



Old age

AND ETHICS OF CARE

Report of the National Advisory Board on
Health Care Ethics (ETENE)

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Old age and ethics of care

This report of the National Advisory Board on Health Care Ethics (ETENE) is targeted at social and health care professionals working with the elderly as well as political decision-makers at the municipal and national levels, elderly persons, their next of kin and other people close to them. It is also meant to provide support to those responsible for formulating eldercare policies in their region and developing basic, advanced and continuing education in the field of eldercare.

In 2001, ETENE compiled a set of shared ethical principles for the entire health care sector. The Advisory Board considers it now important to define and specify how these principles apply to eldercare. The Advisory Board also wishes to contribute to the ongoing discussion on how elderly people can be guaranteed a good, dignified life that meets ethical requirements regardless of what kind of care they need and where the care is provided. We hope that this report will help to identify the challenges facing the field of eldercare and to evaluate and develop ethical activities and improve the ethical sensitivity of actors working in this field. Hopefully it will also generate ongoing ethical discussions about the position of eldercare in the framework of the social welfare and health care service system of Finland.

In the spring of 2007, a committee appointed by ETENE prepared a report on ethical principles inherent to eldercare. Members of the working group included Kari Eskola, Specialist in General Practice; Jyrki Jyrkämä, Professor; Anna Mäki-Petäjä-Leinonen, Doctor of Laws; Leena Niinistö, Doctor of Medical Science; Irma Pahlman, Doctor of Laws, Master of Laws with court training; Aira Pihlainen, Doctor of Health Sciences; Minna Raivio, Doctor of Medical Science; Raimo Sulkava, Professor; and Ritva Halila, Docent and General Secretary of ETENE. The Advisory Board approved the report in their meeting of 25 March 2008.

This report is the result of discussions held by ETENE and the work of the above working group. It focuses on the stage of ageing when a person's functional capacity begins to decline and he or she increasingly needs help from other people and services provided by society, especially by the social and health care sectors. Eldercare is provided jointly by social services and health care. This is why the report addresses the sensitive ethical issues associated with this stage of life from the viewpoint of both sectors.

Briefly, the position of ETENE is as follows:

- Treating elderly persons as individuals forms the basis of ethically sustainable eldercare. Care should be tailored to the needs and wishes of the elderly, respecting their values and taking their opinions into account. Care planning should take into consideration each person's state of health and functional capacity, support provided by people close to him or her, and his or her social network in its entirety.
- Eldercare is provided jointly by social services and health care, and comprehensive planning is therefore essential. Good care should be provided by skilled professionals whom the elderly person knows and trusts, and adequate time should always be set aside for it.
- Elderly people have the right to participate in decision-making regarding their care and care facility. To be able to do this, they need information about various options and their effects. Elderly people have the right to trust that appropriate care and services will be provided that will satisfy their reasonable everyday needs. In the case of long-term care facilities, the wishes of the elderly clients as well as their right to self-determination and privacy must be respected as if the care facility was their private home.
- Elderly people have the right to safe medication. The arbitrary pharmacological treatment of symptoms may cause significant harm. On the other hand, the well thought-out use of multiple medications may increase the patient's well-being. An elderly patient's medications should be comprehensively and frequently reassessed. Data from clinical studies should be applied to eldercare with caution.
- Various types of psychopharmaceuticals are often prescribed to elderly patients in Finland. These medicines should only be used according to their approved indications. Psychopharmaceuticals should never be used to make up for staff shortages.
- The patient's age should never be a reason for denying treatment. However, age-related illnesses and alterations in functional capacity may increase the risks of adverse reactions to therapies and certain treatment measures, which should be taken into consideration when planning treatment. This may also influence treatment decisions.
- Elderly people have a right to be protected by society against exploitation and self-inflicted harm, but their right to self-determination must also be respected as far as possible.
- The status of family caregivers should be reinforced and they should receive better support. The possibilities for relatives and

friends to be involved in the care of their elderly should be promoted, especially in cases where the elderly are incapable of making decisions about their care.

