



Ethical Considerations for Podiatric Medicine in Caring for the Aging Patient—Part 1

This growing segment of our patients has special needs.

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The ethical principles embodied in the management of our older patients are constantly being updated, especially as the health-care system changes. Ethics must always consider beneficence, autonomy, justice, non-maleficence, and the sanctity of life as key elements. In addition, accountability, confidentiality, consent, respect, dignity, integrity, effective communication, flexibility, humility, sensitivity to diversity, rights of conscience, and trust are equally important attributes.

The questions relating to comfort are of great concern as we deal with the increasing numbers of aging patients, those with multiple chronic diseases where that cure may not always be possible. Inscribed on the statue of Dr. Edward L. Trudeau, a pioneer in the treatment of tuberculosis is a 15th century folk saying; the last few words succinctly express the warmth that needs to become a part of healthcare: “To cure sometimes, to relieve often, and to comfort always.”

Patient management, both acute and long-term, emerges as a key issue. There are great concerns for the rights of the elderly, their privacy, and the relationships among those responsible

for providing healthcare to patients. There is a greater focus today on the quality of life and not just saving a life. There are questions that surface in relation to the termination of treatment, particularly in relation to aging. At what point is there harm with no gain from treatment? There is also the issue of public rights and whether the

environmental impact of decisions. Other issues include non-abandonment, futility of care, social justice, honesty, access to care, and conflicts of interest.

The Final Report of the 1981 White House Conference on Aging in its Recommendation Number 148 stated, “Comprehensive foot care should be

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system should be permitted to develop without freedom of choice. Should there be restrictions on podiatric medical care that are not imposed on other professional services treating different parts of the body?

Ethics and bioethics involve more than public policy and statutory issues. Ethics must consider morals and law and recognize that decisions may conflict with individual values. Medical ethics should always seek what is right and consider the medical condition, scientific knowledge, restraints to the psychological, social, economic, and

provided for the elderly in a manner equal to care provided for other parts of the body.” This key position speaks to the need and right of foot and related care for all, including Medicaid recipients. The inclusion of appropriate podiatric services in care programs will often produce dramatic effects. Immobility should become activity.

The genesis of this Resolution was a result of the need to identify the primary and related diseases and disorders of the foot and its related structures associated with aging

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and chronic diseases that develop concomitant complications detracting from the quality of life. For the most part, the focus was on metabolic, peripheral vascular, and changes in sensitivity. Examples of these “at risk” diseases include diabetes mellitus, arteriosclerosis, Buerger’s disease, peripheral neuropathies, amyotrophic lateral sclerosis, intractable edema, congestive heart failure, Raynaud’s syndrome, kidney disease, and uremia.

In 2009, the Veterans Health Administration added visual impairment, physical impairment, neuromuscular diseases such as Parkinson’s disease, arthritis (degenerative, rheumatoid, gout), spinal disc disease, cognitive dysfunction, chronic anticoagulation therapy, obesity, and age itself. Ambulatory dysfunction, podalgia, and pododynia dysbasia are determinants to independence and the quality of life.

Quality of care translates into improved quality of life. Support and encouragement can be directed to independence and a strong sense of personal identity and worth. When the quality of life decreases due to diseases, disorders, disability, and/or age, those precious aspects of self-worth should be restored to a maximum level by caring staffs. Because ambulation is a major catalyst for life, podiatric care can help regain some of the lost dignity by keeping the patient ambulatory and moving about, so that he or she can accept and participate in the social activities provided by families and the community.

Ethics must also include an educational component that considers societal issues in the changing delivery of healthcare. It must also deal with professional liability and cost containment because now there are mechanisms for the rationing of care based on costs alone. Ethics and bioethics are based on respect, obligation, professional responsibility, and patient care issues. It must be an issue of moral relevance.

