Abuse of the elderly: Misuses of power

ERIC J. CASSELL, MD

At first thought it would seem that no particular ethical issues are raised by the abuse of the elderly. Abuse of anyone is wrong, and abuse of the elderly seems particularly offensive. It is this intuitive feeling of outrage about intentionally injuring, misusing, or wronging old people that provides a clue as to what we really mean by the word "abuse." In the ensuing discussion, I express the belief that sometimes when physicians employ their power in a manner they believe to be in the best interests of sick, elderly persons, the physicians are abusing their patients.

When one is old enough, kitchens, bathrooms, and even bedrooms are traps for failed memories and unsteady bodies. Yet we do not consider old persons to have been abused by a bathtub or a shower if they are injured in them. Even the old person who is attacked on the street and beaten or mugged has not been abused in the sense in which we usually employ the term. We reserve the term abuse primarily for those situations in which a person, object, or relationship is wrongly used. This derives from the idea that to use something is to have a relationship with it. To abuse someone means, therefore, to violate the terms of the relationship, to take advantage of the relationship, to use it to the advantage of the user and the disadvantage of the used. The elderly are abused when others in relationship to them use them to their disadvantage.

Relationships of all types, whether with persons or medical instruments, restrict our freedom. To be in a relationship with another person is in some sense to be responsible to the person. To use an instrument is to be responsible for the instrument, although to a different degree than is understood in human relationships. In this era we have come to believe that we have enormous freedom of choice and few restrictions on that freedom. But we have mistaken our enormous political freedom as citizens—which has given us rights and, therefore, power in relationship to the state, its agents, and other citizens that would have been unheard of even a generation ago—with freedom from responsibility for persons, relationships, and objects. It is as though the possession of our enormous individual power to make things happen, multiply the force of our muscles, span distance and time, reduce inequities of personal endowment, increase the computational power of our brains, have access to knowledge and information, and defeat disease and death, entitles us to use this power without restraint.

It is human nature for the individual and the group to be more concerned with the exercise and extension of political and technological power than they are with the restraint of such power. When persons acquire power, they may not only want to employ it, but are jealous of it and guard against intrusions or limitations. In the arena of individual freedom this translates, for example, into the use of law and lawsuits as instruments of personal aggression, and rejection of governmental authority no matter how benignly (as in the United States) it had been previously regarded. In the same manner, a population composed of persons intent on his or her own individual power might be expected to reject authority in general. It should be no surprise that many of the abuses of the elderly stem from our concentration on our powers with neglect of the restraints imposed on us by the web of our relationships.

An examination of some of the kinds of abuse currently suffered by the elderly will make it possible to see how these generalizations about individual power in the modern era apply to the problem.

ABUSE OF THE ELDERLY BY THEIR CHILDREN

 Reports of the physical abuse of old persons by their children or other relatives are more common than one might have thought possible. The elderly are sometimes found to have been beaten regularly, tied to beds, or confined to small spaces. They do not complain to authorities because they are frightened of further physical punishment and because they do not see alternatives to their situation. As with battered children, the awfulness comes not only from the infliction of corporal punishment, but from the lack of justification for any punishment for the offenses described. Battering parents frequently cite the child's crying as the reason for the battering. In the case of the elderly, their complaints about ill treatment are given as the reason for the abuse.

How can a person beat up an old man or woman at all, much less a mother or father? While parents may be perceived as wicked and unloving to their children, with bad memories and life-long resentments a natural consequence, most would not find this to be a justification for retaliatory abuse a generation later. It was wrong when done to the child, and it is wrong when done to the parent.
ABUSE OF THE ELDERLY IN NURSING HOMES

The elderly are abused not only by their children, but also by the managers and the staff. One only has to visit a welfare office or Medicare office to see how the power of a corporation can confuse, stunt, or even injure the powerless elderly. The elderly, like many citizens, may expect their trustworthiness and the respect of their workmen. If civil servants; it is a common belief that the functionary is a real problem, and it is a fact that the government, in the long run, is the real problem of the human being. It is believed to be different in concept, if not in practice. Here again, apart from the better institutions, the abuse of the elderly is common. Inadequate attention, physical and emotional exploitation of the human being, and the poor and sometimes parasites, are well known. Equally common is the practice of using compliance with regulations concerning medical care, nursing, and other things, is often the same thing. As a result, the elderly are not only neglected and left stranded, but sometimes are even abused.