- Elderly people have the right to good symptomatic care and a dignified death. If an elderly person has issued an advance directive or a living will, it must be respected. Decisions about care should be made early in collaboration with the elderly person or those closest to him or her. The wishes and values of the elderly person should be respected. Clear documentation of the care strategies selected for each elderly person facilitates the work of the treatment staff, reduces the anxiety of the family, and increases the well-being of the senior citizen.

Introduction

The number of persons aged over 65 will grow rapidly in the Western world over the next decades. This also applies to Finland. According to the population forecast of Statistics Finland, the number of Finnish citizens aged 65 or older was approximately 870,000 in 2006 but will increase to approximately 1.4 million by 2030. The number of persons aged over 85 is showing particularly rapid growth. According to the population forecast, the number of Finnish citizens aged over 85 was 94,000 in 2006 and will increase to 220,000 by 2030. The fact that over 60% of Finns will live past the age of 75 reflects our rising life expectancy.

Longer lives generally mean increased well-being, more healthy years of life, and better opportunities to be an active member of society for many years even after retirement. On the other hand, the increasing number of senior citizens in both absolute and relative terms has given rise to concerns about the organisation of care and treatment. Ageing increases the risk of morbidity and disability, leads to impairment of mental and physical functional capacity, and increases the need for care.

Advances in medical knowledge and applications have enabled the development of new curative and corrective therapies. However, rapid advances can also turn medical development into a threat to a good life if new treatments and technologies are used imprudently.

In the years to come, social services and health care will need to compete to be able to recruit enough employees from smaller and smaller age groups to care for the ever increasing elderly population. The large post-war age groups are rapidly approaching retirement. A major share of expertise in social and health care will disappear from the working life with them. A large number of health and social care professionals will be needed to care for these large age groups when they truly reach old age. Hence, the health and social care professions must be able to recruit and subsequently hold on to skilled professionals who are able to cope with this work and who can also develop it.

The principle of doing good and avoiding harm dates back to the days of Hippocrates. Further refinements in ethical thought have been made, especially in the 20th century. Current health care ethics are based on professional codes of conduct, international human rights conventions, and fundamental rights and other provisions laid down in the Finnish Constitution.

Health care and the elderly

Old age and the elderly

There is no uniform or generally accepted definition of “old age”. Defining old age on the basis of calendar age is problematic because changes brought on by ageing tend to be very individual. However, certain age limits are used to define retirement age and to compile various types of statistics.

Defining the normal ageing process is one of the key challenges of gerontological research. What is considered normal age-related decline in functional capacity, and which changes should be treated? Can frailty in old age be prevented or delayed, and how can it be influenced? What should be treated and at which stage? Should the goal be to reduce the risk of falling ill, to alleviate symptoms or to treat illnesses? Which treatments are useful, and which ones are ineffective or potentially harmful?

Old age is a stage of life that affects everyone differently. It will inevitably cause permanent physiological changes in us all. Ageing affects a person’s vital functions and increases the number of chronic illnesses. Its effects on mental and physical functional capacity vary, and each individual has a slightly different perception of his or her illnesses, condition and ability to cope with everyday life. Most elderly people stay healthy and fit for many years and can easily cope with everyday tasks, continue living at home and remain active members of their community. However, as their functional capacity gradually declines, they begin to need more and more support from others.

Those with dementia are probably the ones who need the most treatment and care regardless of the age of onset or the cause of the illness. At the moment, there are approximately 120,000 dementia patients in Finland who require treatment and care. Approximately 12,000 people are diagnosed with Alzheimer’s disease or other forms of dementia each year. Moderate to severe dementia affects approximately 4%, 10% and 35% of citizens aged 65–74 years, 75–84 years and over 85 years, respectively. In addition, there are approximately 6,500 dementia patients aged under 65 in Finland. There were 85,300 patients with moderate to severe dementia in 2005, but their numbers are estimated to reach 110,000 by the year 2030. Progressive dementia gradually impairs the patient’s functional capacity and ability to make decisions, which is why he or she increasingly needs help and eventually requires round-the-clock supervision. Many treatment-related and associated ethical issues come to the fore in the care and treatment of dementia patients.

