The Ambiguous Ethics of Involuntary Treatment for the Elderly

BY SIDNEY CALLAHAN, PhD

Sixty-seven-year-old Carmen was brought by her son to a geriatric psychiatrist at a New York inner-city hospital. For 20 years Carmen has lived in a six-room apartment with her sister, her niece, and her two sons, all immigrants from the Caribbean. Lately Carmen had begun to distress her family by persistently collecting and storing garbage in the apartment, first in her room and then in the halls and other rooms. Despite her family's protests, Carmen adamantly denies doing anything wrong or having a problem. "These things keep me happy—they remind me of nature," she claims.

Carmen had quit her job after a confrontation in which psychiatric help had been recommended. She also has refused any benefits, relying on her loyal family to support her. A psychiatrist who tested Carmen found her to be mentally competent, detecting no frank delusions or hallucinations. Carmen was not mentally disturbed enough to pose a serious danger to herself or others. Yet clearly her bizarre behavior was deeply disturbing to her family.

Subtle Dilemmas

What should the psychiatrist do? Carmen continued to refuse all suggestions for treatment. Her family, while in despair, was also bound by a strong sense of filial piety; they were reluctant to coercively intervene or to withdraw support. How could Carmen be brought into treatment against her will?

The prospect of involuntary treatment of elderly family members often presents subtle ethical dilemmas, especially in borderline cases of psychosocial deviance or impairment. People with serious but not dangerous personality problems often feel no discomfort themselves; instead, they inflict pain on those around them. In Carmen's case the familiar ethical principles demanding that one do no harm, be beneficent, serve justice, and respect an aged client's autonomy conflict with one another. A care giver who sees respecting Carmen's individual autonomy and right to refuse treatment as the primary ethical consideration would be ignoring the needs of Carmen's family. In all fairness, don't they count too?

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The old problem of determining *who* exactly is the patient, the individual or the family, becomes acute in cases of disturbed elderly family members. Of course, the patient and the family could be viewed as a unit of care, but only by disregarding Carmen's views of the family situation. An aged person in a loyal, loving family presents a particularly distressing dilemma for those souls raised to "honor thy mother and father." To override an old parent's lifelong decision-making freedom seems an affront to human dignity and to family loyalty.

Intermediate Steps

In Carmen's case care givers might decide to declare legal guardianship or coerced civil commitment, or they might take some intermediate steps before considering such drastic action. Many states, including New York, have legally instituted protective services for adults, which intervene in situations among the elderly described as "self-neglect."

In such cases a family or care giver can file a report with the adult protective service agency, which will investigate. Case workers make an assessment and attempt to employ the least restrictive measures for promoting a client's welfare. Carmen and her family would immediately gain some outside help. A case worker could help her family apply for Carmen's benefits. Or, more to the point, heavy-duty cleaning could be mandated as a health or fire-safety measure. At the very least, some social pressure would add force to the pleas of Carmen's family. The family could also be advised that, if Carmen still refuses all help, the next legal step may be a declaration of guardianship or limited guardianship.

Yet again, before going the legal route of calling in mandated protective social services, the

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in 1990 Mercy set up a dysplasia clinic in response to data that indicated cervical cancer mortality rates in Laredo were three times higher than those found in Texas cities with populations three to six times larger. Using the clinic's resources, the program offers women a year-round referral service where they can obtain Pap smears, physical breast examinations, breast-self-examination training, mammograms, financial assistance, and treatment for cervical dysplasia, says Perez.

In March Mercy instituted the Women's Cancer Control Program. Within four weeks, 257 women set appointments through Mercy's cancer control hotline. Of those, 47 percent underwent both mammograms and Pap smears, 25 percent received financial assistance, and 23 percent were assigned an attending physician.

Primary Care Clinics But the best partnership may be Mercy's recent collaboration with Gateway to establish primary care clinics in key geographic locations throughout the city where the community's poor reside. With Mercy providing the facility, Gateway is able to decrease operational costs and expand availability of primary care services.

In June Mercy collaborated again with Gateway to offer a health center in another area of Laredo that is home to a large segment of the community's indigent. The center provides diagnostic services, medical and clinical personnel, and health education for patients and visitors. "The medical center provides the facility and handles patient registration, billing, and rotation of medical specialists to supplement Gateway's primary care physicians," says Perez. "We subsidize whatever personnel the community health program does not have and work with patients to help qualify them for Medicaid and other financial assistance programs to cover their future healthcare needs." □

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psychiatrist and hospital social worker could arrange for counseling to help Carmen's family members handle their problem themselves. This family may need to be morally convinced of their own rights to just treatment within the common household. Their permissiveness and lack of assertiveness may be a major part of the problem. Some group intervention might succeed in stiffening the family's resolve and getting them to demand that Carmen conform to their living standards.

Now that we all know about those forms of destructive permissiveness labeled "enabling," families can be encouraged to exert "tough love," or justified demands for conformity to society's rules. Sometimes overwhelmed parents in disorganized families also need outside moral support to deal with their out-of-control children or addicted adolescents. At times elderly family members may present similar problems.

The Moral Issue

Is it morally wrong to pressure Carmen and override her own judgment that she does not need treatment? I do not think so. Often "persuaded consent" or "negotiated consent" is necessary in borderline cases of mental disorder in which family and professionals agree that an elderly person and his or her family need help that is being refused. Even if Carmen and those in similar situations live in states without adult protective service laws, professionals can hardly be justified in taking a laissez-faire attitude to their situation.

At times, enforced intervention is a better course to follow. A professional can ethically decide to override individual autonomy when a person suffers from a harmful dysfunction and intervention will benefit both client and family. Even though Carmen is not cognitively incompetent, her inability to work and live by her family's normal standards counts as maladaptive behavior, whether she recognizes it or not. To exert pressure to bring her into treatment will bring benefits to her and to the long-suffering family who cares for her.

Ambiguous cases of borderline conditions affecting the elderly will naturally cause discomfort. No healthcare provider wishes to regress to the bad old days when "ageism" was the rule and the coercive power of professionals was regularly abused. But to fail families in the name of an individualistic ethic of autonomy is equally irresponsible. A benevolent "paternalism"—or, better yet, "maternalism"—may justify forceful interventions.

In a confusing, complex moral situation, beneficence and justice can sometimes trump respect for patient autonomy. Not every elderly patient has an absolute moral right to refuse treatment. □