Ethics must continue to deal with conduct, professional relationships, and human dignity. It must deal with improved knowledge and skills. Eth-

ics must consider and maintain the highest possible level of professional judgment. Ethics must also consider professional responsibility and obligation beyond what might be required to meet the legal basis of practice. Simply being “this side of legal” is not adequate in an ethical, bioethical, and/or moral sense. We should recognize that the public should ultimately determine our future healthcare system, based on pre-conceived need, cost, opinion, and on political impression.

the elderly have basic needs. They include: food, shelter, love; being needed, appreciated, resourceful, healthy, helpful, occupied, useful, and not pitied. The elderly also have some basic rights that include:

- A right to be treated as a human being and not a medical record, bed number, or disease.
- A right to have hope, and to expect others when possible to magnify that hope.
- A right to be cared for by people who care.

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The profession must assume a greater responsibility in protecting and promoting quality care, ethical conduct, and serve as a moving force in the change that will take place in our healthcare delivery system. Foot, ankle, and related care are both basic and needed. State practice acts, laws, and regulations have established this fact and demonstrated a public need for podiatric medicine. Our obligation is to protect that need with integrity.

What does it mean to be old in America today? It means spending more time alone, the potential for neglect, taking a back seat, having less money and a potential for a lower standard of life. It means giving up many things, loss, accepting help from others, and less independence. It means a greater threat of injury, illness, disability, and death. It means trying to determine what you want to accomplish before you die—or what is on your “bucket list.” It means more time alone and the importance of getting along with other people. It means more demand upon your inner resources.

What it needs to mean is that older individuals are accorded the dignity of age. This includes the value of one’s life work, and living life to the end, with all of the respect and grace that the individual has earned and deserves.

It is important to recognize that

- A right to retain dignity as human beings.
- A right to express their own feelings about their lives and about their future and remaining years.
- A right to participate in decisions relating to their own health care and their own lives.
- A right to have their goals changed from cure to comfort.
- A right to be free from pain.
- A right to companionship.
- A right to have people around them who do care.
- A right to have honest answers to their questions.
- A right to have their family accept their conditions and limitations and help them deal with their new focus on life.
- A right to be given attainable goals.
- A right to remain an individual.
- A right to be judged by their own decisions.
- A right to be respected by those who provide for their healthcare.
- A right to be cared for by sensitive people.
- A right not to be pitied.
- A right to be accorded the dignity of age.
- A right to security.
- A right to healthcare.
- A right to an adequate standard of living.

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- A right to non-discrimination.
- A right to participation.
- A right to be free from torture or cruel, inhuman, or degrading treatment.
- In addition, when all else fails, a right to die in dignity and peace.

The care of older patients in our society is changing as it is for every aspect of healthcare delivery. The ethical, moral, and legal issues that involve all of the professions and aging itself are of public interest, financing, and concern. These factors are a growing part of not only the care provided, but also the relationship to the quality of care and determinations as to who will receive care. Professional codes of ethics and state practice acts no longer form the primary basis for the moral, ethical, and legal considerations of healthcare.

Clinical practice and the delivery of healthcare must be involved in the public and social issues of the times. We have the responsibility to recognize these concerns and be knowledgeable for our patients and communities.

The ethical concerns of who will live and who will die and the potential rationing of healthcare no longer become issues of faith and religion, but rather a decision that must be faced by individuals, families, communities, and potentially by society as a whole. These decisions are clearly a greater ethical concern now and will grow in the future, especially with the growing number of older persons and changes in the economics of healthcare.

There is the need to focus on the end of life and the care of the dying. Years ago, people became ill and died, or died from "old age". However, today, the modern advances in healthcare and the management of disease has permitted people to live longer. In addition, an increase in life expectancy has focused new attention on the management of chronic disease, the need for long-term care, the management of the aging, the quality of life for the elderly, and the need to deal

with new health problems that have resulted from longevity. With the aid of new technology, life functions can be maintained, thus requiring new approaches to defining the meaning of 'death'. Today, guidelines for the definition of death are part of state legislative processes in the United States.