Comprehensive care

Elderly people are entitled to have their care needs evaluated, to be heard and to receive comprehensive care. Professionals assessing the situation should consider the elderly patient's symptoms and illnesses but also his or her medical history, social environment and prognosis. The patient's memory, mood, values, psychological and spiritual needs and family networks should also be evaluated.

Quality care supports and strengthens the existing physical and mental abilities and resources of the elderly. An adequate and healthy diet, normal everyday activities, regular exercise and fresh air, hobbies and accessibility of the home and living environment also promote well-being and help maintain functional capacity. Coping at home can be promoted through provision of various support services and aids that facilitate the performance of daily tasks and improve mobility. Promotion of functional capacity in the elderly often requires medication and rehabilitation as well.

Frail elderly people require many forms of help. The skills of many experts working as a team are also needed when planning the care of elderly people. At its best, such multiprofessional collaboration can guarantee good and sufficient services and expertise, but in the worst case, it can result in fragmented and poorly coordinated care provided by a large number of people. Constantly changing caregivers may make the elderly feel insecure, and it may even result in real safety risks.

The goal of care – and the wish of most elderly people – is to allow the elderly to live at home or in a familiar environment for as long as possible. However, we must ensure that frail elderly people requiring many forms of help are not forced to live at home alone, isolated and dependent on constantly changing services. Elderly people who are still healthy and fit should also be offered the opportunity to move to a place where they can reside even after their functional capacity begins to decline. If an elderly person is unable to live at home despite support, the decision regarding his or her next care facility should never be made on the basis of any single indicator but on the basis of a comprehensive multiprofessional evaluation of the person's situation in life as well as his or her personal opinions and care needs.

Elderly people have the right to trust in the provision of appropriate care and services at home as necessary and also in the continued provision of round-the-clock care and protection when it becomes impossible to live at home. A good care facility can also intensify its services when an elderly client's condition deteriorates. Needlessly moving elderly people from one care facility to another can be avoided this way.

There are major differences in the services and service networks of different municipalities. A skilled treatment unit is familiar with the services available in its region and can pick the right ones to satisfy the individual needs of elderly clients. Collaboration between professionals enables modes of operation that benefit the elderly, are meaningful from the providers' point of view, and also demonstrate cost-effectiveness.

There may be considerable differences in the quality of life of residents of care facilities maintained by the health care sector and the social services sector, so it may make a world of difference to the well-being of elderly people which of these administrative sectors is providing the care they receive. There are differences in the care practices and care options offered by health centre bed wards, nursing homes, intensified service housing and supported home care. The care facility may have a significant impact on an elderly person's life, on his or her personal perception of it, and on the way his or her dignity is respected.

There are some unresolved issues that specifically relate to eldercare. A few examples that have also sparked public discussion are presented in the following.

Many senior citizens are lonely, and loneliness is known to increase the risk of major depression and other mental health problems. The elderly do not find it easy to ask for help with their fears and anxiety. Public discussion about the costs of ageing to society or about the increasing costs of medication may also evoke feelings of guilt in the elderly, further aggravating any mental health problems.

It has been estimated that the elderly do not always receive adequate treatment for their pain. This is partly explained by the personal attitudes of the older age groups: complaining about pain has been considered inappropriate, even shameful. Factual and empathetic discussion usually resolves the situation.

A diverse and adequate diet improves well-being and reduces the need for other treatment. Dietary deficiencies, which may lead to impairment of health and functional capacity, are fairly common in the elderly. Not all care facilities provide their elderly clients with adequate dental and oral health care. This is a very significant issue as dental and prosthetic problems may impede communication, predispose to infections and even lead to malnutrition. Oral health and functional capacity play a significant role in the well-being of the elderly.

New technological tools and appliances (e.g. passage control, audio connections, electronic monitoring) have been and are constantly being developed to promote the safety and facilitate the treatment of elderly

people. The suitability of such aids must be evaluated first and foremost from the viewpoint of the elderly, but also from the viewpoint of their effects on the work and working conditions of employees. Technological security measures can significantly improve and facilitate the care and monitoring of elderly people. However, technology can never replace the care given by another human being.

