

Bioethical Issues in the Care of the Elderly

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Ethical Dilemmas and Patient Choice: The New Challenge of Modern Health Care

An 80-year-old male nursing home resident had expressed his feelings about life support and terminal care to his family on several occasions, but had never written them down. He suddenly becomes unconscious and is sent to the Emergency Room at his family's request. On arrival in the Emergency Room he stops breathing and is placed on a respirator. The hospital doctors then learn that he has advanced lung cancer and was expected to die soon. Now that he is on life support, they want to place him in the intensive care unit. The family arrives two hours later and says "This man would never have wanted to go out of this world with tubes and wires hanging out of him. Let him die quietly."

An 86-year-old nursing home patient has been steadily losing weight due to her poor appetite. She is bedridden, unable to feed herself, but is lucid and says, "I've had enough." The doctor and a nephew (her only close relative) decide to insert a feeding tube. The patient repeatedly pulls out the tube, stating "I don't want this." Wrist restraints are applied to try to keep the tube in, but the patient still manages to pull it out, and continues to lose weight.

An 82-year-old woman with diabetes, severe arteriosclerosis and a history of multiple heart attacks, is admitted to a nursing home. After several months, she suffers sudden blockage of the circulation of one leg. Gangrene sets in, and spreads up the leg. The family cannot decide whether to authorize an operation or just to permit measures for comfort and pain relief. The doctors, realizing the woman is at high risk of dying from the surgery, advise the latter. The son is leaning towards conservative measures without surgery, but at the last minute a "long-lost" daughter from out of state shows up, is horrified by the whole situation, and insists that the mother be sent for an amputation.

These 3 cases—all based on real life—illustrate the ethical dilemmas with which patients, families, and doctors constantly wrestle. Not long ago,

most physicians assumed that everyone would want the maximum possible medical care, and most patients relied on their doctors for decisions regarding medical treatment. The only items sometimes discussed between patients and physicians were treatment options. Attempting to prolong life under any and all circumstances was felt to be appropriate, regardless of underlying condition or prognosis, or the wishes of the individual or his or her family.

The past decade—especially since the 1976 New Jersey case of Karen Quinlan—has brought dramatic shifts in public awareness, more open debate on these issues, and changes in physician thinking. While many patients both desire and can benefit from intensive medical treatment of acute illness, these ethical considerations—particularly decisions about whether, and to what extent, to treat—are increasingly being considered a routine part of the clinical decision making process. While our goal is still to preserve or to improve life wherever appropriate, we realize that even the miracles of modern medicine cannot necessarily reverse the natural declines of age, or the effects of some illnesses.

What has changed significantly is the public and professional recognition that making choices — the heart of ethics — is not only a matter for philosophers to debate, but a part of everyday life. Yet even now many health care people are uncertain about what ethics is and how we can apply it to medicine. It isn't surprising that some physicians ask, "Doesn't all this advocacy for ethics somehow unfairly imply that we have been 'unethical?'"

Ethical decision making incorporates values and beliefs. It is not really about imposing some specific philosophical or religious perspective, nor about selecting one viewpoint as uniquely right. Ethics is about clarifying and understanding values in order to see why some positions may be more or less pertinent, appropriate or consistent with definite ideals or goals.

An important purpose of analytical ethics is to provide information that dispels mistaken notions and thereby allows people to proceed more realistically and thoughtfully. Current

ethics research is helping to demonstrate the error of certain common assumptions often used as the basis for decision making guidelines, such as:

- High technology is always a good thing to use in treating illness;
- Most people want to be kept alive regardless of their condition or prognosis;
- Old people tend to give up hope if told the truth, and most would prefer not to know;
- Most people would rather have their doctors make tough decisions for them;
- If we start to allow treatments to be discontinued in some cases, we are simply supporting a trend towards the elimination of unwanted, helpless people.

Forcing everyone to adopt the same conclusion or decision is not ethics. Indeed, converting a limited perspective or value into law or institutional policy frequently does not resolve issues but merely satisfies those who have succeeded in enforcing their views. The key to applying ethical principles in the clinical setting is this: While not everyone will share the same values, desire the same outcome, have the same prognosis or benefit identically from the same options, everyone can and should follow a consistent process, whether in a Missouri nursing home or a California hospital.

