**Chapter -5**

**Geriatric Medicolegal Issues -An area of Concern for Successful Future Trends in Medical Sciences**

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**Introduction**

Elderly form a heterogeneous group as they reflect several characteristics and atypical presentation of several challenges in the particular age group places them at special risk in the healthcare system. They are vulnerable to multiple chronic co-morbidities and hence are of special concern as they have limited incomes, turned down access to care impeded by personal mobility or transportation problems and lack of insurance coverage for health services.

With the ever-growing proportion of elderly population, there is greater demand for geriatric care services especially through conservative approaches with more focus on retention and regain of overall well being.

Challenge includes treating the diseases at complex stages of the diseases due to stereotypical ageist behaviours characterized by lack of perceived need for treatment due to ignorance and delayed reporting for professional help. Their formative years would have involved treatments through more invasive techniques which are recently replaced with the evolution of laser technologies, robotics surgeries and management information systems supported by artificial intelligence. Care giver stress has the potential for predisposing them to health deterioration and this impact on the working age group could invariably affect the economy of a country. According to Corcoran et al in 1991 and Rosseau et al in 1993, about 30% of the care givers were indulged in potentially harmful behaviour towards the elderly whose anger levels were found to be directly proportional to it as found by McNeil et al in 2009 [1-3].

Health care for the elderly has captured national attention due to demographic transition, unmet needs and its spiralling costs. Advancements in the field of science and technology has led not only to a massive expansion in the magnitude of services but also increase in the life expectancy with improvisation in the overall quality of life.

Ethical care provision in the geriatric population is very challenging due to its complexity and hence requires mindfulness.

Major ethical principles include autonomy which gives freedom of choice, justice that offers fairness to all without any discrimination, beneficence that involves in doing only good, nonmaleficence that ensures that no harm is done at any state, veracity which emphasizes on being honest and trustworthy while fidelity which is demonstrated in work and confidentiality that safeguards the privacy as per the Health Insurance Portability and Accountability Act. Reciprocity refers to remaining integrated with being true to own self with respect and support of values and views of others simultaneously.

Failure in the provision of adequate care is called negligence while the same by a professional is called malpractice. Refusal to care for an elder by the concerned person is termed neglect. Omission refers to miss out of what is expected or ordered while Abandonment refers to causing a defenceless state by the dependent individual for an elder person. Intentional torts are acts performed to bring about certain desirable result which may be of assault that threats to injure and battery that refers to unnecessary and unconsented contact. Defamation could be libel or slander which could affect the reputation of an elderly person. Invasion of privacy is an act of interference or violation in the rights of a person who is desires to be alone and undisturbed.

Elder abuse is justified as major public health problem for its implication in morbidity and mortality. It refers to any action that causes distress to an individual who is aged sixty years and above which could be of physical, psychological or emotional, financial or sexual forms. It induces devastating consequences on the health status of the elderly through violation of their fundamental human rights. It is not a mere health issue that could be identified through straightforward assessment and no single standardized screening tool is available for its early detection. About 24% of the Indian elderly were subjected to abuse despite the fact that 75% among them were living with family as per a study by Help Age India [4]. It is often poorly recognized due to lack of witness and the WHO 2012 reports found that about 50% of cases were missed by the primary care physicians in reality [5]. Hence, it is an important aspect to be understood by the geriatric health care provider in order to provide appropriate care and unbiased treatments with elimination of blaming the victim who is actually in need of help.

The reporting policies are generally different across countries. It is considered a crime in the United States where the mandatory reportings are dealt legally. It is often considered as a matter of upholding family honour and remains uninformed by 80% elders in India as per the 2012 Help Age India report which also found that 55% victims never disclosed.

The physical restraint causes susceptibility to adverse effects in older adults and leads to reduction in their quality of life and is applied to only those who are legally detained. only after outweighing against the risk of complications and must not lower the dignity of the older adult for whom it is to be employed only at times when behaviour management is exhausted while the chemical restraints refers to administering psychoactive pharmacological agents.

Patient’s autonomy refers to freedom in withholding or withdrawing a treatment even when it could hasten or culminate in fatality. It is ideal to identify and receive appropriate proxy consent for those potentially incompetent elders at times of medical decision- making where substituted judgements or best interests are considered.

Valid consent is the basis for ethics in health care delivery as well as research. It is always beyond the act of an individual signing a document. It brings about better communication between the patient and the healthcare provider, study participant and the research investigator ensuring that the pros as wells cons along alternative modalities and the potential risks involved are mutually well understood and documented. There are three models namely informative, interpretive and deliberative. Necessary information is provided in the first and additional assistance considering the needs and values along suggestions for desirable outcome is offered in the second model. The thirds model supports friendly discussions and results in the selection of best treatment modality at own will. This model is adopted for geriatric patients in contrast to the paternalistic method and is regarded as team model by Goal et al in 2012 [6].