Good care requires professional expertise and teamwork

Social and health care professionals must guarantee a good everyday life for the elderly who are no longer able to take care of themselves. All units treating elderly people should be able to consult specialists in issues relating to eldercare quickly and flexibly. Tight collaboration networks between various actors in the field improve the possibilities of providing the elderly with high-quality comprehensive care. For such teamwork to succeed, all professionals must both understand and respect the work and expertise of others. Good leadership improves the atmosphere of work communities and also promotes the well-being and commitment of staff.

Developing their professional skills, of which ethical skills form an important part, is the duty and the right of social and health care professionals. The foundation for professional ethics is laid down in basic training, and advanced and continuing education will build on it. Training must strive to establish the ethical principles of eldercare and ethical sensitivity as integral parts of everyday routines. This applies to practical care and geriatric research alike.

Society as a whole and all its sectors influence the well-being of the elderly. The needs of the ageing population must be taken into account in all forms of societal planning.

Medication and the elderly

The medication prescribed for elderly patients differs from that of younger patients for many reasons. Ageing leads to changes in the body and its functions. The proportion of water in the body decreases, while the level of fat increases. Circulation slows down, and so does the passage of medicinal agents through the body. Age-related changes delay the correction of imbalances in vital functions, and drug-induced adverse reactions are more common compared to younger patients, even with dose reduction.

Elderly people living at home generally use 4–5 medicinal products on average, while those living in nursing homes and institutions may receive up to 8–10 different medications. Elderly people may have diabetes, cor-

onary heart disease, cardiac insufficiency, musculoskeletal pain, memory disorders and depression – all at the same time in the worst case. Even if these multiple conditions are not treated with all the medicinal products recommended by treatment guidelines, elderly patients may still end up with a dozen or so essential medications.

Medications used for the prevention of illnesses and for the maintenance of health increase the risk for polypharmacy and adverse drug reactions. Antihypertensive medication has been shown to be beneficial at least up to the age of 75 years, but evidence on the benefits of lipid-lowering and bone-strengthening medicines in the elderly is scarce. Treatment of hypertension may result in dizziness, balance disorders and even falls in the elderly, even when carried out according to recommendations.

When considering medication, the potential benefits of prophylactic therapy must be carefully weighed, taking into account the elderly person's illnesses, the medicines he or she absolutely must take to treat them, his or her sensitivity to adverse drug reactions, and the person's daily life as a whole.

At present, anti-dementia medicines are quite frequently used in Finland, and their use is relatively more common than in the other Nordic countries. According to the 2006 statistics of the Social Insurance Institution, reimbursement for memory-improving drugs was paid to approximately 30,000 patients with Alzheimer's disease out of approximately 40,000 patients in outpatient care and approximately 30,000 patients in institutional care.

Over 80% of institutionalised elderly patients and 12% of elderly people living at home use psychopharmaceuticals, mainly benzodiazepines or antipsychotics. These medicinal products may cause confusion and further impair functional capacity, predisposing elderly patients to accidents and increasing the need for care.

Sedative medication is sometimes necessary to restrict the freedom of movement of restless and confused elderly patients if they cannot be calmed down by other means. In such cases, the doctor must be familiar with the correct use of sedatives and be aware of the possibility of adverse reactions. Using sedative medication to make up for staff shortages violates the principles of medical ethics.

Clinical studies on medicinal products are rarely conducted in the elderly, especially in those aged over 85. Medication decisions must therefore be made on the basis of studies conducted in younger subjects as well as general information about the properties of the medicinal agent

and the effects of ageing in the body. Current Care guidelines are also often based on studies carried out with younger age groups and thus cannot be directly applied to the treatment of elderly patients. Studies indicate that many medicinal products and combination therapies are unsuitable for elderly patients, and the mean dose of an 80-year-old should only be about half of the dose given to a 30-year-old.