That poor care and abuse are not inevitable in a nursing home is easily seen in those run by religious groups. Here the treatment of elderly patients is marked by the attention they receive. It is not true, however, that all religious groups are devoted to the service of God. The care of the sick elderly. The information passed by the way of examinations and inferences of these patients provides an increased opportunity for each one, the community to assess their care. Often, it is not the case that the elderly are neglected, but rather that they are not provided with the care and attention they need and deserve. Obligations to God are exemplified by obligations to all people.

The common practice of the elderly care in nursing homes is rendered by individuals who are less powerful in society. The abuse of sick old persons in nursing homes comes from the abuse of the elderly by both those in control of the relatively powerless and the system which appears absolutely powerless. In these areas, expressions of power can be channelized, unless they are real, and can be given formal or legal recognition by overriding obligation. Obligation demanded by regulations and laws is a poor substitute for personal obligation.

Obligation and responsibility are reciprocal. The personal responsibility of the nursing home care must be directed primarily toward the old person. Alternately, the nursing home caregiver may demonstrate responsibility for old persons. If they are empty, if we believe in the extension of ourselves, and that they cannot be taken care of or treated in disregard of ourselves without offending us. That is to say, that “to do something to my body without my permission to to wrong” is right. It is in these cases that consent to treatment is required from patients. The doctrine of informed consent implies that, “I am the only one who should have the final say about what can be done to my body in my best health.”

It might be argued that I have misrepresented the case. One of the points I was trying to make is that there are personal differences in this regard. The concept of consent is to be done to or for a person’s body is for the person to decide, given his individuality and the role the person, rather than to the state or to God. It is possible that only in this century, in the United States, persons are given a different role in the treatment of their bodies (except when the armed services are involved). The change in the situation is seen in the recent modifications in law in which attempting...

ABUSE OF THE ELDERLY IN HOSPITALS

It follows from what has already been discussed, that the elderly are also abused in hospitals, but here the issue appears more complex. The abuse may arise during the course of medical treatment which is, in itself, apparently proper. The problem arises not with old people who have the capacity to consent to treatment, but those who have lost capacity. Many hospital beds all over the United States are occupied by irreversibly incompetent old people, in whom cognition is progressively impaired and who would surely die but for effective medical treatment of infections and organ failures. Because the treatment that sustains their lives is given despite their previous expressed wishes to the contrary, or contrary to the wishes of their surrogates, they are being abused. Here the abuse arises not from the intentional exercise of power over the powerless, but from the failure to allow physical and emotional exploitation of the human being. Incompetence is not the result of acute illness; it will not disappear when the present illness is over, and there is no effective treatment of the incompetence. Incompetence has usually come on gradually and has been present for many months to years. The usual diagnoses of the mental incapacity are Alzheimer’s disease, multiple system atrophy, stroke, or other organic dementia. All of these patients are known not to have other diseases the treatment of which might restore their competence. I am restricting myself to those who are incompetent, and I mean that they cannot hold a conversation, respond appropriately to questions or gestures, and exhibit no evidence of comprehension. There may or may not be evidence of conscious ness, but these patients usually do respond to painful stimuli.

MARCH 1989/NEW YORK STATE JOURNAL OF MEDICINE 161
situation (for example, in trauma, no one would transfuse a patient whose skull had been crushed simply because anemia is present).

Traditionally, in emergencies and otherwise, three conditions are met. The first of these is that a relationship exists between the patient and doctor, in fact or in custom. In nonemergent care, the patient has become a patient by choice and request, responding in some manner over time, with the opportunity to end the relationship. (In emergencies, the implicit expectation is that the patient would, if able, desire the intervention and become a patient, and the doctor will feel responsible for and to the person no matter what the state of consciousness. The emergency is expected to be over at some time, the recovering patient then being able to respond to what was done on his or her behalf.) The second condition is that in treatment the good of the patient is intended. The good of the patient is not automatically the same as the good of an organ or body part. (Being equated with their body parts is universally disliked by patients.) The third condition is that some concept of the future is inherent in the treatment. It is possible to see the treatment of an episode of disease as an isolated event, but to do so depersonalizes the event as surely as treating merely the body depersonalizes the patient. When the goal is the good of the patient, it is always implied that no matter how bad the future may seem, it exists, and will be better with than without the intervention.

