Ethics in Long Term Care
Wisconsin FOCUS
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The Structure of Ethics

ETHICS AND DEMENTIA
“Act and Omission”

Ms. M is an 88-year-old resident who suffers from progressive dementia with periods of extreme agitation. She carries a diagnosis of dementia with delusions and non-psychotic brain syndrome. Ms. M’s condition has deteriorated over the years. She is non-ambulatory, non-communicative, unable to socialize in any way and disoriented. Ms. M has a DNR order and the family has made it clear that all life-prolonging care should be withheld. In addition to avoiding enteral feeding, the family has recently requested that dietary supplements such as Ensure be withheld. The attending wrote an order that all PO supplements such as Ensure and Health Shakes be withheld. In short, the family has requested that tasty but non-nutritious foods be substituted for the Ensure.
The Process of Ethics (Casuistry)

Methods of Doing Ethics
“Theory and Casuistry”

Theory
Top-Down

Casuistry
Bottom-Middle-Down

The Eye Doctor
or
Reverse Engineering
Casuistry takes place in a three dimensional conceptual space involving multiple data points and is not restricted to two analogues.

We become wiser as we get older because our bank of experience is broader.

Think about Pong vs. a modern video game. As resolution improves, detail becomes visible.

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The Structure of Ethical Argument
The Process of Moral Reasoning
The Default Assumption
The Burden of Proof
Casuistic Exploration
Application to the Current Case

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Back To The Opening Case
The Ethics of Patient Refusal

“The Limits of Provider Support”

Optimal Care

Sub-Optimal/Super-Standard Care

Sub-Standard Care

Staff never have an obligation to commit malpractice.

The Ethics of Patient Refusal

Three Resolutions to Conflict

When care provider A and care recipient B are involved in a dispute whereby B refuses (or demands) care that A believes is (in) appropriate, three options are available:

- A May Give in to B’s Demands (if A is unable to show that B’s choice would involve negligence, abuse or sub-standard care)
- A May Forcibly Overrule B’s Choice (if A can show that B’s choice would require A to engage in negligence or abuse)
- A May Legitimately Refuse to Satisfy B’s Demands, But B May Receive the Demanded Services Elsewhere (if A cannot show that B’s choice would entail negligence or abuse, but A can show that B’s choice would involve A in the provision of sub-standard care)
Additional Case Studies

Ethics in Long-Term Care
“Psychiatric Instability”

Mr. C is a resident in assisted living who has requested to return to independent living. Staff indicate that Mr. C was admitted to assisted living based on concern surrounding his documented suicidal ideation and a desire to closely monitor his medication management, even though he did not meet UAI criteria for assisted living. It is unclear how Mr. C scores on the UAI currently but his physical function has not deteriorated since admission. However, Mr. C does have a history of depression and there is some concern that we will be less able to monitor his mental health status in independent living. The primary ethical issue is based, therefore, on whether or not depression, without associated losses of physical function, creates a legitimate basis for ruling out an individual for living independently.

Ethics in Long-Term Care
“She Knows What She Wants”

Ms. M is an 88-year-old resident who has been diagnosed with dysphagia by MBS and a recommendation has been made that she receive only a mechanical soft diet and thickened liquids. Ms. M adamantly opposes the restriction to thickened liquids and desires to drink water and ginger ale. She is capable of voicing her desire, and she is also able to ambulate and secure liquids for herself. Ms. M has been determined to have diminished capacity to make health care decisions regarding her diet. Her diagnosis is senile dementia with delusions. Ms. M does not have a written advance directive, as she indicated no need to complete one since she wanted her son to make all decisions in the event that she lost capacity, and he is the next of kin. Ms. M’s son has been made aware of the health risks associated with allowing his mother access to thin liquids and he has requested that she be allowed such access. Given the fact that Ms. M is deteriorating secondary to advanced age and an irreversible disease, the son wishes that her quality of life be maximized by allowing her to eat and drink as she pleases.
Privacy and Pathology

“I’m a Collector”
Ms. L and her husband have lived in Assisted Living for the past two years and during that time concerns have repeatedly been raised regarding Ms. L’s excessive hoarding behavior. Difficulties regarding hoarding became so pronounced that the Ethics Committee was asked to prepare a general policy level discussion of the issue. Subsequent to the completion of the policy work on hoarding, staff worked diligently with Ms. L and they were able to help her clean out her apartment significantly and to satisfy health and safety concerns. However, Ms. L’s hoarding behavior has continued and the progress made previously has now been reversed. Staff are concerned that the hoarding behavior creates an unsafe living environment that must be mitigated, that it is significant of a mental illness that would benefit from treatment, and that inappropriate amounts of nursing staff time are now being expended on housekeeping tasks. Since efforts to refer Ms. L to counseling and to assist in maintaining a clean apartment have failed, this ethics consult was requested to identify and examine the ethical implications further intervention.

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“He Smells”
Mr. B is a 92-year-old resident who has a history of hypertension, atrial flutter, macular degeneration, irritable bowel syndrome, back pain and constipation. Mr. B has difficulty with several ADLs including dressing and toileting. Mr. B has incontinence of bowel and on several occasions he has entered public areas with feces on his clothing. Mr. B wishes to remain in his independent living apartment and is willing to hire a private duty sitter for the maximum eight hours per day that is allowed by facility policy, and to sign a release of liability indemnifying the facility in the event that he has a poor outcome. Even with these supports, Mr. B often shows up at the dining room disheveled and odorous. Other residents have complained that he needs to be restricted from the dining room at the very least and also moved to assisted living.

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“They’re Just Bizarre”
Mr. and Mrs. E currently reside in assisted living but they take their meals in the main dining hall. The Es have engaged in a variety of behaviors that indicate an inappropriate understanding of social boundaries and are disruptive. These behaviors include rearranging other residents’ plants, interrupting business meetings in conference rooms, and engaging in bizarre behavior during meals. Examples of disruptive behavior in the dining hall include Mrs. E going table-to-table to introduce people to her stuffed animal. Other residents are annoyed by the Es dining room behavior and have asked the facility to restrict their access to the main dining room.