Elderly patients, particularly those with dementia, do not always receive adequate treatment for their illnesses, which results in many suffering needlessly because of a treatable condition. Inadequate treatment cannot be considered to represent quality care from an ethical point of view. Elderly persons needing treatment should not be left untreated just because the medicinal product in question has not been studied in the elderly or because the patient is already taking many other medications for other conditions. However, finding a balance between good and efficient medication on the one hand and the risk for adverse drug reactions on the other is not a simple task.

The more medicinal products an elderly person takes, the higher is the risk of unexpected and undesirable interactions between them. On the other hand, concurrent use of multiple medications at low doses may improve the patient's condition and reduce the incidence of adverse drug reactions. Therefore, the number of medications and the dose sizes should be frequently reassessed with a critical eye, aiming at maximising the benefits and minimising the disadvantages. A good patient-doctor relationship and persistence are important preconditions for finding the most suitable treatment regimen for each individual patient.

Family and friends

The network of friends and relatives often has a greater impact on an elderly person's independent initiative and ability to cope at home than his or her illnesses. Altruistic and persevering family members can help an elderly relative cope at home even when he or she is quite severely ill. However, taking care of a demented or otherwise frail relative is often extremely taxing. Sometimes the caregiver is the patient's spouse or another relative who may be as old and nearly as frail as the patient. In such cases, the responsibility is often too heavy and the caregiver's strength eventually fails.

Caregivers need time off and other forms of societal support to be able to cope with their responsibilities. Advice from social and health care professionals is often needed as well. Only a small minority of these caregivers has a caregiver contract, and even they often lack the opportunity to use their statutory days off. Promoting the functional capacity of

caregivers through various forms of support and services also increases the well-being of the elderly being cared for. It is also in everyone's best interests to provide support to those friends and relatives who are not receiving home care allowance.

Society has an obligation to take care of elderly people who have no family or whose next of kin live elsewhere. The next of kin living far away often have concerns about the care their elderly relative is receiving, and the distance may make it difficult to communicate with staff. However, developing mutual trust and deciding on a shared care strategy require open dialogue where the concerns of the next of kin are heard and taken seriously. Keeping in touch with the next of kin is particularly important if the elderly patient is no longer able to contribute to his or her care.

The next of kin are also a major resource for the well-being of elderly people who are being cared for in a 24-hour care facility outside their own home. The involvement of the next of kin in the care of their elderly relatives should be promoted and supported.

Restrictions on investigations and treatment

Due to medical and technological advances, demanding procedures can also be carried out on the elderly if such procedures can be expected to be beneficial. The older the patient, the more emphasis must be placed on his or her expected quality of life and functional capacity when evaluating the potential benefits of tests and treatment. The patient's other illnesses and functional capacity before and after the planned procedure must also be taken into account.

It is important to contemplate what can be achieved with the investigations and treatment being planned. Major surgery is always a physically and psychologically taxing event which may involve major risks, and recovery may require long-term rehabilitation and demand a great deal of energy from the patient. The potential benefits and disadvantages must be weighed very carefully in the case of major procedures. Extensive rehabilitation and the procurement of expensive aids can be considered justified if such measures can restore or maintain an elderly patient's mobility and functional capacity or promote his or her independence.

The patient's age should never be used as a reason to deny treatment. However, ageing is associated with many illnesses, various changes in bodily functions and declining functional capacity, which reduce the benefits and increase the risks of treatments and measures. If the potential disadvantages and their probabilities are greater than the expected benefits, treatment should not be given.

End-of-life care

When an elderly person has a progressive illness, we must consider what kind of care meets his or her wishes and expectations, which procedures will improve quality of life, and which procedures will just prolong suffering. For instance, the outcomes of resuscitation and many other invasive procedures are often poorer and the risk of damage correspondingly higher in the case of advanced disease. If the risk of a procedure causing damage is greater than the expected benefits, abstaining from it can be considered justified.

Alzheimer's disease, for example, progresses at its own speed over the years. The average duration of the disease is 10–12 years, sometimes as much as 20 years. In the final stages of the disease, the patient's mobility is impaired and his or her mental capacity and communication skills deteriorate. In the end, the patient may stop swallowing. The risk of death increases with the duration of the disease, the number of other illnesses and the patient's age, but predicting the time of death is often impossible. A demented, bed-ridden patient who has lost his or her ability to speak may die very quickly or live for several years. In such cases, it is important to assess which treatment strategy will benefit the patient and increase his or her well-being the most. This requires a high level of clinical expertise, ethical consideration and good interaction skills.

