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Ethical issues in clinical practice

Ethical issues for older people in the emergency department

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ABSTRACT

The Emergency Department is a specific setting where the challenges of delivering ethical care are especially pronounced related to time pressures, urgency and acuity. Whilst ethical principles are designed to be used in any setting, this article develops their application in clinical practice in the Emergency Department. We discuss capacity assessment and best interest decisions, as these can be particularly difficult in the Emergency Department setting, for example in patients with confusional states. We offer some practical guidance on how to address such scenarios. We discuss the notion of 'frail friendly Emergency Departments' that are ethically designed and capable to deliver frailty attuned care. This is because if European healthcare systems are to respond to the increasing numbers of older people with frailty, there will need to be a step-change in the provision of urgent care.

1. Introduction

Despite variations in the configuration of healthcare services across Europe, the Emergency Department is often seen as 'The Front Door' to secondary care services at times of crisis. By their nature, Emergency Departments are designed to triage and rapidly assess attendees, initiating treatment, referring to specialist services or facilitating discharge. Although this model is highly effective for those with a single-organ problem, the complex and often subtle presentations characteristic of frail older people, demand a more holistic approach.

The risk-benefit ratio associated with decision-making in frail older people in the ED is not the same as for more 'robust' cohorts. For example, whilst hospital can be viewed as a place of safety, enforced bed-rest can lead to reduced muscle mass and increase the risk of adverse outcomes such as falls [1]. In people aged 85+, admission to hospital is associated (but not causally) with a mortality rate of 46% at one year [2]; some of this might be avoidable. Factors influencing such outcomes in frail older people include the existence of cognitive impairment, multiple co-morbidities, polypharmacy and concomitant functional impairment, which makes assessment and management challenging.

These issues conflate to influence decision making with frail older people in the ED setting. An ethical framework can be helpful in guiding the decision making process. In this review we will discuss particular challenges for older people in the ED and the ethical implications.

2. The ethical principles governing decision making

One of the most commonly used frameworks in medical ethics is Beauchamp & Childress' Four Principles [3]. These consist of autonomy (the right of an individual to make decisions), beneficence (acting in the patient's best interests), non-maleficence (acting to do no harm), and justice (fairness and equity). Whilst ethical principles are designed to be used in any setting, this article develops their application in clinical practice in the Emergency Department. When considering ethical dilemmas it can be helpful to consider each of these principles in turn.

Case Study: Mrs A., an 86-year-old lady, is bought into the Emergency Department with suspected sepsis. Staff are concerned that she is confused and may be delirious, and she is refusing to have an intravenous (IV) cannula inserted for IV antibiotics and fluids. You have been asked to cannulate Mrs A. How would you approach this scenario?

Autonomy: Wherever possible, an individual should be helped and encouraged to make their own decision and these decisions should be respected. In this case however, Mrs A. may not have capacity to make this decision as she is potentially delirious. The principle of autonomy is strongly linked to capacity, which is discussed in detail later.

Beneficence: Healthcare professionals should always try to act with the patient's best interests in mind. In most European

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countries, if a patient has capacity then their decision cannot be overridden, even if it is felt that their decision is unwise. If the patient does not have capacity for the specific issue in question, then healthcare professionals should initiate a discussion with those that know the patient well, as well as make reference to any pre-existing statement of preference or values (e.g. Advance Directive) to describe what the patient would have wanted (best interests). In this scenario, if Mrs A. has capacity then her decision not to have the IV cannula inserted would have to be respected. If she does not have capacity, then a decision needs to be taken in her best interests. This would need to take account of the procedure itself (having a cannula inserted can be painful and may be traumatic in the short term if Mrs A. resists the procedure), as well as considering her prior expressed views as regards treatments. It might be that Mrs A. has a long-established preference for avoiding hospital treatment, and has stated that she would prefer to die than be subject to acute hospital care. On the other hand, she might have been planning to attend a daughter's wedding or other such important event, and might want all possible treatment to allow that to happen. These factors need to be explored and understood in order to arrive at a best interests decision.

Non-maleficence: Perhaps the most obvious of the four ethical principles is that as healthcare professionals we should do no harm to patients. Inserting an IV cannula carries certain risks such as infection or damage to the skin. However, not treating suspected sepsis with IV antibiotics and fluids would potentially cause much greater harm and could lead to long-term disability or even death. It is important to use a physician's body of knowledge to provide a 'risk-benefit analysis' of the pros vs. cons of an intervention.