All too often people attempt to make ethical decisions by jumping to the question, "What shall we do?" while bypassing the steps along the way. But conclusions are the endpoint, and along the way we must ask:

- Who makes the decisions?
- Who is capable of making the decisions?
- What are the options for treatment?
- How do we compare options?
- What are our goals and objectives?
- To what extent are each of these options consistent or compatible with our values and goals?

While the doctor is best equipped to present the clinical picture (i.e., "These are your options, and the likely benefits and risks"), the patient (or family) should participate in evaluating the options, with support from physicians and

staff. Broad ethical and clinical ideals actually mesh: maximize individual benefit, do the most beneficial thing possible for a given individual. The importance of ethics policies and committees rests in establishing a consistent process which facilitates the individualization of clinical decision making by patients, families, and professionals. Adherence to a consistent process will enhance our ability to individualize outcomes.

The purpose of highlighting ethical issues is not to take away the physician's prerogatives as a clinician, but to validate the key principle that medicine — like all other areas of life — involves choices. Choices are not a scientific matter but a personal, social, and philosophical one. The balance between the clinician's and the patient's role is this: the patient needs the clinician to help interpret things in ordinary language and to clarify potential risks and benefits of various options; the physician needs the patient to consider the explanations and to participate actively in making choices. The ultimate goal is to enhance personal responsibility in health care decision making.

Doctors and health care facilities are beginning to understand that vigorous high technology medical treatment is not always the best course, and that patients have the right to choose from among treatment options, or even to choose no treatment at all. Physicians are no longer considered to have an ethical or professional obligation to recommend or to order all possible treatments regardless of patient condition or prognosis. Doctors who recommend to withhold or withdraw a treatment under appropriate circumstances are acting in accordance with the currently recognized ethical principles of the medical profession. Sometimes, just relief of pain and other measures to enhance comfort, or to ease dying, are all that are desired or necessary.

The fact that more people are living longer has forced many of us to deal with problems to which we previously may have given little thought. In particular, the elderly are at greater risk for life-threatening illness, are more likely to have an underlying disability from chronic illness or normal aging that impairs their quality of life, and are more likely to have some alteration in mental function or the ability to make decisions.

More frequently, patients and families now face some difficult and confusing issues, such as how to select treatment and make health care

choices for those loved ones who have lost some or all of their capacity to make rational decisions; how to express and record specific personal wishes about medical care in case of subsequent personal disability; and what information should be requested from the doctor or other professionals to assist in making these decisions.

At some time, almost everyone reading this will be confronted with such issues, either for themselves or a loved one. Since these decisions are complex, confusing, and often frightening, many people avoid making them, or think about them only under stress when their ability to use good judgment and make a reasonable choice may be most impaired. Unfortunately, evading the issues does not make them disappear. Eventually, decisions must be made.

Our purpose here is to help elderly people, and their supporting families and friends, understand some of these important issues, explain their rights and responsibilities, and clarify the options for requesting assistance and guidance from their doctors and other health care professionals.

Rights and Responsibilities

American courts have repeatedly upheld two important principles about health care decision making:

- A competent adult has the right to make his or her own decisions about things affecting himself or herself; especially, about what will or will not be done with his or her own body. Only rarely may substantial societal interests override these rights.
- There is a "right to privacy" (also called a "right to be left alone") which includes the right to refuse life-sustaining technologies, or other invasive treatments.

With rare exception, every competent person is guaranteed the legal right to make personal health care decisions. However, many people either cannot, will not, or do not understand how to take advantage of such a right.

What are some of my rights regarding health care decisions?

Every competent individual has the right to be included in decision making about care and treatment, and the right to receive enough relevant information for a "reasonable person" to be able to decide to consent to, or refuse, medical treatment.

The attending physician has an important responsibility to assist this

decision making process by providing accurate and timely information about: overall condition and prognosis; treatment options; and possible or likely outcomes of treatment.

Exceptions to the informed consent requirement include four recognized situations:

- emergencies, when delay in treatment to obtain consent would result in harm to the patient;
- unanticipated conditions that arise during surgery, when obtaining consent would expose an individual to the risks of the second procedure;
- when a person's mental or physical well-being would be threatened by disclosure (therapeutic privilege);
- when an individual has expressly waived his or her rights, and expressed a desire not to receive information.