The definitive treatment of acute episodes of illness in the hopelessly sick, hopelessly incompetent elderly patient meets none of these tests. The patient does not request the treatment. The presumption that the patient would request the treatment if able is extremely doubtful, because a significant number of persons would not wish to live given these circumstances. Treatment is possible but does nothing for the underlying problem. It is difficult to know if the treatment is doing good or harm. No restored individual will emerge at the other end of the acute situation. No relationship is involved at the time of treatment or in the future. The doctor may feel some sense of responsibility but will be in conflict as to whether his or her treatment discharges the obligations. The good of the person is not necessarily intended. And the actions are largely in disregard of the future.

**MEDICAL THERAPY AS A FORM OF ABUSE**

To abuse someone is to violate the terms of your relationship with them and to take advantage of the relationship. The elderly are abused when others in relationship to them use them to their disadvantage. The incompetent elderly are abused by treatments meant to keep them alive in the face of the inexorable progression of their underlying disease. It is difficult to apply the term “abuse” in these circumstances because, with rare exceptions, the intent of physicians treating such patients is good. Why, then, does the abuse come about?

There are three reasons. First, it is not primarily the sick person that is being treated, but rather events that happen to the patient. For example, the events of sepsis, hypotension, renal failure, and carotid sinus dysfunction are perceived as separate occurrences, rather than as an episode in the ongoing history of a sick person. Because of this, there is no sense of a life that came before sickness and into which the sickness, the death, and the events preceding death must be fitted. There is also no sense of the future to which the patient will be returned. Some therapies are fitting; however, others are not, because these treatments do not fit the story of the person’s life and terminal illness. Medical therapy that is oriented towards events rather than patients is, in fact, an abuse of the person. Pernicious effects stem not from fate but from those who take care of the person when he or she is most defenseless.

The second reason is that the treatment reflects what the technology of medicine allows physicians to do, rather than what the patient requires. In this regard, the technology should not be seen as merely an inanimate tool, but rather as an extension of the personal power of physicians. We do not utilize technology because of what it will do, but because of what we can do because of it. We do not support failing renal function when it serves no long-term purpose because a dialysis device can do so, but because the device extends our power to support the failing kidney. It is the inappropriate use of power that must be resisted, not technology itself.

The third reason that elderly patients are often abused in hospitals by physicians who have good intentions is that if the proper restraint of power were exercised, physicians would have to express their obligations and responsibilities to the sick patient instead of merely to the patient’s body. But what is good for the body is generally a straightforward matter, while the good of the patient may be uncertain, difficult to ascertain, and ambiguous. There is little wonder that decisions are made on the basis of the physiologic parameters that flow from labsheets and monitors rather than the personal determinants. Doing the right thing requires careful history taking, intensive and difficult questioning, and painstaking mediation between family members with differing opinions.

**CONCLUSIONS**

Abuse of the elderly occurs primarily because of the exercise of power by others unchecked by obligation or responsibility. Law and regulation are poor sources of restraint of the powers of others over the helpless elderly. In general, it is the web of mutual obligations and responsibilities that regulate the power of the participants in social relationships. In medicine, it is the obligations and responsibilities of physicians in relationships with their patients that have regulated their actions over centuries. When no actual relationship is possible, as with unconscious or completely incompetent elderly patients, obligations and responsibilities flow from the traditional and ideal conceptions of the relationships developed over the centuries and still current in medicine. When these are forgotten or their uncertainties and ambiguities forgone for the greater certainty and simplicity of purely technical medicine, then the power of physicians over individual patients is left unchecked. It seems to be in the nature of the human condition that in the absence of checks and restraints, power is almost invariably abused. Based on the treatment of the incompetent elderly, this seems true of medicine also, despite the profession’s underlying benevolent purpose. Obligations and responsibilities to ill persons remain the primary defense against the abuse of the sick.