Justice: The principle of justice, that we should act fairly and equitably, means that all individuals should have equal opportunities to receive care appropriate for their condition. Older people with frailty often exhibit differential challenge–namely that most in need are least able to access services. This might be due to sensory deprivation impairing communication, or disability leading to reduced access to care. Or it may be that services are not appropriately configured and attuned to the needs of older people with frailty. An ethical service will be cogniscent of these issues and make provision for the more vulnerable members of society accordingly.

2.1. Assessing capacity

2.1.1. Definition of capacity

In English law, capacity is defined by the Mental Capacity Act (MCA) 2005 [4] as a decision specific ability to understand, weigh and retain information and verbalise one's ideas and preferences. The MCA proposed that individuals lacking mental capacity should be enabled to exercise their extant (or remaining) decision-making capacity [5]. This legal definition does not give specific measures of an individual's ability to comprehend information. Rather, it is acknowledges that capacity is dynamic and that the 'threshold' varies according to the gravity of the decision to be taken. Transient circumstances such as delirium, tiredness, dysphasia etc. can hinder an individual's thinking process and ability to make a sound judgement or engage in a task. Equally, the capacity threshold for apparently simple issues such as a choice of clothing or food, will not be the same as decision about life-sustaining treatment, even in the same individual. Therefore capacity should be examined in the context of the specific issue at hand. In the ED context, acute conditions such as pain can affect capacity and competence directly. The MCA acknowledges the possibility of fluctuations in capacity, and reminds decision makers that reassessment may be necessary at a later stage–or deferment of non-urgent decision until capacity can be reassessed.

2.1.2. Capacity assessment

Issues surrounding capacity and consent may arise in any age of patient in any healthcare setting and of course do not just apply to older people in the emergency department. However, these issues are particularly relevant in the older population, as they are more likely to suffer from conditions, which may impair capacity, such as delirium or stroke. They are also more likely to have conditions which make it more challenging to assess capacity such as hearing or sight impairment and communication difficulties. Addressing such matters in emergency departments can also be more difficult than in other healthcare settings because decisions are being made by professionals who have never met the patient before, in an environment which is often noisy and time-pressured.

Assessing capacity properly and appropriately is crucial because deciding that somebody lacks capacity and enacting the best interest's framework impacts upon autonomy (see below on best interests). All health and social care professionals should be trained to assess patients' capacity for the treatments that they might offer; high stakes decision might require the involvement of specialists in capacity assessment, such as psychiatrists.

Capacity is a time-specific and decision-specific assessment. It must never be assumed that because a patient has a potentially impairing condition such as dementia, that they do not have the capacity to make a decision. Every effort should be made to help the patient to give informed consent. This may include providing written information, using sign language, finding the patient's glasses and hearing aids and taking the time to understand, and be understood. In the case of delirium, characterised by fluctuations, the need to re-evaluate capacity is key. This is particularly relevant if healthcare professionals feel there is a need to use restrictive measures to keep the individual safe, e.g. preventing them from leaving the department. Such actions, although generally well intentioned, must be balanced against the individual's rights and freedoms. Healthcare professionals have a responsibility to familiarise themselves with the relevant legislation and are encouraged to seek advice in difficult situations.

2.1.3. Assessing patients with confusion

It may also be more difficult to thoroughly assess patients who are confused as they may not be able to give a comprehensive history of events, symptoms and past medical history. They may also be unwilling to cooperate with physical examination and tend not express pain or discomfort in the usual ways. It can therefore require much more time, patience and skill to assess such patients. One commonly used option is to take a collateral history from a family member or carer. However, it must be remembered that collateral histories are not always a source of accurate and impartial information. Clinicians should be careful not to break patient confidentiality unnecessarily when discussing patients with others, and specifically should be alert to the possibility of 'elder abuse'.

Delirium, particularly the hypoactive variant, represents a specific challenge that is often currently missed or overlooked especially in the busy ED environment [6]. Recognition of 'brain failure' and prioritising investigation and management should receive the same clinical urgency as respiratory or renal failure. The presence of delirium is not a diagnosis in itself, but in the vast majority of cases, an indicator of an underlying health condition, including sepsis, electrolyte disturbance, drug effects, constipation and others. These health states require their own treatment along with other supportive measures for the delirious patient. Recognition of the change relies on collateral information about the individual and their usual cognitive state. Communication both to ED and subsequently ward staff that the patient has delirium, as well as explanation to their family and carers are critical in ensuring the patient is managed appropriately, recognising their vulnerable health state.