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# Autonomy and paternalism in geriatric medicine. The Jewish ethical approach to issues of feeding terminally ill patients, and to cardiopulmonary resuscitation.

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## Abstract

*Respecting and encouraging autonomy in the elderly is basic to the practice of geriatrics. In this paper, we examine the practice of cardiopulmonary resuscitation (CPR) and "artificial" feeding in a geriatric unit in a general hospital subscribing to Jewish orthodox religious principles, in which the sanctity of life is a fundamental ethical guideline. The literature on the administration of food and water in terminal stages of illness, including dementia, still shows division of opinion on the morality of withdrawing nutrition. We uphold the principle that as long as feeding by naso-gastric (N-G) or percutaneous endoscopic gastrostomy (PEG) does not constitute undue danger or arouse serious opposition it should be given, without causing suffering to the patient. This is part of basic care, and the doctor has no mandate to withdraw this. The question of CPR still shows much discrepancy regarding elderly patients' wishes, and doctors' opinions about its worthwhileness, although up to 10 percent survive. Our geriatric patients rarely discuss the subject, but it is openly ventilated with families who ask about it, who are then involved in the decision-making, and the decision about CPR or "do-not-resuscitate" (DNR) is based on clinical and prognostic considerations.*

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## Introduction

The last few decades have witnessed increasing awareness of the importance of autonomy of the patient among medical practitioners in the community and in hospital, in contrast to the paternalistic attitude that characterised medical practice before the 1950s.<sup>1</sup> This more liberal approach, however, has bred its own ethical and practical problems for the geriatric physician and his team regarding attitudes to the autonomy of

the old person, especially in situations of management of life-threatening situations such as cardiac arrest, or artificial feeding of patients with high dependency. There are also instances where current ethical thinking does not entirely conform with religious or cultural norms of some societies. Some of these issues in Jewish religious practice have been discussed and summarised in this journal.<sup>2</sup> This paper will discuss considerations of autonomy of the elderly in relation to the issues of artificial feeding and resuscitation in the light of our practice in a hospital where the practice of medicine is consonant with Jewish religious law.

The Shaare Zedek Medical Center in Jerusalem serves all communities in Jerusalem irrespective of creed or nationality, and contains all the facilities of a community hospital with teaching obligations. The founders of this 110-year-old center declared that the practice of medicine must be in keeping with the Halacha, Jewish orthodox religious law, in reference to ritual practice, and matters concerning ethical and moral outlooks in the area of health and disease. Our discussion will refer to facts and opinions in current literature on the above issues, and will point to our views and practice in the geriatric department.

## Patient consent and compulsory feeding

Refusal of food usually implies physical or mental illness. Sometimes, it is necessary to employ forced feeding, or at least i-v fluids, until the primary cause has been treated. Moreover, in the elderly, food rejection is a major symptom of depression, and forced feeding might be mandatory until the patient's emotional balance recovers. When the refusal to eat occurs in the context of a dementing or malignant illness, the reason may be an accompanying depression, which can respond to drug treatment, and therefore the problem of feeding might be solved when there is improvement in the mood. In day-to-day parlance, "terminal" can mean death within a few

hours, or that the patient has a few months to live. In the latter case, efforts must be made to relieve the anorexic state, and one cannot assume that refusal of food necessarily reflects the wish to die. A general principle enunciated by Daniel Callahan is relevant to this discussion.

“What happens to movements or practices when they are taken out of the hands of the first pioneers, who act thoughtfully and carefully after due deliberation, and are put in the hands of large numbers of people who may not approach them with the same care?... what if caregivers withhold food and water thoughtlessly, carelessly, and incorrectly, thereby causing much suffering... That could well happen, as easily as other forms of abuse periodically reported in nursing and chronic care centers”.<sup>3</sup>