It is important to discuss matters such as resuscitation, intensive care and other therapies with the elderly patient, people close to the patient and the entire care team before the patient's condition deteriorates to such an extent that he or she is no longer able to express any care-related wishes. In the optimal situation, decisions about care are made on the basis of such a discussion after due consideration and without needing to rush. If the patient's condition changes dramatically, the outline of care should be reconsidered and a new assessment appended to the patient records. The assessment rarely takes the form of a one-time decision or the final one – in most cases, it is a process and a series of consecutive decisions.

When making decisions about outlines of care, the patient and the people closest to him or her should always be told that a decision to abstain from resuscitation or intensive care, for example, does not mean that the patient will receive poorer care or no care at all, but rather that the focus, goals and means of treatment will be adjusted to ensure the well-being of the patient. Alleviation of symptoms and maintenance treatment will be continued and intensified, but needless treatments which would only prolong suffering will be abandoned so that the patient can be treated in the way that suits him or her best.

The doctor in charge of the patient's care decides when the patient should be moved to symptomatic (palliative) care or hospice care, but the decision should be made after discussing the matter with the patient or the people closest to the patient and in agreement with them. As with other decisions about outlines of care, this decision should be clearly noted in the patient records to ensure that the treatment strategy remains uniform also outside office hours.

A "do not resuscitate" (DNR) order is a narrow interpretation of a much more extensive treatment strategy. This decision should be restricted to apply only to the cessation of chest compressions and electrical cardiac pacing if the patient goes into cardiac arrest.

"Withhold life-sustaining treatment" rules out a larger group of treatments. In general, it means the discontinuation of all therapies that sustain the patient's vital functions (such as antibiotics, hydration, intravenous nutrition, cardiac pacing, dialysis or respirator treatment). If life-sustaining treatments are withheld, it is no longer necessary to monitor these vital functions with devices or blood tests. This outline of care is best suited for situations where death is already close. The treatments being withheld should be specified and noted in the patient records in detail, and the justifying reasons should be recorded.

The expression "allow natural death" has also been used in the literature to signify this treatment strategy. It is perhaps the clearest and most precise explanation of what the terminal care of a severely demented elderly person with multiple illnesses is about.

Provisions on eldercare

The social welfare and health care provided to those resident in Finland is based on international conventions on human rights signed and ratified by Finland, the Finnish Constitution, the Act on the Status and Rights of Patients (“the Patient Act”), the Act on the Status and Rights of Social Welfare Clients (“the Social Welfare Client Act”) and other laws and regulations on social welfare and health care. The Finnish Constitution stipulates that everyone is equal before the law and no one shall, without valid reason, be treated differently from other persons on the grounds of age, health or other factors pertaining to his or her person. However, there are no laws prohibiting people from treating other people differently in the treatment of an illness if age, for example, affects the risks of treatment, the selection of medication or the prognosis of recovery.

The Patient Act stipulates that everyone is, without discrimination, entitled to the health care required by his or her state of health within the limits of available healthcare resources at the time in question. The patient shall be treated without violating his or her human dignity and with respect for his or her convictions and privacy. Corresponding rights pertaining to social welfare are laid down in the Social Welfare Client Act.

Elderly people usually receive their services as part of the regular activities of social welfare and health care. The only provision specifically applying to services provided to the elderly is found in the Social Welfare Act. According to this provision, in non-urgent cases the municipality is responsible for providing persons aged 80 years or over access to an assessment of the need for social services by, at the latest, the seventh weekday from the date when the client, his or her legal representative or relative, or some other person or authority contacted the municipality in order to obtain services. This also applies to persons receiving the highest care allowance payable to pensioners. This provision reflects the principle of high-quality services inherent in the Act, which aims at promoting the functional capacity of the elderly and the possibilities of elderly people to live at home.

