Abuse of the elderly: Misuses of power

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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 technologic power than they are with the restraint of such power. When persons acquire power, they 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 each 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.

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There are many reasons acceptable to society for a child to refuse responsibility for an aged parent. This is implied in the current welfare laws that sharply limit a child's responsibility for an indigent parent. What makes the abuse particularly noxious is that the child has already accepted responsibility for the dependent parent.

Notice the distinction our society makes between the elderly person who is beaten up by a street thug and the elderly person beaten up by their offspring. The former violence is not cited as an instance of abuse, but the latter is. In the one, there is sympathy about the bodily injuries, the implied lack of safety for the frail elderly, and the sense of injustice and outrage that a young thug should pick on a defenseless old person. In the latter case, there is sympathy for the pain and bodily injury, but also empathy for the anguish we believe is in the old person's heart, sadness that an old person should be so helpless, and outrage that a child could do such a thing to a parent in an apparent betrayal of their relationship.

If there are instances of children battering their elderly parents, then lesser forms of physical and deprivational abuse must also exist and are in all probability more common. Here the child takes some responsibility for the parent's bodily needs, but abuses his or her greater power over a now powerless parent. That it is frank abuse and not merely mean-spirited, small or nasty behavior comes from the relationship of child to parent. As one does not expect parents to abuse their power over their young and helpless children because of their relationship, we do not expect mature children to abuse their power over elderly parents because of this relationship.

One may make convincing arguments for the utility of the social rules that govern relationships, but they are teleological. The social rules of relationships cannot be proven or derived scientifically, because they arise in the moral dimension of human behavior based on ideas of right and good, and science does not recognize the axes of right and wrong or good and bad. Such matters are indifferent to nature, but they are vitally important to humankind. The social rules of relationships are followed because they exist, and because their very existence testifies to common acceptance. While these rules are not derived from argument or science, they can provide the basis for further discussion. The rules of relationships are largely concerned with the relative exercise of the powers of the participants and their responsibilities. It is part of the political history of Western civilization that progress has been marked by the protection of the weak from the strong. The great equalizer is the rule of law in a country dedicated to individual freedom. But law and regulation have distinct limitations as means to control the abuse of powers within a relationship. They cannot supplant the need for a sense of obligation and responsibility instilled in the participants in any relationship. It is impossible to legislate or write regulations to cover every instance of the interaction of one person or group with another person or group. Laws and regulations change slowly and, in the very nature of their genesis, lag behind changes in social rules and customs. There is, in fact, some reason to believe that when law and regulation are over-abundant, the individual sense of responsibility suffers and perhaps even atrophies.

Abuse of the Elderly in Nursing Homes

The elderly are abused not only by their children, but also by representatives of society in positions of power. One has only to visit a welfare office or Medicare office to see how the power of a bureaucrat can confuse, stymie, or even injure the powerless elderly. The elderly, like many citizens, may expect little else from the bureaucracy and its civil servants; it is a common belief that the functionary is in fact primarily responsible to his governmental superior, and not to the beneficiary. The nursing home, however, is believed to be different in concept, if not (sadly) in outcome. Here again, apart from the better institutions, abuse of the elderly is common. Inadequate attention, physical inconvenience, disregard of the humiliation imposed by incontinence and incapacity, and other insensitivities, including physical abuses, are well known. Equally common is excessive emphasis on compliance with regulations concerning medication, accident reporting, bedrails and the like, while human needs are neglected and patients "warehoused."

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 responsiveness to individual need with compassion and kindness. Religious nursing homes excel in providing this because they are dedicated to the service of God through the care of the sick elderly. The inconveniences posed by the incapacities and infirmities of these patients provide an increased opportunity for each caregiver to demonstrate service to God. Obligations to God are exemplified by obligations to sick persons.

Much of the actual care of the elderly in nursing homes is rendered by individuals who are of lesser power in society. The abuse of sick old persons in nursing homes comes about through the actions of the relatively powerless against the almost completely powerless. In these arenas, expressions of power can be mean-spirited, unless they are held in check or given purpose by overriding obligation. Obligation demanded by regulations and laws is a poor substitute for personal obligation.

