in this law is rather specific and implies an acute case where professional treatment is necessary. Otherwise, the children must care for their parents. From this point of view then, sending aged parents to homes or to hospitals without due reason and cause is an abdication of filial duty and, considering the implications of the medical opinion stated in the accompanying article, it is an act of hastening the end. If this happens when the parents are lucid, their agony over the treatment received by the hands of their children will certainly not enhance their "right to die in peace and dignity." This statement is borne out by the fact that people hospitalized with terminal illness often express a desire to return into the midst of their loved ones to die there in peace. In light of the foregoing, the moral and religious obligation of filial duty imposes a heavy burden on the children in making their decision of what to do with their parents.

The mitigating circumstances for the children in deciding whether to send an elderly patient to a hospital might be the following:

1) *Physical limitations*

When children live in different cities and are unable to provide the adequate care and supervision in person and where for some season the parent cannot be moved into their own home—the house is too small, there are other cases requiring care and treatment, etc. —we might apply the exemption and delegate to others the responsibility for proper treatment.

2) *Economic necessity*

Where home treatment would impose an unbearable financial burden and where hospitalization might be provided for by outside agencies, the children may have to resort to such expediency.

3) *Unavailability of personnel*

When, with the best of intentions, the children are unable to give personal service and even with adequate financial means they cannot secure proper care, they would have to avail themselves of the hospital facilities.

Ideally, when there are no children, the duty of medical care for the elderly would devolve upon the closest relatives. However, one must be realistic and know that generally personal service is not given to the elderly by relatives and therefore in most cases hospitalization is the solution.

[1] Shulchan Aruch Vol. IV, Chapter 1:16.

II. Treatment of the Dying

Another issue of ethics is the prolongation of medical treatment in terminal cases. Since this article deals with the elderly, not with the general treatment of terminal cases, the following should be understood in specific terms of the elderly, and not in all "terminal" cases.

Prolongation of medical treatment in terminal cases is motivated by a desire to hold on to the beloved one as long as possible, to satisfy one's conscience and sense of duty that everything medically possible has been done to preserve or prolong life.

Treatment is continued in the confidence and hope that medical science can halt the inevitable, or in the hope that a cure will be found during treatment.

For those reasons children and relatives, or agencies, will spare no effort and cost to provide medical treatment in order to keep the flickering life of the patient for a few more days, weeks, or months, as the case might be. In many cases, they succeed in keeping not more than a comatose, incoherent, vegetating being from attaining the final release from suffering, complete physical and mental disintegration, while at the same time prolonging the agony of those who care most for the dying.

It would seem to this writer, that it would be far more in keeping with the dignity of life "and peace of the dying" or the moribund, to permit him to die without increasing pain, without permitting him to deteriorate into a mass of disintegrating tissues which wipes away the traces of his former human self. Administration of drugs or whatever medical procedures are used may prolong life only in the technical sense and there is room for grave doubt whether this is in keeping with our concept of the dignity of man.

There are secondary, but important considerations also that militate against this "conventional" attitude. In the first place, one might mention the psychological and emotional stress upon the immediate members of the family of the moribund. They must suffer for days and weeks hoping against hope for a miracle that will not occur. They are alternately uplifted and downcast by the inexorable course of the dying of their beloved, experiencing many times over the moment of death. This wear and tear on the nerves and emotions cannot but have a debilitating effect, so that ultimately death of their beloved will leave them not with a feeling of sorrow, but many times with a feeling of relief. Meanwhile, their emotional stress will find outlets effecting unhappily other areas of human relationship. In the process, also, the image of their loved ones will be not that of a lovely and loved human being but that of a pitiful wreck, too gruesome to recall, marring for a long time the beauty of memories.

Not infrequently, there are cases in which the process of prolonging the life of one member of the family who is really beyond hope will inflict such financial burden upon the other members of the family that may wreck not only the present economic stability of the family, but the future as well.

Many a time life-time savings are eaten up by a long and hopeless illness. Often families must assume long term debts to prolong the futile attempt.

Can such sacrifice—money and the assumption of long-term debts—be demanded when it will do no good, in fact, in the light of the foregoing, might well be irrational?

Jewish tradition, which bids filial duty without limitations and would demand everything to be done for the sick, in the case of the dying manifests a liberal

attitude inasmuch as it permits "the removal of anything causing a hindrance to the departure of the soul . . ."[2] It also prohibits any action which may lengthen the patient's agony by preventing a quick death.[3]

Therefore, it is possible to advance the view that when an elderly patient is diagnosed by the best medical opinion to be moribund and beyond hope of recovery and of return to life with dignity, it is acceptable to permit him to die without medical interference, save that of easing pain.

Who is to make the decision? Can man play God? These are the most challenging and therefore the most difficult questions to answer. As we have indicated above, medical science is rapidly changing and therefore making the decision even more difficult.

There appears to be one certain fact, however, indicating some guide in making decisions. Death is a certainty. While medicine is changing, it does not yet pose physical immortality as a practical possibility. Therefore, ruling immortality out, we are left with the definite prospect of dying as a function of time. With the best possibility, medicine may find cures for illnesses hitherto diagnosed as inexorably fatal. Therefore, one might hesitate to advocate the foregoing in the case of such patients whose age would suggest greater recuperative powers.

In the case of the elderly, who, even in the absence of mortal illness, would succumb to the ravages of time, prolongation of illness will not hold out recovery and life under normal circumstances. Weighing the experiences with the terrible suffering of the patients, who are no longer even conscious of life, against the love and affection of relatives, against the instinct to keep alive and keep our loved one alive, this writer feels that physicians should be able to counsel and responsible relatives should accept a decision of *laissez passer*.

Conclusion

If hospitalization of the aged by the medical evidence is deleterious, in view of the traditional duty of the children to give personal service to their parents, it should be resorted to only if serious mitigating circumstances make it the only solution in caring for the patient.

Physicians should view their own recommendations for the hospitalization of the patient in the light of medical ethics. They should also feel it their duty to enlighten the relatives about to make similar decisions about the possible consequences.

As for moribund patients, who according to best medical diagnosis are beyond hope of recovery to life with dignity and whose prolonged suffering produce a progressive deterioration resulting in mental and physical disintegration to the patient and also in great psychological and emotional stress upon the relatives along with a catastrophic financial burden, it is entirely proper and permissible to permit them to die in peace, rather than to keep them technically alive by all available means.

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[2] *Ibid.*, Vol. IV, Chap. CXIV:1.
[3] *Ibid.*