Ethical Considerations for Podiatric Medicine in Caring for the Aging Patient—Part 2

This growing segment of our patients has special needs.

BY ARTHUR E. HELFAND, DPM

Editor's Note: *In part 1 of this article, Dr Helfand focused on the components of an ethical care policy toward the aging population, and he discussed both the elderly patient's "Bill of Rights" and the ins and outs of the ever-present "extension of life" issue. In part 2 he will explore the relationship between laws and ethics, healthcare cost concerns, the primary clinical and social issues affecting older patient care, and health advocacy concerns for physicians. Finally Dr. Helfand focuses upon how ethical and bioethical issues are ever-changing in today's world (and surely will be in tomorrow's world as well).*

Code of Ethics

A profession usually has a single national organization, which has formulated a national Code of Ethics or a series of Principles of Ethics that govern the activities of the individual members of the profession. Although there is no legal binding of individuals to these principles, membership usually implies peer review as a professional for continuing membership.

A profession has a body of systematic scientific knowledge and technical skills that are required for practice. The members of the profession usually function with a degree of autonomy and authority as defined by individual state practice acts, and regulated by the states and/or federal activity. In addition, there is a general assumption that they alone have the expertise to make decisions in their area of competence.

Laws and ethics are not synonymous since their enforcement differs. One might broadly define ethics as concepts that encompass both thought and deed. Law usually deals only with deed. There are mitigating factors that changed the very focus of what had been established as professional ethics for many years. The recent court rulings pertaining to advertising is an example. Another example is the changing system of healthcare delivery that, in an effort to contain costs, has modified freedom of choice and may ration certain elements of care, particularly for specific population groups. Nevertheless, regardless of the circumstances, the end does not justify the means.

These changes in our society and the breakdown of some of our valued principles have often produced a belief that a lack of integrity in high places should be condoned, and in low places considered good practice or a way of doing business. The health professions cannot and never should tolerate anything but honesty from and for the professions and for the public whom we serve.

Since the late 1960s, there has been a growing concern about the escalation of healthcare costs.

We must also recognize that both laws and ethics are closely related to religious beliefs and social experiences. Given this fact, the student who enters our educational systems, comes to us with his or her own concepts of the values needed to serve humankind. Proper "role models"

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may provide some influence pertaining to these ethical and moral concepts, but the Judeo-Christian belief, the golden rule, the respect for body, mind, and property of an individual must remain sacred.

Ethics in a moral sense deals with good and bad, right and wrong, and moral duty and obligation. The very oath taken by each graduate of our educational systems are in themselves an ethical pledge and needs to be read on a periodic basis. This pledge, in effect, establishes the principles of conduct governing the graduate in behavior throughout his or her professional career. It is augmented by codes of ethics that are usually a part of individual state practice acts, and by principles or codes of ethics that are a part of the obligation of serving humanity. In addition to these rules, regulations, oaths, and codes, there is yet another focus when applied to all practitioners.

Ethics must include bioethics, which encompasses the moral issues, questions, and problems arising in practice and in the areas of biomedical research. Although the issue may not always be about death and dying, the issue of care, disability, impairment, mobility, and autonomy for a patient, particularly with increasing numbers of aging patients seeking care, may be just as important when viewed in relation to the quality of life, the worth of an individual to society, and the dignity of the individual patient.

Values must be practiced, retained, and reviewed throughout one's professional and private life.

Concern for Healthcare Costs

Since the late 1960s, there has been a growing concern about the escalation of healthcare costs. The initial concern focused primarily on the impact of inflation relating to Medicare and Medicaid expenditures that subsequently affected federal and state budgets. Some concern was voiced by other elements of the system, but the primary actions to control costs were taken by government agencies. As increases in third party coverage made paid care of some form available to many, practitioners modified their practice management techniques to deal with a system that emphasizes numerical codes and standard descriptions. Deviations from the printed standard codes and phrases, even though they may have been appropriate, were discouraged as the need to automate the system grew. Claim forms processing moved from manual review to computer screens.