Among the arguments advanced in favour of withholding nutrition in terminal or demented patients is the non-distinction between artificial feeding by nasogastric (NG) or gastrostomy tube and other “medical” treatments, and the weighting of burden against benefit.<sup>4-5</sup> Feeding is a basic human necessity, outside the limits of decision-making involved in medical treatment, and therefore should be pursued in the same way that treatment of pressure areas and general hygiene of the body is continued with the dying patient.<sup>2-7</sup> In our geriatric ward Sonnenblick *et al*, interviewing the offspring of terminally ill patients, found that the majority believed that food and fluids should be continued in the terminal illness, even when the patient had requested “no treatment”.<sup>8</sup> The mandate of medical care is to relieve or palliate disease, and provide basic physiological and psychological health support, but in our opinion, this mandate does not extend to judgmental decisions as to whether a person should live or die by giving or withdrawing those supports, so long as they are not actually harmful.

The question of burden, although often argued in an ethical context, seems more appropriate to be judged as a clinical problem. The discomfort of nasogastric (NG) feeding is minimal to many patients; while percutaneous endoscopic gastrostomy (PEG) is a mildly invasive non-surgical procedure which is well tolerated except in severely debilitated patients.<sup>9</sup> Simple peripheral i-v infusions are often no burden, and dying patients can tolerate a sub-cutaneous infusion if fluids cannot be given intravenously. Ethical problems of burden arise if the patient must be forcibly tied down in order to maintain permanent NG feeding; or if there are no peripheral veins available, and a central i-v line, with its inherent dangers, is the only route for continuing adequate

feeding. The expected clinical benefit from feeding must outweigh the significant risks and suffering caused to the patient, otherwise it should not be done. The small percentage of complications arising from NG or PEG feeding, some of which can be serious or fatal, must be considered within the clinical background of each patient.<sup>9-10</sup> However, situations must be avoided where institutional administrative dictates are the main indication for carrying out tube-feeding, rather than absolute clinical necessity. The issue of tube-feeding is often not that of burden, but of whether the feeding is appropriate or relevant.

An important argument brought against the relevance of enteral feeding for the terminal or demented patient is that it does not help the patient’s symptoms, nor does it improve his or her functional status; pressure sores are no less common than in those fed orally, and there is a high mortality among tube-fed patients.<sup>10-12</sup> In answer, one cannot be certain that deprivation of food or water won’t add to symptoms which are causing suffering. In the patient with advanced dementia, without obvious physical symptoms, the main consideration should be that complications from the feeding should be minimal, and potential suffering less than if nutrition were to be withheld. If the danger of aspiration from oral feeding is significant, then tube-feeding should be arranged, with careful follow-up. Most patients who reach this stage are not likely to improve their functional status in any event. Many of them are in a catabolic state, or will be as a result of recurrent infections, and feeding should be seen as part of basic nursing care, subject to the possibility of complications.<sup>13</sup> The argument against the anti-social aspects of tube feeding and the depersonalisation of the patient in an institution<sup>14</sup> does not seem relevant, because it is his serious illness that necessitates basic care, and the psychosocial problems which may arise from artificial modes of feeding can well be alleviated by tender care exercised by family, caregivers and professional staff. Care and compassion need not be diminished in the presence of a gastrostomy. Craig has rightly stated that the obligations of physicians to provide alimentation and hydration to terminally ill sedated patients include the emotional needs of relatives, and she doubts the extent of serious side effects of artificial nutrition in properly controlled management.<sup>15</sup>

The sanctity of life, including extreme old age, is a fundamental consideration in the question of forgoing life-sustaining treatment or nutrition in terminal disease. This is a basic part of the Jewish ethic,<sup>16</sup> and is accepted by many authorities, including our department, as a dominant value in

