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## MEDICAL CARE OF THE ELDERLY FROM THE CARE PROVIDER'S POINT OF VIEW

### Opieka medyczna nad seniorami z punktu widzenia opiekunów

Słowa kluczowe: opieka medyczna dla seniorów, hospitalizacja seniorów, choroby przewlekłe wieku straczonego, postawy opiekunów

Key words: medical care for healthy elderly, hospitalizations in old age, chronic illnesses in old age, coping with aging, caregiver's attitudes to care of elderly

#### Streszczenie

Starzenie się społeczeństwa w świecie kultury zachodniej, kreuje wiele palących wyzwań, szczególnie w zakresie ochrony zdrowia i opieki medycznej. Z jednej strony pojawia się wiele oczekiwań w zakresie szerokiej dostępności zaawansowanych metod leczenia, zapewniających poprawę zdrowia i podniesienie jakości życia, bez cierpienia i bólu. Z drugiej jednak strony naturalnemu procesowi starzenia towarzyszy zjawisko pojawiania się chronicznych chorób, opornych na leczenie i tworzących nieuchronne sytuacje uzależnienia osób starych od ich opiekunów. Pomiędzy lekarzami nie ma konsensusu co do tego, jak długo i w jaki sposób kontynuować leczenie, szczególnie przypadku tych przewlekłych chorób typowych dla wieku starczego. Te zjawiska powodują, że leczenie może okazywać się nadmiernie inwazyjnym (wręcz uporczywym), a pozytywne efekty samego leczenia na poziomie somatycznym, są osłabiane przez obniżającą się jakość życia.

#### Abstract

The aging of the population presents modern Western society with a variety of different challenges, especially in the areas of health and medicine. On the one hand, there is a need for elderly patients to receive medical treatments that are supposed to improve or preserve the existing quality of life and to prevent the extension of a life without quality, with suffering and pain. On the other hand, aging is accompanied by the appearance and exacerbation of chronic illnesses, reduces the treatment benefits of medical activities and increases the risks of irreversible physical dependence. Furthermore, the lack of consensus among physicians regarding the willingness of treatment and the proper timing of the treatment of the elderly poses questions about the quality of treatment for the elderly. Thus, in the opinion of different care-providers and in comparison to other age groups in modern Western society, the elderly do not enjoy the treatment advantages of medical activities proven in the treatment of other age groups.

Quality care of the elderly population is a global goal and an interest shared by all decision makers in modern Western society. Furthermore, the aging of the population raises concerns and challenges that Western society had not necessarily recognized previously and which are mainly evident in the fields of medicine and health. An increase in the percentage of the elderly in the population subsequently leads to the appearance of a new range of illnesses. These illnesses require medical follow-up, treatment, and daily support for the patient (Soreide & Desserud 2015: 1). Many hospitals face the challenging burden of coping with the elderly population, which is a population characterized by clinical instability and high risk of deterioration in cognitive ability, often leading to hospitalization (Mercante et al. 2014: 703).

Furthermore, every invasive or noninvasive intervention for the assessment or treatment of illnesses or medical situations may harm the individual's autonomy and functioning and may lead to dependence after hospitalization. In the case of the care of elderly patients, a functional limitation after hospitalization is, for the most part, irreversible. In other words, hospitalization of the elderly is far more complicated and extended, and entails multiple implications for their life and health (Mercante et al. 2014: 704; Scala 2016: 1).

For successful handling of the aging of the population, a modern Western society must acknowledge that the elderly are not similar to other social groups. This group requires unique medical reference unparalleled to other social groups. The research of diseases and physiological situations that accompany the process of aging and care is called geriatrics. It is an area that belongs to the field of medicine and constitutes a subfield of internal medicine. Geriatrics, due to its focus on the unique needs of the elderly, is different from other areas of medicine. The body of the old person is physiologically different since, during the aging process, the functioning of the human body begins to decline, thus causing the development of different diseases. The rate of decline in the functioning of the systems and the appearance of chronic diseases depends on the previous lifestyle of the individual. Consequently, old people develop many chronic illnesses and develop general functional decline rapidly relative to young people (Mercante et al. 2014: 704; Gerlich et al. 2012: 297–298).