How should families make health care choices for loved ones who have lost some or all of their capacity to make decisions?

You have the right to be told the treatment options, and their potential risks and benefits. You are entitled to information and basic assistance from staff professionals if you wish to document your specific wishes, or change your mind about previous declarations.

Some people who are perfectly capable of making such decisions find it very difficult to do so, and prefer that their family or doctor make them instead. You have the right to designate someone else to make these decisions. If you choose to do so, you should understand that the consequences may not be as desirable when others make choices for you, as when you choose for yourself.

If you decide to assign your right you should consider clarifying this in writing somewhat as follows: "I understand that I have the right to receive and act upon information pertinent to my personal and medical condition. However, I prefer not to receive such information, and instead request that my physician/family not give me such information, or that they should make these decisions for me."

What are my responsibilities?

Making difficult ethical and medical decisions is most appropriately a *partnership* between a patient, his or her family, and an attending physician. Some people say, "I'm just the patient and I don't know anything about medicine. I come to the doctor, and I expect advice on what to do. Why should I be told I have responsibilities?" But when any of these partners evade or neglect their responsibilities, the process is less effective and there is a greater chance for confusion, misunderstanding, and dissatisfaction.

Therefore, you should provide your doctor with accurate and appropriate information about your condition, symptoms, medications, wishes, and problems. This helps the doctor understand the situation and offer the best possible advice.

If something about your condition, proposed treatments, or various options is unclear, request additional information or explanation. Where possible, ask for time to think things over. Most of these decisions have too many lasting consequences to be left to misinterpretation or partial understanding.

Always try to repeat in your own words, either orally or in writing, what you *believe* the doctor has told you. There is no better way to see if both of you are on the same wavelength.

It is important to appreciate that there is no such thing as a guaranteed outcome, or a totally risk-free procedure. In medicine, we must always deal with *probabilities*, some greater than others. Many people are afraid they will do the "wrong" thing. However, the goal is not to make a perfect decision, but the best decision possible under difficult circumstances, which often means choosing among several imperfect options.

Despite possible impressions from news releases of famous medical centers and intensive press coverage of spectacular medical events, the truth is that many of the treatments we can offer are still less than optimal. Often we must try a treatment for a period of time, and then reevaluate the situation to see if it changes for the better or the worse (time-limited trial). Decisions about whether to resume, increase, change, withhold, or discontinue a treatment must often await such trials.

What questions should I be prepared to ask?

Like everything else, much of the battle is to know the right questions to ask. As health care professionals, we try to consider questions like these in

making recommendations:

1. How likely is the treatment to help the condition or problem?
2. What are the possible risks of the treatment, and how likely are they to occur?
3. How likely is the treatment to cause additional pain or suffering?

You and your family should also try to follow an orderly process of asking questions and gathering information, including:

- information about the condition and prognosis. What is wrong with me (or my relative)? What does this mean? What is the most likely outcome of this condition or problem?
- asking questions about treatment options. What are the options for treatment? How likely is each treatment to actually bring some improvement, or at least to prevent further decline? Is the treatment simply postponing or prolonging an inevitable death? What are the risks of each option? How likely are complications of the treatment? If complications are likely, could they cause additional pain and suffering? Which of these options do you (the doctor) recommend, and why?

At this point, whenever possible, you should take time to think about things and talk them over with family, friends, or others. However, it is a good idea to write down key points, to be sure that the details are clear.

Mutual efforts at adequate and appropriate communication, and mutual understanding of rights and responsibilities, can help make both medical and ethical decision making processes more orderly and thoughtful. We have found that when doctors, patients, and families all are encouraged to follow this process, different viewpoints are discussed and clarified, misunderstandings can be dramatically reduced, and reasonable decisions in your best interest can be made.

Identifying a Primary Decision Maker

Most of us are both competent and interested in making our own decisions, especially about health care and treatment. The law protects the right of a competent individual to make decisions about his or her treatment or care, regardless of whether others disagree. But a growing number of problems involve those who appear to have lost some capacity to make their own decisions, who are judged incompetent by a court, or who seem to pose a threat to their own health and safety and that of their loved ones.

When a person is deemed incapable of making personal health care decisions, health care professionals must obtain *substitute* consent. "Substitute consent" (sometimes called "proxy consent") refers to having one person make decisions or judgments for another, or offer consent on behalf of another person.