In the decade of the 1970s, a series of regulatory actions were taken to slow the rise in healthcare costs and expenditures, and methods were developed to monitor practice care patterns, create standards, norms, and criteria, and to focus on quality care and needed health services. We saw some elements of wage and price control in the healthcare system. We saw reasonable cost limits under government-funded health programs for hospitals. Limits were imposed on practitioners but not on the technical and supply components of clinical care. Professional liability and general liability premiums escalated out of control and, in many cases, became a prohibitive cost for some practitioners in all fields, as well as for those institutions and agencies responsible for care. Professional standards review organizations have surfaced and have given way to similar professional review organizations with no true mandate for equal peer or practitioner review. The projection for "cook-book" care began to surface as a mode for the future. Certificates of need and health planning arose but the true "cap" on construction did not materialize in the manner initially projected. Few examined the fact that labor and supply costs and the technical revolution, as opposed to practitioner costs, were also primary sources of inflation. How do such increases affect the moral, ethical, and legal aspects of the delivery of quality care, especially for the older patient?

In the 1980's, a new term evolved in healthcare delivery...competition. This competition was not for patient quality, but was based on lower costs and the filtration of care to non-practitioners and supervised delivery methods of care. The system of care was manipulated as a way of doing business. In the vast majority of cases, this created business practices that have tended to remove the personal touch or "bedside manner" from the doctor-patient relationship. In many cases, the cost of advertising services became a large line item in budgets, but was not responsible for improved or direct patient care.

There is a clear understanding that exploitation will not be the case in the payment of services, regardless of the method of payment by either the patient or a health insurance carrier.

There is a need to recognize that changes in the systems of reimbursement should foster quality and not discard the ethical codes and principles of practice that have been a part of the healthcare system for past decades. There is a need to assure proper methods of informed consent, practitioner-patient relationships, and protection of the rights of patients, confidentiality of records, a freedom of choice for both patient and practitioner, and the fostering of continued respect and dignity that have been associated with the health professions. We also need to consider newer and improved methods of health information and education so that the public has an appreciation of health and can make rational and reasonable decisions about the delivery of their personal healthcare services.

Some of the primary issues affecting the care of the older patient

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include but are not limited to the following:

- The medically compromised older patient
- Family conflicts with treatment issues
- The emotional aspects of staff
- How long to maintain an individual on life support?
- Clinical and ethical parameters in the selection of patients or advanced invasive procedures
- Ethical issues in bypass surgery
- Irreversible brain damage
- Multiple suicide attempts
- Patient and family rights
- Determinants of competency
- Ethical dilemmas in the chronic patient
- HIV + as an issue in the older patient
- Assisted living
- Long-term care
- The right to die

Applied Considerations

The primary application of professional ethics stems from the Code of Ethics as developed by professional associations, the codes and regulations as set forth in various individual state practice acts and the regulations applied to misconduct that are included in specific regulatory programs. There is no one set document, code, or set of principles that can contain all elements of ethical practice and conduct as the morals of society change as time progresses and as the courts and regulatory bodies adopt new provisions of codes.

The initial concept embodies the belief that the best interests of patients must always be the primary aim of the practitioner in both an ethical and moral sense. There is a need to practice the belief that services provided by members of the podiatric medical profession must be performed with integrity, compassion, honesty and respect for human dignity. There is a need to provide assurance of competence through continuing education and clinical experience. There is a need to provide assurance that consultation and additional opinions are sought and utilized to meet the best interests of patients in keeping with individual technical skills of practitioners. There is a recognized need for appropriate communication with patients and their families while still maintaining the confidentiality constraints of law and sound professional judgment. There is a clear understanding that exploitation will not be the case in the payment of services, regardless of the method of payment by either the patient or a health insurance carrier. There is a clear acceptance that those practitioners who engage in

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fraud and deception are identified and have such activities curtailed. Finally, there is an accepted duty to place the patient's welfare and rights above all other considerations to assure maximum benefits to the patient and public.

Competence and Expertise

Practitioners need to recognize their own levels of competence and expertise, and perform only those procedures for which they have been trained to do. Experience must be accompanied by supervision and review to avoid any misrepresentation of training, credentials, experience, and ability.

There is an accepted belief that second opinions and consultations will be sought when requested or when the diagnosis is in doubt. In addition, referrals for opinion and care should be made freely whenever the welfare of the patient is at stake. The need to recognize special skills, knowledge, and experience is an essential element of professional care.

Surgical intervention in the older patient should follow an appropriate and adequate pre-operative assessment of the clinical findings and indication for surgery, and the physical, emotional, social, and occupational needs of the patient. In addition, the relationship of the proposed procedure to the needs of the patient in terms of his or her activities of daily living also needs proper consideration. The issue of the improvement of the quality of life is a key element in the justification for a surgical procedure, particularly in the older patient.