With regard to the frailty of the elderly person's body, five parameters are addressed: a significant unintentional decline in body weight; self-reported fatigue; weakness (without other medical reason); walking at a slow pace; and poor physical activity. These parameters are the basis that must be taken into account when caring for the elderly

in hospitalization, even before setting the treatment program for a medical problem (Soreide & Desserud 2015: 5). For most of the elderly, autonomy constitutes a necessary condition in care during hospitalization or at home and is a secure basis for quality of life regardless of the multiplicity and complexity of chronic illness. Independence; continuity of residence in the elderly person's home; autonomy in decision-making (medical and other); preservation of existing physical functioning – all these and other factors define the level of autonomy and medical care in the elderly person's life and constitute a starting point in old age (Smebye, Kirkevold, & Engedal 2016: 1–2).

Because of the development of modern medicine, physicians who specialize in pulmonary diseases have succeeded in extending and improving the lives of many pulmonary patients who, in the past, were fated to die in severe pain and with a short lifespan. Today, through treatment and invasive and noninvasive respiratory support, physicians have succeeded in significantly extending the life of patients who have chronic lung diseases. However, an increase in the survival rates of chronic patients does not correlate with satisfaction with the quality of life. Still today, chronic lung diseases entail reduced quality of life and dependence on others as a result of shortness of breath. Thus, despite existing medical means, pulmonary diseases are characterized by a limitation in the everyday activity and considerable discomfort (such as difficulty in breathing, sense of strangulation, weakness and depression). Longevity, which today is achieved through medicinal and device-based treatments, no longer satisfies either the physicians or the patients. A modern medical viewpoint sets new treatment goals. When patients and their families are placed at the center of the treatment, longevity as a goal no longer suffices unless caregivers can succeed in achieving a high level of quality of life and mental and physical wellbeing. This change in the treatment goals in modern medicine is especially prominent when speaking about the care of the elderly who are suffering from chronic pulmonary diseases. It is commonly agreed among physicians that care of the elderly suffering from respiratory diseases is palliative and constitutes care for the rest of their life. Patients who have chronic respiratory disease in the terminal stages of the disease may require more invasive treatments, even at the cost of additional harm to their quality of life, especially when regular treatments no longer help as they did at the beginning of the illness (Scala 2016: 2).

In nephrology the situation is similar. Social values influence medicine. Western culture places at the top of its priorities the individual's autonomy as a supreme social value. Accordingly, physicians guide the

patients to make decisions that address this value. Therefore, there are many cases in which a decision to begin dialysis is not a medical decision intended for the patient's health benefit, but an outcome of the individual's personal, cultural, and social values and those of his caregiver. In this situation, a large number of dialysis patients undergo treatment following social expectations and pressure, and not because of any medical benefit or the patient's wishes. Consequently, guidelines from the medical associations are influenced more by the values and expectations of society than by medical benefit. This situation indirectly causes the medical misuse of dialysis (Ying, Levitt, & Jassal 2014: 972). Nevertheless, for end of life treatments, it is necessary to obtain full cooperation in the decision-making process from the moment of the determination of the assessment, based on the severity of the disease and the patient's wish – and not on their age (Scala 2016: 1).

In the field of cardiology, the situation is not different. The interests and wishes of heart patients are not considered during the treatment decision-making process or the management of chronic heart disease, whether it is emergency or routine (Schroder, Fink, Schumann, Moor, Plehn & Richter 2015: 3). Moreover, the patient's decisions and wishes often rely on the physician's prognosis, which is the outcome of a collection of statistical data. Therefore, it is possible that the physician's recommendation will not suit the individual patient. Additionally, the decision regarding the timing of invasive interventions, such as mechanical ventilation, for respiratory support, is in the hands of the caregiver, based on clinical data, with the complete neglect of the patient's wishes, especially in situations of medical emergencies, such as the beginning of mechanical ventilation (Scala 2016: 2).

Also in dialysis (treatment of terminal renal insufficiency) the decision from the very beginning, especially concerning a situation of medical emergency, lies in the hands of the physician and is not discussed with patients and/or their family. Yet this form of treatment entails considerable suffering, physical limitation, and permanent and significant harm to the patient's quality of life regardless of the patient's age. Furthermore, dialysis entails considerable suffering and severe complications, such as infections and electrolyte disorder. When a nephrologist is convinced that dialysis will not bring benefit to the patient, even if the patient requests this, the physician is entitled to deny the patient the treatment. However, even if the physician is certain that the treatment of the chronic illness will bring more benefit than harm to the patient, the patient has the right to refuse the treatment, despite the anticipated benefits of the treatment (Germain 2015: 55).