Identifying the primary decision maker is thus highly dependent on determining an individual's decision making capacity. Once it is determined that the patient does not have sufficient decision making capacity to make a particular decision, or to make it alone, then the issue becomes much more complicated, especially if that individual cannot express, or has not expressed, his or her wishes or feelings on relevant matters. In these latter instances, we cannot eliminate uncertainty or subjectivity, but we can usually *reduce* both.

I've heard stories of families making decisions for their relatives, without involving them. Can they do this?

A competent individual has the right to make personal health care decisions, even if such decisions do not reflect what others think is the "best" thing to do. In most cases the patient is the *primary decision maker*. Family can and should still be involved in the discussions when the patient is the primary decision maker, but the patient should not be bypassed in favor of the family's wishes (unless he or she has specifically authorized someone else to decide). The not uncommon practice of turning directly to family to make decisions for hospitalized old patients who are automatically assumed to be "senile" is not legally or ethically supportable.

What do we do if a close friend or relative clearly does not have the capacity to make personal health care decisions?

First, seek medical help in deciding whether the change in *mental* function may be due to a *physical* problem or illness. Confusion, disorientation, or poor decision making in a person who formerly used good judgment may be clues to a treatable medical problem such as alcoholism or thyroid disease, to depression, or to the side effects of medicines such as heart or blood pressure pills, antidepressants or tranquilizers, muscle relaxants, or sleeping pills. Sometimes, when such problems are treated, or the medications decreased or discontinued, a person's mental function may improve enough to enable some decision making.

Families and friends can help doc-

tors by providing evidence of a change in mental function. They should describe the time frame ("It happened suddenly about a month ago" or "This has been going on gradually over the past year"); the abnormal or unusual activity; and any associated changes in physical appearance or overall function ("My mother tires more easily" or "My wife is worse in the evenings, about two hours after she has taken her medicines").

Therefore, first ask the doctor if there is anything that can be done medically to improve the mental function necessary to making decisions.

Do all people lose their decision making abilities to the same extent?

No. Even Alzheimer's patients lose their capacities to different degrees and at different rates. Therefore, even the patient who is not the primary decision maker should still participate in the decision making process to the greatest extent possible.

What happens if the problem is irreversible?

When necessary, a substitute primary decision maker should be identified as soon as possible. If the problem is long-standing or known to be irreversible, families should make doctors and health care facilities aware of the names of any specific designated or court-appointed individuals with substitute decision maker authority.

What are the potential problems of such conclusions?

One issue is to ensure that there are safeguards to prevent a capable person from being overruled or declared incapable, to serve the interests of others. Another concern is to see that the interests of an incapacitated person are considered, and his needs met appropriately.

What happens if there is no consensus about a person's decision making capacity, or about who should be the primary decision maker?

This is a most difficult situation for the doctor and other health care professionals, because multiple decision makers can create substantial controversy and confusion. Wherever possible the family should select a single spokesperson. This person may not be the only one in a family to consider information or make decisions, but should at least be the primary contact person or spokesperson. When conflicts cannot be resolved, the facility may need to take legal action to decide whose wishes take precedence.

It is preferable to work out such issues without having to resort to legal

channels. We may request a family conference to involve all interested parties and attempt to reach an acceptable conclusion. Your participation in such a conference will help.

What happens in court?

Usually, the court appoints someone to investigate the situation and report the findings to the court, to guide the judge. The court issues a *competence* ruling, which may include more than just health care decision making capacity. Based on a determination of partial or total incompetence, the court may authorize limited or total guardianship, or other protective services. In that case, another person, or the court itself, will assume decision making responsibilities for health care and possibly other areas of that individual's life.

As a substitute decision maker, how do I know that I'm accurately representing the thoughts or wishes of my family member?

What are some of the options for protective services?

They may range from guardianship, to limited guardianship, to mandatory hospitalization for medical evaluation and treatment, to placement in an institution such as a nursing home or another long-term care facility.

How is a substitute ("proxy") decision maker chosen?

A substitute decision maker is usually either (1) designated by the individual or (2) appointed by the court. Individuals can best ensure that their personal choices will prevail by designating someone while they are still able to do so. A durable power of attorney grants specific authority to another person to make decisions in the event of subsequent incapacity. You or your relative can also write a living will, or leave other specific instructions. Such instructions only apply if a person loses, or does not regain, decision making capacity.