Obligation and responsibility are reciprocal. The personal responsibility that marks the best nursing home care must be directed primarily toward the old person. Alternatively, the nursing home caregiver may demonstrate responsibility for old persons' bodies apart from the old persons themselves. Most of us believe, however, that our bodies are extensions 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 is to wrong me." It is on that basis 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 behalf," and acknowledges that there are personal differences in this regard. The concept that what is done to or for a person's body is for the person to decide, implies that the body belongs to 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 almost absolute right over their bodies (except while in the armed services). The change in attitude can be seen in the recent modifications in law in which attempting suicide is no longer a crime. (Members of some religious groups believe that the body is God's dominion, and this view sharply limits a person's right to withhold consent for its treatment.) Thus, in the nursing home setting, poor care provided to the body abuses the person. Humiliations that come about because of the treatment of the body are humiliations of the person. These abuses are least present in settings such as religious nursing homes, in which caregivers feel responsible and have obligations to the patients which limit the exercise of power over the powerless elderly.

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 issues are more complex. The abuses may arise during the course of medical treatment which is, in itself, apparently proper. The problem arises not with old persons who have the capacity to give consent for treatment, but with those who lack 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 frequently given despite their previously 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 physicians' responsibilities and obligations to old persons to provide checks on the technologic power employed in their treatment.

To avoid misunderstanding, let me clearly define the patient population of which I write. These old persons have several characteristics apart from the presence of their current acute illness. Their incompetence results from chronic, irreversible mental incapacity. Their incompetence is not the result of acute illness; it will not disappear when the present illness is over, and there is no effective treatment for 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, multi-infarct dementia, strokes, or other organic dementias. All of these patients are known not to have other diseases the treatment of which might restore their competence. I am restricting my comments to patients whose usual state is such 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 consciousness, but these patients usually do respond to painful stimuli.

It might be argued that I have misrepresented the case. One might contend that incompetent elderly are not being abused; rather, they are being properly treated because they are being kept alive. However, is keeping them alive proper treatment or abuse? Since the issue exists solely because of our current technologic power, we must ask ourselves whether it is an abuse of this technologic power to use it for this purpose. I have pointed out that power is best held in check by obligations and responsibilities, and that these arise primarily in relationships—that, in fact, it is obligations and responsibilities that maintain the balance of power within personal relationships. Physicians maintain relationships with the public, the law, other physicians, the hospitals in which they practice, the profession itself, and patients. While all of these relationships affect the exercise of physicians' power, they derive from the principles that guide the relationship of an individual doctor with an individual patient.

In the care of the incompetent elderly, no actual relationship with the patient is possible, and the doctor's actions are guided by idealized notions of the doctor-patient relationship and the associated responsibilities and obligations of the physician. Nowhere is there warrant for the belief that obligations or responsibilities to patients are discharged by the care solely of the diseased body, particularly when the treatment is in disregard of the patient's wishes. Care of the diseased body is not necessarily care of the patient. When treating patients such as these, physicians state that they are doing it for the benefit of the patient; that if they do not support failing organs or treat infection, the patient will surely die. It is worthwhile, therefore, to question why any episode of disease is treated.

Legal Considerations

Many physicians say that they are legally obligated to treat incompetent elderly patients, and that they may be sued for malpractice or prosecuted if they do not provide treatment. Unless the patient has left directives requesting such treatment, or the patient's legal surrogate requests treatment, physicians are under no such obligation. If patients' moral surrogates ask that they be treated, despite their lack of standing as legal surrogates in New York State, physicians are probably correct in continuing treatment. Too often, however, the family is put in the position of being asked, "Is it all right if we let your mother die?" after which it takes a brave family to insist that senseless treatment be discontinued. More often, the recourse to legalisms is merely an excuse not to exercise judgment in the treatment of a patient who requires the physician's best judgment of when it is truly wise to treat or not treat. Treating the patient because the hospital counsel insists that the hospital be protected, or because physicians want to protect themselves, regardless of the good of the patient, is in itself a definition of patient abuse.

Why is any episode of disease treated? Treatment traditionally occurs because a person asks to be treated, a physician concurs that a reason for treatment exists, a treatment actually exists, more good than harm is anticipated, and the physician is not being asked to do harm, damage normal tissue, or become involved in a probable cause of death (as in high-risk surgery). Doctors also act when patients are not able to request treatment, that is, in emergencies or with an unconscious or acutely incompetent patient. Here the essence of the situation is its immediacy; it is an event, a complete circumstance of its own. In these situations, doctors treat because a medically recognizable problem exists which would lead to permanent disability or death.

If no urgency exists, physicians usually wait until the patient can ask for treatment. Further, treatment is considered to be possible when it will not do harm, and it is directed towards at least a meaningful possibility that a viable person will emerge at the other end of the acute

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 job right 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.