The choice of a convenient treatment alternative should be based on an open discussion between the physician and the patient regarding the patient's preferences for the rest of their life. A research study conducted in Germany shows that most elderly people (more than 90%) do not speak about their expectations regarding their end of life treatment. During their visits to the family doctors (general medicine) patients do not initiate conversations about death and treatment for the rest of their life. Physicians, in their meetings with elderly patients and their family, avoid conversations that may lead them to decisions regarding life and treatments before death. The tremendous mentalemotional? difficulty in discussing end of life treatment leads both the patients and the caregivers to erect a barrier that does not allow the tailoring of appropriate and holistic treatment for the elderly person. Likewise, cardiologists avoid speaking of the fact that heart failure is a terminal disease that may cause sudden death despite medical care (Gerlich et al. 2012: 298).

The prevalence of chronic morbidity, a background of respiratory, cardiac and renal insufficiency, and decreased resistance of the immune system – all these are reduced body functions characteristic of the natural process of old age. Nonetheless, today clear definitions of illness and care in old age are lacking. There is a confusion between curative care, palliative care, and end of life care. The situation is complicated in the decision-making process of the treatment of the elderly (Dousdampanis, Trigka, & Fourtounas 2012: 360–364). Care of the elderly is perceived without exception as end of life care and leads to different treatment behavior, in comparison with younger adults. Thus, for example, the decision to move the patient to the intensive care unit depends on the patient's age. In other words, the chances that an older adult who is suffering from a worsening of chronic respiratory illness will reach intensive care, in comparison to a young adult, are not high (Scala 2016: 2–3). This situation is also similar with nephrology. Despite prevailing opinions of many nephrologists concerning the medical advantages of early dialysis, the primary consideration is the age of the patient. This fact is not surprising at all. A research study conducted over the years in England, Italy, and Australia, found that above the age of 75 the rate of kidney disease rises significantly. Thus, dialysis not only does not extend life and in fact t harms the quality of life, but may also harm and further damage the patient's health. As the patient's age increases, the situation becomes more severe (Germain 2015: 56–57). Advanced age is a negative predictor, regardless of whether this is routine or emergency, invasive or less inva-

sive treatment. Emergency treatments save lives and are more aggressive. Hence, emergency treatments such as urgent operations, regardless of their level of aggressiveness, among the elderly may cause more harm than benefit. Therefore, the biological changes and the physical weakness and frailty related to age cause the caregivers to weigh each case separately (Soreide & Desserud 2015: 4).

According to Germain (2015: 57), it is not ageism not to offer dialysis as a treatment for the elderly patient who is suffering from renal insufficiency. Elderly patients who suffer from terminal renal insufficiency have a short lifespan, and therefore the nephrologist's role, first and foremost, is to prevent unnecessary suffering of the patient, or at least to reduce it to the greatest possible extent at the end of life, . The elderly who are suffering from terminal renal insufficiency constitute a social-economic problem that will become even more complicated. As with any other chronic illness, under-diagnosis and over-diagnosis are equally detrimental and will cost the health system in Western society additional costs that are expected to be higher than regular (Dousdampanis, Trigkla, & Fourtounas 2012: 367).

The source of health discrimination and inequality that is expressed in the diagnosis of the illness and the treatments suggested for patients and family members derive from values and social-cultural expectations. According to Schroder et al. (2015: 1), the main basis for inequality between patients in health is their socio-economic status. In addition, age only exacerbates the existing discrimination but does not constitute a source for the problems. For instance, research studies conducted in England, Germany, and Holland show similar results – the rate of mortality among cardiac patients from a low socio-economic level is higher than the rates of mortality among cardiac patients from a higher socio-economic level. As the age of the cardiac patients increases, the mortality rates increase at all socio-economic levels. However, the rate of mortality among adults with a low socio-economic status indicates a sharper increase in comparison to that of the high socio-economic level. A close look at the problem shows that patients who are painstakingly monitored by a cardiologist and remain for longer in cardiac rehabilitation are more educated and better-off patients. In addition, more than 76% of the cardiac patients who come from socio-economically well-off backgrounds undergo expensive invasive interventions for the purpose of the renewal of blood flow to the heart. It is known that intervention for the purpose of blood flow improvement is an activity whose benefit is high when it is as close as possible to a cardiac incident. Therefore, if a patient has money and the possibi-

lity of rapidly coming to an emergency cardiac medicine institution, he has higher chances of receiving intervention for the renewal of the blood flow to the heart (Schroder, Fink, Schumann, Moor, Plehn & Richter 2015: 1–3).