I agreed to cosign for financial responsibility. Doesn't that make me responsible for health care decisions as well?

No, not necessarily. The guarantor is not necessarily the most interested, involved or qualified person for making

substitute decisions.

As a substitute decision maker, how do I know that I'm truly representing the wishes or thoughts of my family member?

The best way is to have explicit written directives (such as a durable power of attorney or living will). Other helpful, but less reliable considerations include (in order of decreasing dependability):

- a person's previous explicit written directives
- a person's previous explicit oral statements or directives
- a person's previous general statements of values or preferences
- what a reasonable person would do in the same circumstances ("best interest" standard).

Selecting Treatment Options

After receiving information about condition, prognosis, and treatment options, patients or family members may need to make some decisions. Presenting treatment options is actually the *endpoint* of a process. There are several very important reasons for adhering to a consistent, orderly approach, prior to presenting options: (1) greater likelihood of doing what is best for the particular individual; (2) likelihood of greater understanding by patient and family; (3) prevention of confusion; (4) greater understanding by other professional staff about what they are doing or not doing, and why; and (5) substantial protection against possible liability.

What general options do I have for selecting treatment alternatives?

Many people view treatment options from the "all-or-none" standpoint; that is, they must either choose vigorous all-out therapy or choose nothing at all. Many people express their fear that choosing the "limited treatment" option commits them to neglecting their loved one. It is very important to understand that there are legitimate in-between possibilities.

Today, there is no such thing as "doing nothing." Measures to provide comfort, such as the relief of pain, are in fact doing something, and may be the most humane and compassionate choice in many cases.

Treatment options can and should be as flexible as possible. It is often possible and appropriate to choose such things as time-limited treatment trials, or supportive care. The *time-limited trial* refers to treatment for a limited time, with subsequent reassessment, and possible discontinuation if it

is ineffective or presenting more burden than benefit. *Supportive care* refers to symptomatic relief, control of pain, turning and positioning, comfort, sedation, without vigorous or aggressive management of medical illnesses.

If you have any doubt or questions, you can consider a time-limited trial. Later treatment decisions will then depend on the person's response to the treatment trial.

What are some situations for which options may need to be discussed?

Treatment options should be considered for *both* the treatment of acute illness and the plan regarding possible resuscitation.

The *critically ill* are those suffering from an illness or general decline that makes them more susceptible to acute illness, or who are more likely to die if they should suffer a serious acute illness such as a heart attack, stroke, or pneumonia. The *terminally ill* are those for whom death is imminent, or who have a condition that is known to be fatal and will not respond to any known treatment.

Anyone may forgo or refuse one kind of treatment or life-sustaining technology, yet desire or be a candidate for other kinds (e.g., no CPR or no ventilator, but antibiotics or tube feedings, if indicated). It is up to the individual or a substitute consentor to specify the extent and limits of the treatment desired.

How might I best express these decisions?

You should try to express these choices as explicitly as possible, in such concrete terms as:

- Transfer me to the hospital under any or all circumstances.
 - Leave me in my nursing home bed and treat me as best you can, but don't move me to a hospital
 - Do not resuscitate me (do not do CPR) if you find me without pulse or respirations.
 - Resuscitate me if you see me suddenly stop breathing, but not if I suffer an unwitnessed cardiac arrest.
 - Treat any and all of my illnesses, and resuscitate me.
 - Treat any and all of my illnesses, but do not resuscitate me.
 - Treat certain of my illnesses, but not if it involves painful or high-risk procedures, extraordinary life support measures, or extreme distress to me or my family.
 - Don't treat my illnesses, and do not resuscitate me, but just keep me comfortable and free of pain.
- In summary, the bottom line of

deciding *What is to be done?* is best accomplished as an orderly, shared process, as follows:

- The doctor evaluates the individual's medical condition and prognosis;
- A person's decision-making capacity should be reviewed and verified;
- These evaluations should be discussed with the patient and/or substitute decision maker;
- If the individual lacks decision making capacity, another primary decision maker needs to be identified;
- The competent patient, or the substitute decision maker for the incompetent patient, should make the doctor aware of any statements of wishes, durable power of attorney, living will, or other related thoughts or opinions;
- Patients and families should request help in understanding or deliberating their options for documenting their wishes;

More and more families are asking what they can do to halt futile treatment of a loved one.