Practitioner concerns in caring for the older individual should also be expressed as health advocacy. Some of the components include:

- Talking to your patient
- Accepting what the patient says
- Believing your patient
- Touching your patient
- Holding out hope for your patient
- Attempting to relieve discomfort and pain
- Supporting a patient claim or reimbursement if valid
- Becoming your patients' advocate
- Being honest with the patient
- Referring when and as appropriate
- Not blaming patients for their problems
- Not making the patient worse
- Doing for the patient what is indicated and needed
- Maintaining the patient's dignity
- Respecting the total needs of the patient

The patient has a right to expect treatment as a human being and not a medical record number, bed location, or disease. The older patient should expect to be given hope and have others magnify that hope when possible. The older patient should expect care from people who care. They should expect to retain their dignity as human beings, express their own feelings about their own lives and about their future remaining years, and participate in decisions relating to their own healthcare.

The older patient should expect care from people who care.

There is a need to refocus goals from cure to comfort. There is a need to recognize that older patients should be free from pain; should have companionship; should have people around who care; should receive honest answers to questions; and should have their families accept their conditions and limitations and help them deal with their new focus on life.

The older patient should be given attainable goals; be permitted to remain an individual regardless of the living arrangements; be judged by their own decisions; be respected by those who provide for their healthcare; be cared for with sensitivity; not be pitied; and be accorded the dignity of age. Moreover, when all else fails, the patient should expect a right to die with dignity and in peace.

Summary

The ethical issues of today are changing. There is a greater consideration of the social issues as they relate to medical care. The questions of comfort are of greater concern as we deal with increasing numbers of aging patients and chronic disease, and cure may not always be possible. Thus, patient management is a key issue. There are greater concerns for the rights of patients, their privacy, and the relationships that need to be maintained between doctors and their patients. There is a greater focus on the quality of life and not just saving a life. There are new questions posed in relation to the termination of treatment, particularly in relation to aging and at what point is there harm and not good from treatment. There is also the issue of public rights. Should the healthcare system be permitted to develop without freedom of choice, or restrictions on foot and related care that are not imposed on any other profession or service? Ethics and bioethics in itself is more than a statutory issue. It is more than policy which must include educational issues that consider society's concepts in the changing manner of healthcare delivery. It must now deal with professional liability and cost-containment, as there are now mechanisms for the rationing of care based on costs alone. Ethics must be based on respect, obligation, professional responsibility, as well as clinical care issues that demonstrate moral relevance.

Ethics must continue to deal with conduct, professional relationships, and human dignity. It must deal with improved knowledge and skills. It 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. Just being "this side of legal" is not adequate in both an ethical and moral sense.

We must recognize that the

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public ultimately will determine our future healthcare system. It will evolve based partly on a preconceived need, partly on cost, partly on opinion, and partly on politics. The health professions must assume a greater responsibility in creating a system that includes older individuals to believe that "life is beautiful". We must assure ethical conduct and serve as a moving force in the changes that will take place in our healthcare delivery. Foot health and care are both basic and needed. Our state practice acts, federal and state laws, and regulations have demonstrated a public need for podiatric medicine. Our obligation is to protect that need and promote quality care with integrity. We have added years to life and must assure that the added life includes meaningful living.

Principles of respect, veracity, justice, non-maleficence, and beneficence must remain paramount.

As we look to the future, we must always remember to be proud of our profession. We must remember to be strong but always recognize when we need help to care for our patients. We must remember to be honest in all ways and to be humble, for we can never tolerate a lack of integrity. We must remember to have compassion and to aim for high goals. We must follow our aims with dignity and learn to master ourselves before we attempt to master others. We must always remember how to laugh but never forget how to weep. We must continue to reach for the future but never forget the past or those who helped make our profession what it is today and will be tomorrow. After all of these things, we must remember to have a sense of humor so that we can be serious. We must remember always to respect the rights of others and always to accord the elderly the dignity of age. We must remember to have an open mind and to recognize and assume the responsibilities mandated by being a member of the podiatric medical profession.

The real test is yet to come. Principles of respect, veracity, justice, non-maleficence, and beneficence must remain paramount. For then and only then will the true meaning of concerned practitioners surface and permit comfort, compassion, and dignity to serve as primary public health concerns for the elderly. **PM**

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