the framework of medical ethics.<sup>17</sup> This value might sometimes conflict with the expression of patient autonomy,<sup>18</sup> although Jewish religious law does recognise the right of a competent terminally ill patient to refuse measures, including feeding, which might prolong his suffering without improving his prognosis.<sup>2</sup> Since the loss of life is absolute and irreversible, one has to examine whether factors other than the primary illness may account for the patient's rejection of food, as exemplified by Glick in the case of a hunger striker.<sup>19</sup> Physicians are compelled to define clearly when treatment or feeding becomes futile,<sup>20</sup> rendering cessation justifiable, as it sometimes is. Futility would be defined here in the narrow physiological sense - that no therapeutic support will confer any beneficial impact on symptoms, or alter the disturbance by the disease of the basic mechanisms of homeostasis. The subject and implications of "futility" were recently reviewed in a detailed cross-disciplinary symposium.<sup>21</sup> In the face of the overriding value of life itself, quality of life or psychosocial considerations are less important value judgments in the matter of futility. Even a minimal contact with the patient might enhance his "quality" of life, but his medical attendants cannot always judge the extent of that enhancement. The physician must assess when suffering and hopelessness of prognosis outweigh the sanctity of life, and whether palliative measures may relieve the suffering that causes the patient to crave his death.

## Resuscitation

### ELDERLY PATIENTS' AND PHYSICIANS' VIEWS

The issues of autonomy and paternalism are not always clear in regard to decisions about cardiopulmonary resuscitation (CPR) or "Do not resuscitate" (DNR) orders amongst patients admitted to an active geriatric ward. Policies and recommendations to discuss the option of DNR or CPR with patients in hospital are widely adopted, but less widely practised.<sup>22-24</sup> Respect for the autonomy of a person who has a cardiac arrest should be a major factor in deciding whether to apply or refrain from full resuscitation measures, including assisted respiration. However, many elderly people have not stated whether they would wish to be resuscitated from a cardiac arrest, are absolutely opposed to any such attempt, or would leave the decision to the treating physician. Some appear to be willing to discuss the subject, either in an outpatient setting,<sup>25</sup> at home,<sup>26</sup> or in an acute care facility after remission of the acute illness,<sup>27-28</sup> although a number of patients in hospital with whom the subject of CPR or DNR was broached reacted with considerable anxiety.<sup>29</sup> The number

of elderly persons opting for CPR is low in nursing homes, but the majority of old people sampled in the community would demand it, and between 10 and 20% of those surveyed recommend CPR even when the person is demented. Furthermore, 84% of acutely ill patients opted for CPR in a geriatric unit in New York, in which free discussion was initiated, giving them ample opportunity to change their minds.<sup>30</sup> The views of patients and of their physicians often do not coincide, either for CPR or DNR.<sup>27-31</sup> Not all physicians feel comfortable in discussing CPR or DNR, particularly in cases of assumed futility.<sup>32</sup> Physicians may also sometimes have too sanguine a view of the prognosis of CPR.<sup>33</sup> The variability of attitude to resuscitation exists not only between patient and doctor, but also between doctor and nurse.<sup>34</sup> Knowledge of the poor outcome of resuscitation and of its implications can act as a general guideline and deterrent to patients.<sup>35</sup> However, although full explanation of the hazards and poor outcome of CPR can reduce the number who have chosen this option,<sup>36</sup> it has also been shown that changes in initial choice of DNR to CPR preference in the course of the hospital stay was five times commoner in those who showed improvement in depression status, indicating the need to be aware of mood profile during such a discussion.<sup>37</sup>

### *Utility or futility?*

Is resuscitation in the elderly worthwhile, or are we condemning them to further suffering, and agony for their anxious families, clinging on to vain hopes? In a recent study of CPR, no statistical difference in survival, or discharge from hospital, (26%) was shown between those over 70 years and the under-70s, nor in survival up to three years.<sup>38</sup> This study, however, was selective in that most patients suffered from coronary ischaemia or had a myocardial infarction. The pre-morbid function had been good in the old as well as the young. Although these two factors predict a relatively better prognosis after cardiac standstill, these findings do mitigate against a general veto on resuscitation of old people. Moreover, outcomes of CPR may differ between one hospital and another.<sup>39</sup> Careful selection of candidates for CPR amongst the elderly can improve the proportion successfully resuscitated,<sup>22</sup> but there is a tendency to write DNR orders more readily for older people on the basis of age alone.<sup>40</sup> The older person (over 80 years) is more vulnerable to the metabolic and cerebral results of cardiac arrest and outcomes up to 10% survival to discharge are often less good than the 20-25% quoted in younger patients.<sup>41</sup> Ten per cent, however, is a substantial enough

minority to deny an *a priori* policy of not offering CPR to the elderly in general, but would tend to exclude an old person with multisystem disease, and with limited function and high dependency. The moral dilemma arises when, contrary to weak medical indications, the patient or his family demands attempted CPR. In those cases, the factors surrounding the decision by the person, and particularly the family, are often not related to the illness, but to psychological and cultural bias.