In the deterioration of chronic respiratory diseases, regardless of the patient's age, on balance, there are two treatment choices: mechanical ventilation and non-invasive ventilation. Non-invasive ventilation is a treatment of choice in many medical situations, such as COPD (Chronic Obstructive Pulmonary Disease), pulmonary edema, hypo-ventilation following obesity, and deformation of the chest. This type of artificial respiration has many health advantages and entails fewer fatal complications in comparison to mechanical ventilation. Sometimes non-invasive ventilation does not, over time, supply the patient's respiratory needs, and then there is a need for artificial ventilation that entails intubation (the insertion of a breathing tube into the lungs). In addition, non-invasive ventilation, in comparison to mechanical ventilation, harms the quality of life less, although it does limit the freedom of physical movement to nearly the same extent. Among the elderly, it is the preferred possibility. There are many reasons for this. The main reason is that non-invasive ventilation harms the quality of life less. This is a critical consideration in a population such as the elderly, who are defined as a population at the end of life (Scala 2016: 3).

Nephrologists have a similar dilemma when they are caring for the elderly population with chronic diseases in the kidney and urinary system. What should be done when it is necessary to shift to more invasive means for the purpose of the treatment of chronic illnesses? First, no harm must be done. For all physicians, regardless of their specialization, the main consideration in the choice of treatment for the patient following chronic disease is the benefit versus the harm that the treatment may bring with it. When the treatment of the outbreak of a chronic illness is provided to a patient of an advanced age the benefits of the treatment are lessened and the chance of possible harm increases (Germain 2015: 1).

The worsening in chronic illnesses and deterioration in the situation of the elderly patient leads the caregivers to adopt emergency treatments, some aggressive in nature, which may be less beneficial at the end of the intervention. In addition, a prognosis of intervention that is based on chronic morbidity among the elderly population, for the most part, leads to undesired outcomes. However, studies indicate that more than one-half of the elderly population above the age of eighty who undergo urgent operations lives an average of at least

three additional years, due to the urgent surgical intervention performed. On the other hand, among patients above the age of eighty, there is an increase in the death rate following emergency operations, hospitalizations become longer, the rate of the need for intensive care increases, patients' functioning is harmed, and the level of dependence on others is increased. It should be taken into account that the mortality rates rise as the patients' age rises. Research conducted in Denmark shows a mortality rate of about 48% among the elderly above the age of 75. Among the elderly above the age of 90 the mortality rate doubles in comparison to younger patients. It is important to note that the mortality rate after a surgical intervention is influenced by the invasiveness and urgency of the operation itself. As the patient's age increases, the mortality rate significantly increases in all the categories.

This finding is not at all surprising. Unlike other areas in medicine, such as pediatrics, in geriatrics uniform treatment protocols have not yet been formed for the treatment of the elderly person. The absence of these treatment protocols not only leads to unexpected and even deficient outcomes in the treatment, but also leaves too great a freedom to make decisions to the physicians in the treatment arena, and consequently there is great difference in the treatment offered to the elderly patients. In other words, evidence-based activity with controlled outcomes in the age group of the elderly is an outcome of guidelines and the formation of protocols that will cause structured and tested treatment for all the elderly. This is like pediatrics, which has used structured protocols for many years that were formed on the basis of the multiplicity of clinical research studies in the field (Soreide & Desserud 2015: 1–2).

Today, there is no agreement among surgeons regarding the desired outcomes of surgical intervention and the correct level of aggressiveness in invasive treatments among the aging population. In addition, there is considerable competition over the existing resources and, as of today, the allocation of the resources in the health system, including in the emergency department, relies not only on the patients' medical needs but also on their age (White 2014: 48).

In parallel to the aging of the population and the constant rise in the rate of the elderly, there is an increase in the number of the elderly with cognitive decline who, for the purpose of making health decisions in general and any medical care, in particular require a guardian. Cognitive decline at different levels of severity characterizes the elderly population in general. About 30% of them suffer from a cognitive decline of a severe level (such as severe dementia) and continue to



live in the community until they die. Despite their high percentage in the population of the elderly, their end of life care is essentially different from the care of the elderly who do not exhibit cognitive decline. For instance, research conducted in the United States found that the old age institutions providing daily care spend about \$11,461 less on an elderly person with cognitive decline in comparison to an elderly person whose mind is clear. The situation is similar in comparison to the percentages of death in hospitalization. Death of elderly people suffering from dementia in hospitalization is 17.9% less since they do not turn in severe situations to medical service. In addition, the elderly who suffer from cognitive decline are moved 9.4% less during their hospitalization to intensive care units than the elderly who do not suffer from cognitive decline. These differences among the elderly between subgroups derive primarily from the difference in the current policy, according to which end of life care, when there is a known background of significant cognitive decline, must be less medically aggressive and more supportive and preventative (Nicolas 2014: 1–2).