- Based on condition, prognosis, and consideration of these statements and wishes, the doctor should discuss the options with patient and/or substitute decision maker, as appropriate;
- Presentation of treatment options should include some discussion of potential benefits and risks, and the likelihood of problems or complications, *specifically for the individual* in question, instead of as vague generalities.
- The doctor and primary decision maker should periodically review the individual's condition, prognosis, and decision making capacity, and the appropriateness of the conclusions or decisions about treatment in light of any changes in status or condition.

Considering Life-Sustaining Treatments

One special area of discussion and concern is that of so-called "life-sustaining" treatments. *Life-sustaining treatment* means any medical procedure or treatment which could prolong a person's life. Life-sustaining

technologies have been defined as *drugs, medical devices, or procedures that can keep individuals alive who would otherwise die within a foreseeable, but usually uncertain, time period.* The may include CPR (cardiopulmonary resuscitation), mechanical ventilation, renal dialysis, antibiotics, or artificial methods of providing nutrition or hydration.

Deciding whether to use these treatments is difficult and often emotional, because of the implications for trying to save or extend a life.

While such treatments are often invaluable — indeed, lifesaving — more and more families are asking what they must do to halt what they believe is futile treatment of a loved one, when the person is terminally ill or when treatments are clearly either not helping or are inconsistent with the person's wishes.

Whether extending life is a good thing depends in part on the likelihood that treatment can somehow stabilize or improve an individual's condition and prognosis, and help maintain a reasonable condition or personally desirable quality of life.

Decisions about what constitutes appropriate or excessive life-sustaining treatment in a specific case should be reached through discussion involving the attending physician and appropriate decision makers.

The attending physician should discuss the treatment options and their potential risks and benefits, with the patient or appropriate substitute decision makers. The attending should explain why he or she recommends for or against various treatments.

When the relative benefits or burdens are unclear, or about equal, it is sometimes appropriate to provide treatment for a period of time; either the treatment or the time frame may be limited, as appropriate.

Most doctors and other health care professionals now agree that there is no ethical or professional obligation to prescribe such treatments when the treatment is unlikely to improve health status or overall condition or prognosis, or is unlikely to return the individual to a quality of life consistent with his or her overall wishes or prior statements.

Two increasingly evident social and legal trends are: (1) to support the right of individual self-determination; and (2) to support discontinuation or non-use of high technology or life-sustaining measures in cases where they are not likely to help, or have not been helping.

When is it appropriate to consider forgoing resuscitation?

Cardiopulmonary resuscitation (CPR) is an emergency procedure which attempts to restore breathing and heartbeat in a person whose heartbeat or breathing (or both) have stopped. Basic life support includes external cardiac massage and mouth-to-mouth or bag ventilation. Advanced life support may include drugs, electric defibrillators, or mechanical ventilation.

"Do Not Resuscitate (DNR)" or "No CPR" decisions are those which specifically authorize the limitation or omission of resuscitation efforts. Such orders are becoming increasingly common as people recognize the limits of medical technology and assert their wishes for a peaceful end. The right to forgo resuscitation is well established.

Such orders are often appropriate, based on:

- presence of terminal illness
- consideration of explicit patient wishes or of a general philosophy of life
- deterioration of quality of life
- unlikelihood that medical treatment can substantially reverse a problem or sustain more than a vegetative existence.

Because the situation of cardiac arrest is always an immediate crisis, decisions to forgo CPR should be made as far in advance of the crisis as possible.

You should seriously consider discussing this matter with your doctor if you are a patient, or a relative or friend of a patient, falling into one of the following categories:

- hospice patients, or terminally ill nonhospice patients,
- those with severe irreversible disabling conditions,
- those with existing advance directives or living wills,
- those who express a desire to discuss the matter,
- those who have suffered irreversible loss of consciousness,
- those likely to suffer cardiac or respiratory arrest.

Nevertheless, keep in mind that a DNR patient can, and should, still have other medical interventions (such as treating infections or heart attacks), consistent with his or her condition, prognosis, and wishes.

Following are some procedures regarding DNR decisions:

- The attending physician should ascertain the treatment decisions of the patient or substitute decision maker relevant to the question of resuscitation.