Extending Life

The issue of the appropriateness of extending life surfaces as a part of the discussion of death. Maintaining individuals on respirators with severe brain damage and no chance for a decent quality of life raises the issue of 'dying with dignity.' Added to this

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issue is the definition and determination of quality and dignity.

During the last decades, the resources of the nation in relation to healthcare have been expended due to the development of new technology and procedures. There is no question that these developments have placed a strain on the financial aspects of our healthcare economy. However, when one considers the future implication on costs, as our population ages, the potential for difficult decisions remains.

Although ethical issues have been with us as a society for many years, their primary activities were focused on the individual patient, individual care needs, and the relationships with individual healthcare providers. We are now moving towards greater public and social policy issues that pertain to healthcare. We must believe that health is a basic human right, which stresses quality care and delivery for all. As we recognize that the potential costs are extensive, we again focus on the need to develop a policy, which could include selective care and even the rationing of care. Thus, a potential ethical and moral question surfaces as to what

system of change has raised ethical questions about fairness in the distribution of services. The moral issues posed by these changes may well influence our society for many years to come. When one relates these concerns to the delivery of foot care and other services for the elderly, we need to relate these needs to the quality of life. One

the appropriate degrees to provide care for patients. All of the health professional associations have always had a strong emphasis on moral and ethical values, as well as the legal structures that are a part of and must exist within all independent health professions.

Although there is no uniform or consistent meaning to the term pro-

The professional educational base along with seasoning and experience, must foster knowledge, judgment, competence, and responsibility.

might ask if a segment of the human anatomy should be viewed with less importance.

If we know that the elderly, for the most part, are vulnerable and represent a poorer segment of society, the morality and ethics of reducing care to the poor, the elderly, the disabled, and the terminally ill become a factor that must involve more than dollars and cents. Given the position that there is a need for a national health policy, there is also a need to avoid balancing the books of healthcare on the backs of the

profession or professional as it relates to the health field, there are a number of uniform components, which usually mark the practitioner. They include but are not limited to a formal process of education. That process includes both the scientific as well as the liberal fields in addition to the particular skills associated with the special area of practice.

In addition, there is an educational base to understand the human side of clinical care, the need for social concern for the patient and society, and the need to weigh the ethical and moral issues as well as the legal aspects of providing care. For example, regardless of the concerns for cost containment, retrospective review, or the issues of liability and defensive healthcare, doing what is right and just for the patient must surface as the paramount issue. Thus, the professional educational base along with seasoning and experience, must foster knowledge, judgment, competence, and responsibility. Subsequent to the formal educational period, a process of examination and certification provides licensure.

At times, additional education is required prior to licensure and following the granting of a degree. This provides greater assurance to the public and permits the professional to gain a formalized and supervised period of experience to structure knowledge, understanding, judgment, and to perfect competence. Be-

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Do we withhold care to the elderly as they have limits on their contributions to society?

criteria might be applied to such a projection. Do we withhold care to the elderly as they have limits on their contributions to society? Do we reject funding services for long-term care and/or homebound patients, as they may always remain wards of the state?

As science expanded its vistas and people began to live longer, the need for expenditures to provide healthcare costs increased in a dramatic fashion. Thus with an increasing number of elderly the question of quality of care becomes an issue, and even more so, the expenditures in relation to the quality of life. The

aged, who for the most part, have paid their dues to establish the system. The moral and ethical questions that must be considered in relation to aging are those of discrimination in our desire to satisfy the need for cost-containment.

Professional Ethics

The health professions and professional ethics evolved because of public need. The legal basis for the professions were created by state practice acts in all of the United States and the District of Columbia. In addition, the practice acts are limited to those individuals who hold

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cause of the legal structure for licensure, the educational process reflects community sanction and approval. In addition, a formalized period of post-doctoral education usually leads to specialization and formal recognition by board certification and/or specialty society membership that requires examination and/or peer review for qualification. **PM**

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