Moreover, according to the 2010 guidelines of the Renal Physician Association, it is necessary to avoid dialysis among the elderly who suffer from severe dementia, especially if it is not possible to obtain the patient's cooperation during the therapy. According to researchers from Canada, factors such as a decline in the ability to communicate, the absence of the ability to understand the complications entailed in dialysis and the inability to make decisions independently are absolute contraindications against dialysis. A situation of inability to make a decision regarding the commencement of invasive treatment whose benefits are doubtful projects the responsibility for the decision regarding the treatment on a relative who is the guardian of the dementia patient, who also provides his care. An elderly person with dementia, because of his illness, cannot make complicated medical decisions. In the final stages of the disease, the patient is not able to express his opinion. Therefore, the decision to begin dialysis, as well as other invasive interventions, is in the hands of family members or guardians. Thus, the decision that is made by the family of the elderly person who suffers from dementia to begin dialysis relies on the sense of fear of family members that perhaps their decision to deny this or another treatment to the dementia patient will lead to his decline. Physicians who make care decisions for dementia patients are led by similar feelings. Caregivers are afraid of being blamed by family members and by society that perhaps they did not do enough for the patient (Ying, Levitt, & Jassal 2014: 972–973).

The duty of the caregiving staff in the framework of normal reciprocal relations is to legitimize the elderly person to express emotions in care, especially when difficulties in expression are identified; in this way healthy coping with the process of aging and adjustment to the physiological changes entailed by age is built. In the next stage, for the purpose of the making of a decision in the treatment framework, both the caregiver and patient must crystallize a clear perspective regarding the end of life care. The caregiver's role is to help the elderly patient form clear attitudes regarding his desires in the continuation, so as to help his family members and formal caregivers continue to uphold his values and beliefs in the continuation (Dousdampanis, Trigka, & Fourtounas 2012: 360–361; Pejner, Ziegert, & Kihlgren 2012: 1). A minority of the elderly leave directives for the family members regarding their treatment preferences. When a decision regarding the care remains in the hand of the formal caregiver or family member, it is possible that the goals in treatment will not be identical to those of the patient (Ying, Levitt, & Jassal 2014: 972).

Modern Western medicine has shifted from a paternalist approach (according to which the physician decides everything) to a participative approach (according to which a process of decision making occurs in close cooperation between the caregiver and the patient). However, in the discussion of the care of the elderly, especially dementia patients, the accepted approach has not changed and remains paternalistic. For example, among elderly patients undergoing dialysis about 52% maintained that the beginning of the dialysis was the physician's decision. Only 35% of the patients who participated in the research study felt that the medical decision to begin dialysis was based on their personal desire that was discussed with the physician beforehand (Ying, Levitt, & Jassal 2014: 973).

Alongside medical treatments for the purpose of coping with the implications of chronic diseases (such as dialysis and tracheotomy), there are natural processes of aging that require intervention. During aging, there is a decline in the energy intake that is expressed in the decline in the intake of the quantity or volume of food and calories. A number of different explanations have been proposed for the natural phenomenon of the decline in the consumption of food, including a decline in physical activity (external energy consumption) and internal energy use required for the internal processes of digestion and absorption in the body. Healthy aging is a process in which there is a correlation between the decline in intake and the decline in use. However, in a significant percentage of the elderly, the decline in the

energy intake is greater than the decline in the energetic use, and therefore the result is weight loss. The decline in the consumption of food among the elderly is on a psychological-behavioral, social, and medical background and on the background of age-related physiological changes. All these factors disrupt the balance between intake and expenditure and cause a deterioration in the nutritional situation to the point of undernourishment. Nonetheless, among the elderly who suffer from dementia the development of eating problems is particularly frequent, in comparison to the problem in the general elderly population (Mendiratta et al. 2012: 610).

Consequently, the caregivers often adopt different means to improve or maintain the elderly person's nutritional status. Common means include a nasal tube and gastrostomy (PEG – Percutaneous endoscopic gastrostomy); the gastrostomy tube is more common as the caregivers' choice among the elderly at the end of life. The insertion of a feeding tube (PEG) is intended to improve the consumption of food and liquids and to allow medicinal treatment for chronic illnesses. For instance, in the United States the frequency of the elderly with cognitive decline who live in institutions is about 18%–34% of the total number of elderly patients. About 30% of these patients are elderly who suffer from dementia (Goldberg & Altman 2014: 1733–1734). PEG as a means of feeding is a widely used and preferred instrument for long-term use. It became popular because of its advantages, which exceed the possible complications deriving from its insertion and/or use among the population of oncological patients, muscular dystrophy patients, and post-CVA rehabilitation patients (Mendiratta et al. 2012: 609–612).