The right to self-determination and the elderly

The right of patients and social welfare clients to self-determination is laid down in the Patient Act and the Social Welfare Client Act. These provisions are of particular importance in the context of eldercare.

According to law, the patient shall be treated in mutual understanding with him or her. If the patient refuses a certain treatment or meas-

ure, he or she shall be treated, as far as possible, in another medically acceptable way with mutual understanding. If the patient cannot decide on the treatment to be given, important treatment decisions, such as the decision to withhold life-sustaining treatment, require the consent of the next of kin, another person close to the patient, or the patient's legal representative.

Only a patient who has sufficient understanding of the implications of his or her decision has the right to refuse all treatments that are being planned for him/her or that have already been initiated. The patient's legal representative, next of kin or other people close to the patient do not have the right to forbid any treatment that is necessary to ward off a threat to the life or health of the patient. The decision about the necessary treatment shall be clinically justified. However, the doctor is not required to give treatments that are not in the personal interests of the patient even if the person giving the consent demands them.

According to law, a steadfast and valid advance directive (living will) issued by the patient shall be respected, and the patient shall not be treated against his or her will. An advance directive states how the patient wishes to be treated if, for reasons such as unconsciousness or dementia, he or she is unable to participate in decision-making relating to his or her care. An advance directive usually prohibits the administration of life-sustaining treatment when there is no hope of recovery. It does not prohibit the use of resuscitation or intensive care measures in situations where the patient can be expected to recover from his or her illness with the help of these measures. An advance directive may also include more specific personal wishes regarding care and quality of life. An advance directive may be a written document appended to the patient records. An oral advance directive is also valid and must be noted down in the patient documents.

The patient is also entitled to authorise someone else to make treatment decisions on his or her behalf in situations where he or she is incapacitated. This trustee shall interpret the patient's wishes when the patient is incapable of expressing them. The person acting on behalf of the patient can be named in the advance directive or in a continuing power of attorney.

The Act on Continuing Powers of Attorney entered into force on 1 November 2007. It defines a new legal instrument by which an individual can arrange the management of his or her affairs in advance in case he or she should later be incapacitated by an illness or some other cause. In this document, the patient defines the matters covered by the authorisation.

The patient can authorise someone else to represent him or her in matters relating to his or her financial affairs or health, among other things. If the patient is no longer able to manage his or her own affairs because of dementia, for example, the appointed trustee can request confirmation of the authorisation from a local register office. The local register office is also responsible for supervising the actions of the trustee.

A continuing power of attorney does not supplant the right to self-determination laid down in the Patient Act. The trustee is the patient's legal representative, but his or her role shall always be secondary to that of the patient if the patient is still capable of making decisions about his or her treatment.

If illnesses that pose a threat to functional capacity, such as dementia, are diagnosed early, elderly people still have time to make independent plans about their future. At this point the patient is usually still capable of issuing an advance directive, a continuing power of attorney or a last will and testament. In fact, it is preferable that the possibilities to plan ahead be explained to the elderly patient at the time of diagnosis. This promotes his or her right to self-determination.

Outsiders can sometimes try to take advantage of friendly senior citizens whose strength and mental capacities are failing. Elderly persons can also cause themselves harm or put themselves in danger through actions for which they cannot be held responsible. Appointing a trustee to look after the interests of an elderly person whose functional capacity is declining is one way of providing protection to those whose ability to protect themselves and defend their rights has been essentially impaired. This supervision of interests should be restricted to the management of affairs that the person is incapable of taking care of, i.e. usually financial affairs.

Regardless of whether the decisions are being made by someone authorised by the senior citizen or a person appointed to supervise his or her interests, the senior citizen should always be treated and his or her affairs should be managed in a way that serves his or her best interests.

Restricting the freedom of movement of the elderly

Numerous measures to restrict the patient's freedom of movement are used in the health care of elderly people. These include e.g. magnetic belts, safety bed rails and strapping the patient to a chair or a bed. The Finnish Constitution stipulates that no one shall be deprived of liberty arbitrarily or without a reason prescribed by an Act. However, there are no specific provisions on restricting the liberty of individuals suffering from somatic illnesses. Strapping down a patient is always a serious violation

of the patient's personal liberty and integrity. Strapping may also be associated with health hazards and even increased mortality.