- When the decision has been made to forgo CPR, the attending physician will write a brief note, which includes: (1) reason for no CPR, (2) the decision maker, (3) other pertinent participants in the discussions, (4) date and time of relevant discussions.
- The attending physician should decide when to write the "DNR" order after consultation and agreement with patient or substitute decision maker.
- The attending physician will write a "No CPR" or "Do Not Resuscitate (DNR)" order in the chart.
- The attending should write the DNR order directly, except under extraordinary circumstances.
- A verbal DNR order should be witnessed and documented by two nurses, and should be countersigned within 24 hours.
- If there is no DNR order, resuscitation may be begun at the discretion of the staff, until further clarified by the attending physician.
- Once begun, any resuscitation attempt may be called off by the attending physician if there is no significant response.
- The attending physician should periodically review the DNR order after reassessing the patient's condition, to ensure that the order remains appropriate.
- When the patient is transferred to another facility, information about the DNR status will be sent with the patient.

Supplying Nutrition and Hydration

Food and water are usually ordinary parts of ongoing care of an elderly patient, but under certain circumstances may be considered as life-sustaining technologies or medical treatments. These circumstances include the use of alternative routes of nutrition and hydration, such as nasogastric tubes, gastrostomy tubes, intravenous lines, hyperalimentation catheters, or hypodermoclysis (infusion of saline solutions subcutaneously) in patients who are unable to take in adequate amounts of food and fluids by mouth. Under certain circumstances, the actual or potential discomfort, pain, or complications involved with providing these alternative sources of nutrition and hydration may outweigh the possible advantage of these treatments. Following are some guidelines and procedures regarding nutrition and hydration:

- As in any treatment decision, the right of the competent patient to

refuse life-sustaining technologies involving the use of alternative means of nutrition and hydration should be respected.

- A substitute decision maker may make a similar refusal, if it is in accordance with the patient's previously expressed wishes, and consistent with the condition and prognosis.
- Where indicated, attempts should be made to evaluate or treat those potentially reversible conditions which may affect a person's ability to ingest or digest food and fluids.
- Cognitive impairment alone is not sufficient to justify withholding of food and fluids. The patient's overall medical condition and prognosis must be carefully considered.
- The attending physician should appropriately and carefully document the decision in the medical record.
- Consent should be obtained for the purpose of placing tubes or catheters for long-term alternate nutrition and hydration.
- Time-limited trials of alternate nutrition and hydration may be indicated, to see if there is improvement in condition or level of comfort.
- Discontinuation of alternate nutrition and hydration should be preceded by appropriate consent from a primary decision maker.
- If artificial nutrition and hydration are not used, everything possible should be done to ensure patient comfort and freedom from pain.
- Thirst or dry mouth may be relieved by appropriate use of sips of water, ice chips, or lubricant.

Issuing Advance Directives

What is an "advance directive"?

Many people have heard about the "living will" idea, and some have even written one. But few realize that "living wills" are but one of several ways in which a person can offer "advance directives."

Advance directives refer to *any* statements of wishes or directives concerning a person's philosophy or instructions for care in case of subsequent inability to consider the options or express those wishes. As the most direct and explicit evidence available of a person's wishes and feelings, advance directives are welcome and extremely useful guides for health professionals.

Patients have the right to issue them, and health care professionals have an ethical responsibility to help patients with them, by providing appropriate

documents, clarification, and support.

Advance directives do not take effect *until* an individual becomes incapacitated (for example, by losing mental function because of Alzheimer's Disease, by suffering a severe stroke, or by lapsing into coma). As long as you remain competent, able to consider health care issues, and to communicate your wishes, you will be asked to make decisions or express wishes as the need arises.

We strongly encourage you to make advance directives to help clarify your personal values and feelings, select a substitute decision maker, and serve as a guideline in the event of future incapacity. This is especially urgent if there is a diagnosis or change in condition likely to raise questions about limiting or discontinuing treatment.

What forms can such directives take?

There are two main categories of advance directives. *Treatment directives* (including the living will) encompass statements about specific treatments which an individual wants to receive or forgo. For example, a treatment directive might state, "I wish to receive treatment in an intensive care unit, if necessary, but I would like such treatments to stop if my condition worsens and it does not appear that they are helping me."