While its disadvantages following complications in the insertion and/or use in the elderly population in general and in the population of dementia patients in particular are not sufficiently clear, these do not often exceed its advantages in treatment. Although the insertion of the feeding tube (PEG) among the elderly and especially among dementia patients does not prolong survival, does not improve the elderly person's nutritional status, and increases the mortality around its insertion, in recent years the percentage of the insertion of gastrostomy is constantly and consistently rising (Mendiratta et al. 2012: 610). Among elderly patients with dementia, mortality following PEG insertion ranges from 13% to 54% and at the end of the first year after the insertion of the gastrostomy the percentage increases and ranges from 78% to 84%. Mortality among the elderly after insertion of the feeding tube is significantly higher than among other patients. In addition, survivability after the insertion of the gastrostomy among the elderly

with dementia is only about 195 days. This finding is significantly low, in comparison to survivability among other groups using gastrostomy (Goldberg & Altman 2014: 1735). For the most part, the decisions of physicians to insert a gastrostomy among the elderly are not evidence-based because of the lack of research studies that provide true and full data among the elderly. When physicians make the decision to insert a gastrostomy, for instance, in oncological patients, they rely on the prolonging of the patient's life, the improvement of the patient's quality of life, the reduction of risk that the stomach contents will reach the lungs, the promotion of physical well-being, and the improvement of the nutritional status. However, among the elderly, and especially among the elderly with dementia, the insertion of a gastrostomy does not achieve similar treatment benefits (Mendiratta et al. 2012: 612). However, the aging of the population and the rise in the elderly who need help raise the need for additional skilled and professional caregivers. The insertion of an internal feeding tube enables more comfortable treatment for the caregiver, allowing one caregiver to provide service concurrently to a number of patients (Goldberg & Altman 2014: 1738–1739).

Emotional support constitutes a necessary basis for medical treatment, especially when referring to end of life treatment in general and among the elderly in particular. The emotional component in daily care not only improves the subjective assessment of the patient's health but also improves clinical outcomes. However, the elderly need a caring and understanding emotional environment and caregiver not only in times of sickness. In everyday life, when there is a loving environment that is emotional and pleasant, the elderly adjust better to different situations related to aging and the appearance of chronic illnesses and can even cope with them more effectively and easily (Pejner, Ziegert, & Kihlgren 2012: 2). The building of a good communicational culture between the caregiver and the elderly patient and his family enables the care to be enriched with emotional and social support and more holistic, more dignified, and more comfortable care to be provided (Gerlich et al. 2012: 301).

The professional obligation of nurses is to provide for the patient a solution to his emotional, physical, social, mental, cultural, and spiritual needs during the medical treatment. However, in actuality, the creation of a pleasant and sensitive treatment environment is not obvious. It necessitates considerable emotional and professional investment on the part of the nurses who work in the institution. The nursing staff describe daily work as stressful and difficult and

requiring the simultaneous management of many professional tasks that must be performed with great precision and at regulated times. Therefore, the creation of an effective atmosphere, for the purpose of a high level of medical care, is not always possible. In the opinion of nurses, medical treatment in a pleasant and sensitive atmosphere requires time, many skilled staff members, and a reduction of the task load. Hence, there are many situations in which the nurses refrain from meeting their patients' non-medical needs (Pejner, Ziegert, & Kihlgren 2012: 2). It is easy, as a caregiver, to be task-oriented and limited to professional skills. However, to hide behind the biomedical activity, without emotional involvement, is to perform the work superficially. For the elderly who suffer from severe cognitive decline, instrumental care without emotion does not yield good outcomes. Among the elderly with advanced dementia, the medical care at the end of their lives entails suffering and considerable pain. Therefore, a caring emotional and mental attitude in the medical intervention is more important than is the intervention itself (Nicolas 2014: 6–7).

