Ethics and the Elderly

Scenario

Dr Slick Snyman is an orthopaedic surgeon with a special interest in hip replacements. He has a 5/8th post at the local government hospital and a busy part-time private practice in a private clinic. On the same day last week he saw two patients with hip fractures which he considered should be managed with hip replacement. Both patients were elderly.

The first patient was seen in the public sector hospital. This patient was a 69 year old African man, Mpho V. He had a long history of alcoholism with a number of medical and surgical admissions. He was knocked down by a car and sustained numerous lacerations and bruises but his most serious injury was a displaced intra-capsular fracture of the femoral neck. Despite mild emphysema, Mpho is considered a good anaesthetic risk. He consented to surgery with an 'X' on the form.

There is however, a limited budget allocated to prostheses in the hospital and an informal selection process is used to allocate hips. There is also concern regarding the quality of hip prostheses supplied on contract to the hospital. The device on contract is a 'less expensive', metal-on-metal joint. Similar prostheses have been withdrawn from use elsewhere.

The second patient is a 89 year old white woman, Anne. She was seen in the private hospital. She has a previous history of hypertension, hypothyroidism and a left haemiplegia. She fell while engaging stairs and fractured her right hip. She appears somewhat confused and disoriented. She has made an attempt at signing the consent for surgery form administered by the nurse aid. She is no longer covered by medical insurance but her children are contributing to her care.

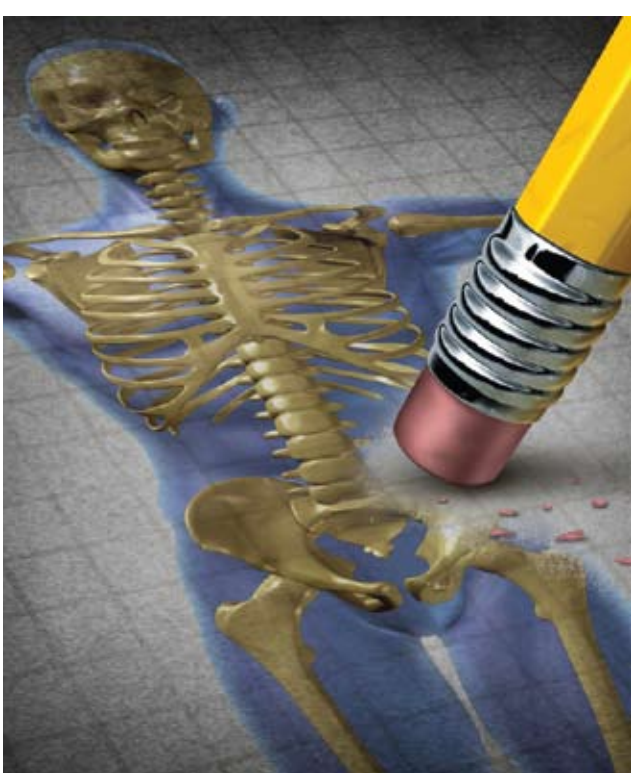
These cases bring to the fore many ethical issues that arise in the treatment of the elderly as well as dilemmas of a more general nature.

Some ethical issues

Informed consent

In both of these cases, it appears that the process of informed consent has likely been subverted. One of the pre-existing requirements for informed consent is that the patient should be competent to consent. It is common that elderly patients may not be fully competent (or more p.c. 'capacitated') to understand the choices at their disposal. Competence is not an all-or-none business and the patient's autonomy may be improved by instituting many processes. Simple matters like addressing the patient in the home language, avoiding medical jargon, talking clearly and loud enough to assist the hard-of-hearing and treating pain may often improve understanding. This may take time and patience; often both are in short supply!

More formal assessment of competence in the elderly may be aided by utilising one of the structured tools designed



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for this purpose.[1] If, even after optimising the situation, the patient still appears unable make a competent decision, then the doctor must rely on either a valid advance directive or more commonly surrogate consent. The next-of-kin should make the decision using 'substitute judgement' values (as opposed to the 'best interest standards' used in surrogate consent in children). The question is asked, "Knowing Anne (or Mpho), what do you think that she would have requested under the circumstances?" Surrogates may have conflicting interests or even if well-intentioned often get it wrong - about 40% of the time.[2]

Cost containment

In both these scenarios, costs must be considered. There is increasing realisation that even for well-resourced or insured patients, there are limits to affordability. Hip fractures are common in the elderly and the incidence rises with increasing age. The cost per case in the Netherlands is about €20,000[3] (R240,000). Rationing of healthcare is a reality in both the public and private domains. Who should decide, and using what criteria, whether Mpho should receive one of the prosthetic hips?

Resources and scarce resources

The allocation of medical resources is often a haphazard process all the way from the treasury down to the clinic. In the private sector highly profitable activities often take huge precedence over more mundane, basic, cost-effective care. Cross subsidisation is practised in both the private and public sectors. Often those who shout the loudest get the most. There may be a brand new scanner in the imaging department while there is only amoxicillin in the pharmacy.

The allocation of especially scarce resources requires pre-existing guidelines or protocols and these protocols need regular review as conditions change. There are a variety of factors that may be considered when drawing up a protocol. Equality and equity should recognise that all lives are inherently equal. If this were the only consideration then a simple lottery could be used to allocate. However, most health care workers would prioritise certain patients above others. The sickest patients may demand urgent allocation but prognosis should also be factored into the decision.

Quality- or disability-adjusted life years (QALYS/DALYS) could be used. It may be just to consider social usefulness of the potential recipient or even 'punish' previous high risk behaviour. In this respect, for example, a person who has previously regularly donated blood may 'reciprocally' receive a scarce resource ahead of another patient or conversely a chronic smoker may be denied a lung transplant.

The main responsibility of central government is to decide on macro-allocation such as Education vs Health vs Defence. Provincial government should then prioritise how the health allocation is divided; Primary vs Secondary vs Tertiary. The allocation of scarce clinical resources is usually the responsibility of the local institution and thus follows the budget. The decision on, for instance, who gets the ICU bed is the responsibility of the ICU managers. Community representation in the process is essential. It is disappointing that hospital administrators often wash their hands of these decisions and give little support in this regard, probably fearing litigation.

In the case of Anne, conservative treatment and safe bed rest may well be a more humane practical and ethical alternative to operative intervention. The case of Mpho may be more difficult. Hip replacement and attention to his addiction seems a feasible option.

Societal inequity

The poor (and the rich) are always with us and there will always be disparities between the medical care available to those in the private and public sectors. Our ethical responsibility is to ensure that at least a reasonable level of care is available to all. In this scenario, for example, the standard of the hip prosthesis available in the public sector is called into question. It has been recognised that there is an ethical need to maintain an orthopaedic joint registry to ensure that interventions are more effective than alternatives.[4] Perhaps the largest ethical elephant in the room is the wide disparity between sectors in SA. It remains to be seen whether the NHI will successfully address this.

References

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