Proxy directives identify specific individuals authorized to make certain decisions on behalf of someone who becomes incapable of making decisions or expressing wishes. For example, "I authorize my wife to make medical care decisions on my behalf, in case I am incapacitated and unable to express my own wishes."

What is a durable power of attorney?

A power of attorney is a document which enables a person to authorize someone else to make decisions and sign documents on his behalf. A *durable* power of attorney is one which is applicable even if the person can no longer speak for himself or verify his wishes. In many states, a durable power of attorney—a comparatively simple and inexpensive document—may be used to authorize both treatment and proxy directives. A durable power of attorney is your most flexible route, and can avoid considerable future conflict and misunderstanding. This document may cover either health care or personal property, or both.

What exactly is a "living will?"

A living will is a legal document in which a person states how he or she will want to be treated if terminally ill and unable to express such wishes. Note that this deals specifically with

the possibility of a terminal illness, and therefore *does not* necessarily cover other eventualities, such as the use of life-saving technologies to treat critical but possibly nonfatal illness or injury. Therefore, a living will alone may not express all your wishes or concerns about your treatment or cover all appropriate situations.

Most states specifically authorize individuals to write living wills, and require that their form follow guidelines.

How do I complete a durable power of attorney or living will?

You can make an advance directive at any time. We can provide you with sample documents, but you should contact an attorney or other knowledgeable person for information about tailoring such documents for your own situation.

If a durable power of attorney, living will, or another similar document already exists, you should tell us, if we do not ask about it. Copies of any such documents should be included in the medical record. If the document was done originally in another state, it may have to be redone to comply with state laws or regulations.

If you do not have such a statement or document and wish to make one, you should ask your social worker for some assistance.

Once I issue a living will or advance directive, can I change my mind?

You can change your mind at any time. The advance directive has value when a person becomes critically ill, but *cannot* appropriately consider a situation or express choices.

If you have an advance directive, you should review it periodically (approximately annually) to ensure that it continues to reflect your wishes. If you do change your mind, it is better to avoid confusion by voiding an existing directive and writing a new one, than to write over an existing one.

Clearly, the possibilities of disability, or critical or terminal illness, are not things that people like to think about. Yet eventually they happen to us all. While we might feel that "I'd prefer to cross that bridge when I get to it," many of us will come to that bridge in no condition for making the crossing. In our own best interest it is preferable to consider and document our feelings and wishes sooner, rather than later.

Steven A. Levenson, M.D., is Medical Director of the Levindale Hebrew Geriatric Center and Hospital, in Baltimore, Maryland.

The Burning

Age is the anathema of numbers.
You come to it as to a burning field
yet you have to keep walking,
feet hot on the cinders, black grass,
smoke acrid in your nostrils. Must show
good faith you are not walking
toward an abyss—which of course
you know you are. But now and then
there's a clearing, a little oasis
of air, occasion of conviviality,
and all around you stand those
who speak of the numbers as if
they are oblivious, immune to them.
They remind you how long it's been.
Billions of years ago, you say,
we drove up the mountain, my first
love and I. We had made love
by the sea and in the sea
and then we headed for stars.
Same road, same mountain, same stars.
But they believe nothing,
least of all that they too
will come to it. And so you slog on,
lucky in love, in the burning.

David Ray

Hospital Exit

So many beds! But these are all white,
flat and trim. No feather mattress
with a valley to fall in, no covers
of crochet with each square unique
of the thousands Grandma stitched.
Pile up these beds like slabs of paving
stones
and they could reach the skylight.
I think now that that's the way out—
not the clanging red EXIT doors,
but up into the air, a fading light
like a winter afternoon.

One daughter had that many beds,
always travelling, piling up the nights.
The other's here to be cheerful
and check that the nurses are feeding
me well. "Do you know what day it is
today?" I know. But it's just another
pearl

on a slipping string. "February 4th,"
she goes on. "It's my birthday today."
What does that matter, I wonder.
And I must have said it out loud
for she looks startled, hides the hurt.
But there are many pearls to slip
through
fingers. I'm back at the beginning
of the string again, being chided for
jumping
in a mud-puddle in the Sunday-best
clothes
that had taken all-night sewing.

I know you're here, daughter
of the snowdrop month.
But now the slabs of white beds
are just touching the skylight,
and their pillowcases say EXIT
in red-slashed embroidery.

Judy Ray