One of the additional challenges in the care is the achievement of social-cultural equality among patients, regardless of age, gender, race, and nationality. The obligation of all the caregivers is to care for all on an equal basis, with awareness of differences between patients following the treatment requirements (Napier et al. 2014: 1618–1619). In the framework of the perception of equality as a supreme value, modern Western society defined healthcare as a basic human right. Consequently, throughout history, public policy developed to enable the financing of different medical services for the entire population. Nonetheless, the aging of the population leads to the need to reconsider how the medical resources in society should be divided so as to achieve maximum benefit not only for the individual but also for society as a whole (Thorsteinsdottir, Swetz, & Albright 2015: 2094–2096). Some researchers do not agree with this argument. Equality as an important social value guides the caregivers to enable treatments for patients who need it, regardless of the consideration of the patient's age, gender, and economic ability. However, in reality, Western society raises many barriers on the way to achieve such treatment. One of the most important barriers in society is age. Thus, in reality for the elderly, especially the very elderly, there is no equal treatment neutral of age considerations and economic efficacy. Lacking political power and social protection, devoid of economic ability, and consuming expensive medical services, the elderly become "transparent" to society and are pushed to its margins as a weaker group. Therefore, it is not at all

surprising that many formal care-providers maintain that the treatment of elderly people is significantly of lower quality, especially when it is compared to the treatment of children in a similar medical field (Ying, Levitt, & Jassal 2014: 973–975).

The aging of the population in modern Western society challenges the caregiving staff in many ethical issues, such as the allocation of medical resources, intergenerational justice, and issues of life and death (such as resuscitation and euthanasia). Yet ethical issues in the care of the elderly population are far more complicated, following negative attitudes towards the elderly in the general population; the health system is influenced by the social mood. Therefore, negative opinions are prevalent also among the caregivers of the elderly. In modern society, elderly people are perceived as a burden (Napier et al. 2014: 1626–1628). Thus, in the present era of difficult competition over resources, such as for example a bed in the emergency room, a physician will provide clear preference to a young patient or a child, even if his medical prognosis is less good than that of the elderly person. In other words, the value of the sanctity of life of the child or young person is more important for the physician than that of the elderly person. Such a decision of the physician, like many others in treatment, relies on values and norms that draw their power from the unequal culture of modern Western society. So, if the patient dies during the medical treatment, the care-providers' performances may be examined and interpreted as inadequate more frequently when the deceased patient is a child or a young person than when he is an elderly person (Soreide & Desserud 2015: 3).

The care of the elderly is discriminatory and takes into account considerations that are not relevant to ethical medicine, such as costs of medical treatment versus possible benefit. As expected, the elderly turn to medical services more than do young people, since they suffer from chronic illnesses more frequently than do young people. Consequently, the cost of the care of the elderly population is significantly higher than that of the younger people. In reality, a medical decision based first and foremost on the benefit of the medical treatment is fated to create a discriminatory attitude against the elderly on the basis of age (White 2014: 46–48; Napier et al. 2014: 1630–1632).

Death at an advanced age is perceived in modern Western society as a natural phenomenon. In contrast, death at an early age, especially in childhood, appears to be exceptional and should not occur. In light of the aging of the population, the demand for expensive medical services is steadily increasing. The increasing demand versus the lack

of medical resources, the need for quality medicine at a high level for as many people as possible push the physicians in reality to base their decisions on many considerations, such as age, medical benefit, the physician's morality, and the patient's wishes, when ethical considerations are not at a high decision priority. Despite binding professional ethics, the patient's age is a main consideration in medical treatment. Therefore, medical treatment given to the elderly is found at a low level of quality and, as such, it constitutes a social norm in modern Western society. Thus, the aging of the population that leads to an increasing number of the elderly and the decrease of the birthrate that leads to a decline in the percentage of children both lead to the investment of more resources per child than per elderly person. Also, every treatment of the elderly is defined as end of life treatment. Therefore, it does not receive the same investment of resources as other unique age groups do, such as children. In other words, the infrastructures of the treatment of the elderly are deficient, and nearly all care-providers do not participate in their training in unique courses in geriatrics. In addition, in comparison to the treatment of young people, the treatment of the elderly not only is not personal but also frequently is not humane and is performed under conditions unsuited to the situation (White 2014: 50–51).

The use of gastrostomy among the elderly with dementia as a means of feeding is a controversial issue. On the one hand, its benefits among the elderly are not proven and the complications it involves exceed its benefits. On the other hand, the rate of insertion in this population has been steadily increasing in recent years. In other words, a medical decision to begin internal feeding using a gastrostomy among the elderly is accompanied by considerations that are not related to the benefit of the elderly person himself, and therefore many ethical dilemmas arise on this matter (Mendiratta et al. 2012: 612).