#### *Cultural factors*

In addition to professional attitudes, cultural attitudes about CPR and DNR vary in different countries.<sup>42-43</sup> The recent prospective study in Israel<sup>8</sup> on attitudes of children of parents admitted to a general hospital in the terminal stages of disease showed that one quarter of the interviewees requested CPR for their parents. There appeared to be a discrepancy between what the children thought their parents wanted, and what they (the children) recommended, and what they would recommend for themselves. Religious observance and closeness of relationship with their parents were the major factors determining the attitude to continuing life-sustaining treatment.

#### *Our practice*

It is difficult to come to definite conclusions with universal application on the ethics of CPR versus DNR because of cultural and even regional variations in outlook and outcomes, because cardiopulmonary resuscitation fails in most elderly patients, and confusion still reigns regarding who among the elderly wish or do not wish to have attempted resuscitation. Medical factors, ie diagnosis (including co-morbidity) and prognosis regarding the chance of leaving hospital, must remain the main indication to the physician in attempting CPR in the elderly. Patients' social circumstances and family urgings one way or the other should be lesser considerations after the patient's decision, if there is one. The difficulty in using guidelines from the literature is the minority of patients who are the exceptions - those who survive, despite a prediction of failure, and the ten per cent of elderly CPRs which are successful, especially if the arrest is witnessed.

In Israel, there is no legislation demanding written DNR orders, and no legal obligation on doctors to discuss DNR with patients, and a "living will" is regarded as a recommendation rather than having any legal standing. In our hospital, in conformity with Jewish religious law, the sanctity of life is a prime ethical principle, and cultural and religious factors do influence our practice in resuscitation. This principle does not override

DNR in the case where resuscitation would merely prolong suffering in a patient with a hopeless prognosis. It is rare in the geriatric wards for patients to broach the subject of DNR or CPR or to state that they do not wish resuscitative measures to be undertaken, and many are incapable of discussing it. Occasionally relatives initiate a discussion requesting all life-sustaining treatments including CPR. We involve relatives in a DNR decision if a patient is mentally incompetent; often they wish the decision to be taken by the doctor.

Our policy with geriatric patients has been to administer CPR according to medical and prognostic criteria. It is rare that the patient has expressly forbidden it. Dementia *per se* is not a contra-indication to resuscitation, since there are many degrees of personal functioning within its context, and often the medical team are not fully appraised of the degree of interaction of the patient with his family. We condemn the principle of scaling down medical care for the feeble elderly or demented, just because their lives appear less profitable to society.<sup>44</sup> Good communication, ideally at a cognitive rather than an emotional level between the patient, relatives and the physician may solve many conflicts of opinion regarding CPR or DNR.<sup>45</sup> There should be understanding among the health care staff about their own opinions, and consultations with an ethics team may help to resolve personal and inter-personal dilemmas. Present practice among the population in a geriatric ward indicates that in the absence of clear expression of autonomy by the patient, the physician often remains the one who has to make the final decision.<sup>40</sup>

#### **Conclusion**

The debate on feeding the terminally ill and performance of CPR in the elderly have been prompted by advancing technology in medicine, and changing values regarding the individual in a democratic society. We have put forward the view that the moral value of the sanctity of life as reflected in Jewish religious practice remains as a constant variable, together with the consideration of autonomy of the individual. Therefore hydration and nutrition are given to patients with terminal illness, as long as it is not potentially harmful. Similarly CPR is carried out if the medical team judges that the clinical background seems to offer a reasonable prognosis for life without significant additional suffering. These measures reflect a limited degree of paternalism stemming from a moral code which demands honouring life as an absolute value, but which still

respects the autonomy of the patient with regard to his suffering.

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