Advance Care Planning (ACP) denotes discussion sessions of the patient, proxies and the health care team which involves comprehensive communication to arrive at plan in the desired direction which is goal related respecting the decision enabling a smooth end of life. However, no such legislations exist in India contributing as a barrier in the delivery of providing adequate care for terminally ill patients as the scenario is overwhelmed by personal beliefs and experiences regarding demise.

Numerous physical, cognitive and sensory deficits are strongly correlated with advancing age and causes interference in the consenting process as the older adults who have encountered these have its impact on the capacity for interpretation or reporting of the symptoms, understanding of the professional communications and ability to comply with recommendations. Furthermore, an impaired elder may resent the intrusion of a family member into his or her patient/dentist relationship. The independent decision making capacity for consent includes ability to comprehend diagnostic information and treatment options for opting the modality after weighing its risks and benefits.

The ethical issues of elder care are very often regarded sensitive and revolves around the relevant ethical principles and the psychosocial aspects of aging which governs their decision making capacity, the types of consent to be obtained that is valid in the court of law, the denial that happens due to lack of knowledge and adherence to traditional misconceptions along disbelief of treatment outcomes and the advance directives (ADs) which refers to the living will and durable power of attorney as per the desire of the older adult.AD plays a crucial role in facilitating end of life decision-making. This necessary element has not been much popular in emerging nations due to its idiosyncratic bioethical development [7].

End –of Life Care is remarkably becoming significant as 70% of the deaths are non sudden. It may also extend up to euthanasia or physician assisted suicide. The former refers to deliberately ending the life of an older person on request while the latter involves self-administration of lethal medication resulting in the same. It involves complex medical decisions and its widespread practise is in the industrialized regions and is subjected to cultural influences at developing nations.

Palliative care is new trend which aims the integration of physical, psychosocial and spiritual care for improvising the quality of life and this offers a cost-saving benefit.

It is the responsibility of every health care provider to proceed with collective decision after clear discussion about the pros and cons regarding the treatment plan and has fiduciary responsibility playing a major role in adhering ethical obligations to good stewardship of patients as well as organization.

Consideration of advance directives and provision of all heath related information in written is essential as per the Patient Self-Determination Act of 1990. However, the decisions have high tendency to fluctuate over a period of time due to transient changes as consequence of decreased ability to comprehend and communicate. Hence, it important to verify the decision of the elderly for its consistency, coherence, apprehension, adequacy of disclosures and must be ensured that it given voluntarily. It is legally determined by the competency of the elderly which takes in to account the mental ability for testimony as well as capacity to execute related formal documents. The competency of the elderly patient has received little empirical investigation in the literatures and there exists nil gold standards for its corroboration [8].

Ethics is about the declarations as to what is right or wrong while its applications to matters of life and death are called as bioethics. Ethical conflict arises at times of facing challenges with unsatisfactory alternatives or when decisions are to be taken while dilemmas arise in situations that seem to have incapacity for satisfactory solutions. There are three types of ethical conflicts namely moral distress, uncertainty and dilemma. The former refers to causation of distress in an individual who desires to perform righteous actions due to inhibition by the constraints of an institution or society while the latter refers to scenario that encounters mutual support for dual inconsistent actions for which moral principles apply as well. The root causes for ethical dilemma are competing values and loyalties along with differing perspectives due to varied cultural, socio-economic and political backgrounds. For instance, DNR refers to do not resuscitate which is legal but it must be justified with the request of the patient or medical indication when performed [9].

The ethical dilemmas decision making model takes in to account moral principles and comprises five steps. It initially involves the collection, analysis and interpretation of the data and then the dilemma is stated following which all the choices of action are considered based on the advantage and the disadvantages of each alternative that consequently results in decision making. The final step involves evaluating the effectiveness of the final decision [10].

Effective communication which is a skill in the art of medicine may prevent the ethical dilemmas and thereby its associated consequences or issues as it mostly arise due to inadequate patient and practitioner interaction. Appropriate review of an older adult’s medical indications and influential health status factors along the understanding of patient’s choices, goal or expectations may provide ease in handling thus providing mutually acceptable decisions at times of ethical dilemma for both the health care provider and the elderly [11].

**Conclusion**

Appropriate policies and public statements are the needed to overcome the stigma on ageism, encouragement of self reporting abuse coupled with enhancement of public health awareness programmes on elder abuse, promotion of research to facilitate appropriate collection of data to formulate suitable preventive strategies for overcoming menace of elder neglect and violence, development of adequate infrastructures to support elderly at times of mistreatments and mount of access towards services through advocacy and empowerment are the strategies to be adopted for protecting the dignity of the elderly. Geriatric services should be planned such that it caters the needs of both the care giver as well as the recipients. Futuristic developmental trends in medical sciences involving gerontological approaches should be evidence based and supported by theoretical frameworks resulting in commencement of effective interventions through collaboration with interdisciplinary team. Institutional systemisation of advance directive processes in India would ease the delivery of geriatric health care services as it would aid in the development of palliative care which is still in the initial stage.

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