At the basis of every medical decision, there are fundamental values for every patient in medical care: his right to autonomy, and his right to treatment that is given through the caregiver's taking of responsibility. Informed consent on the part of the patient is intended to preserve the individual's basic values in medical treatment and to provide him with the opportunity to make a decision independently. When a caregiver and patient agree on the medical care, the patient expresses his understanding and willingness for care and the caregiver brings with him his personal values, moral position, and knowledge of professional ethics (Wandrowski, Schuster, Wolfgang, & Steger 2012: 141). However, in modern Western society, informed consent has

become something technical that is exploited by caregivers without the proper attention being devoted to its meaning. Informed consent is not only protection of the individual's autonomy as a value that society worships but also the meticulous assessment of the patient's wishes, values, and preferences and respect for his decision, even if it is not identical to what is done in society (Thorsteinsdottir, Swetz, & Albright 2015: 2094–2096).

Ethical issues that the caregivers face are different from general medical ethical issues, and they are found in the field of end of life care. End of life care of the elderly is supposed to be based on the quality of the communication with the patient more than on different medical interventions intended to extend the lifespan in the younger population. However, nurses who care for the elderly cope unendingly with the dilemma between the elderly person's autonomy and the benefits of care or autonomy and the moral justice of care. Such situations are prone to trouble, bring about a conflict in care, and give an interpretation with a multiplicity of contradicting values. The solution of the moral conflicts that grow from the care of the elderly is supposed to bring about the greatest benefit for the patient and is always to be aimed at the patient's wellbeing. The moral distress which the caregiver feels generally also characterizes the atmosphere in the organization where the treatment interaction occurs. The lack of openness and a work environment that prevents the caregivers from maintaining sensitivity towards what happens causes them to adopt behavior that is swallowed into the mechanical routine and lacks an emotional attitude towards the patients and towards peers in the workplace. When the caregivers work under pressure against their own moral beliefs, they feel frustration and create distance and emotional alienation from their work with the elderly (van der Dam, Abma, Kardol, & Widdershoven 2012: 251–252).

Physicians who care for the elderly feel that the care or cessation of care at the end of life is based for the most part on the treatment prognosis and not on the patient's own desires. According to many physicians, the existence of treatment instructions in medical situations is far more obligating than ethical considerations or the upholding of the patient's values, since the failure to uphold treatment directives may be interpreted as assistance in death or medical malpractice (Dousdampanis, Trigka, & Fourtounas 2012: 365–367; Germain 2015: 55). Today, many physicians feel an absence of ethical tools in their ability to cope with issues at the end of life among the elderly. The absence of ethical tools, the moral distress that derives from treatment decisions, binding



professional values, and responsibility for the patient – all these and many other factors cause the physicians to suffer a difficult ethical professional dilemma: to make decisions according to the existing directives or to go with the patient's preferences and perform what is assigned to him morally. Lack of skill and ability to make ethical decisions at the end of life harm the quality of the care and the well-being of the elderly person in his final days and worsens the caregiver's mental distress (Wandrowski, Schuster, Wolfgang, & Steger 2012: 145).

Morally and legally the elderly are entitled to receive care of a level of quality equivalent to that of young patients. However, today ethical medical care in the elderly population does not exist, following the lack of laws that create a strong basis for the creation of a social atmosphere for this (Wandrowski, Schuster, Wolfgang, & Steger, 2012: 145–146). According to White (2014: 46), the legislation of appropriate laws and the enforcement of these laws in actuality may cause a change in the care of the elderly and overcome the indifference of Western society towards the elderly population and their medical care. Today, the treatment of the elderly is perceived by society and the care-providers themselves not only as having less quality but also as less humane. Therefore, work in institutions for the elderly is interpreted by care-providers as less prestigious and therefore is not desired. Furthermore, work with the elderly is less well remunerated than other areas and is accompanied by many mental tensions and hard physical work combined with many tasks and a limited staff. Consequently, skilled and professional care-providers of a high level not only tend to leave institutions for the elderly but also from the start of their career path attempt to avoid going to work in these institutions (White 2014: 48–51).

In the future, it will be necessary to raise a new generation of caregivers of the elderly who have social sensitivity and respect for the elderly and their care. A preliminary condition for moral change among caregivers of the elderly is the creation of appropriate conditions in society (White 2014: 51). In the opinion of many care-providers of the elderly, the time has come to change the miserable reality that has been created in the care of the elderly. The required change will lead to an improvement in the quality of treatment of the elderly and will make it professional and quality, humane and respectful – equal to the medical treatment of other age groups (Wandrowski, Schuster, Wolfgang, & Steger 2012: 144–146).

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