Restricting the patient's liberty is sometimes necessary. According to the National Authority for Medicolegal Affairs, an elderly patient's freedom of movement may be restricted against his or her will to ward off a serious threat to his or her personal safety, but only to the extent necessary at any given time. The patient's liberty may only be restricted after all other possibilities have been evaluated and deemed insufficient. The decision must always be based on a detailed evaluation of the patient's individual situation. The decision is made at the discretion and under the responsibility of the doctor in charge of the patient's treatment, who must give equal consideration to the benefits and disadvantages of the restriction. The patient must be adequately supervised during the restriction on his or her liberty. The decision must be justified and noted down in the patient records. Continued restriction must be frequently reassessed.

Distinctive features of ethics in eldercare

Everyone has a unique, inviolable human dignity. In this context, respecting human dignity means that elderly people must be treated as unique individuals whose opinions must be heard. Ensuring that the dignity, right to self-determination and privacy of elderly individuals are not violated by the social and health care system requires active effort.

Everyone has a unique history and a different life story. Ethically acceptable care is provided individually, taking the elderly person's story and wishes into account. Functional capacity and coping with everyday activities can be evaluated with scales and numbers, but behind those numbers there is always a person whose everyday life is made easier by other people such as family members, friends and often social and health care professionals as well.

Many public statements, as well as stories and anecdotes by the elderly, reveal that the needs and wishes of elderly patients are not always observed. Slightly demented, frail senior citizens appreciate a familiar, home-like environment and want to be able to cope with everyday activities despite their illnesses and complaints. An elderly person's wishes relating to his or her life can be respected in any care facility if enough attention is paid to it.

Respecting privacy often requires giving consideration to the small things that nevertheless may be very important to the elderly. Those in need of extensive help are at risk of losing their privacy and human dignity. Personal hygiene, sensitive personal data and personal relationships,

for example, are private matters, and everyone working with the elderly has an ethical obligation to keep these issues confidential. The right to privacy is also the constitutional right of institutionalised elderly patients.

The right to self-determination and autonomy means that the elderly have the right to participate in decision-making relating to their treatment whenever possible. To be able to do this, the elderly need information about various treatment options and their effects. In addition, respecting an elderly person's right to self-determination often means taking into consideration his or her other wishes relating to care and everyday activities. The patient's autonomy may only be restricted to the extent necessary to ensure the success of treatment. Taking up the right to self-determination requires having the capacity to make decisions, which must always be assessed on a case-to-case basis and depends on the patient's mental capacity and the complexity of the decision to be made.

The principle of doing good and avoiding harm requires evaluation of the patient's care as a whole. The benefits and disadvantages of planned treatments should be assessed by contemplating their effects on the patient's quality of life.

To develop and evaluate care and treatment, it is necessary to conduct research in elderly people and systematically collect information, e.g. on the effects of medicines in the elderly. Adherence to the principle of doing good and avoiding harm also requires paying attention to risk management and accident prevention.

The principle of fairness requires that patients with similar care needs be treated according to the same principles. The right to receive good care and treatment is independent of the patient's age, place of residence, social status or any other personal characteristics. Availability and distribution of treatment should only be influenced by the need for treatment, not by the party paying the bill. However, taking the patient's age into account in treatment decisions is justified if age affects the expected benefits of treatment.

In conclusion

Everyone has the right to safety in their old age, which includes the right to receive necessary treatment and good care. As a society, we have an obligation to ensure that the elderly receive the care they need and that their human dignity, right to self-determination and right to live according to their personal values are respected. We can assess the current state and development needs of eldercare by thinking how we would like to be treated when we are old and in need of help and care.

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Links

- Advance care will form, courtesy of the Alzheimer Society of Finland:
www.alzheimer.fi/
- Quality of life will, courtesy of Suomen Muistiasiantuntijat ry:
www.muistiasiantuntijat.fi

Information on and examples of advance directives: Duodecim medical database: http://www.terveyskirjasto.fi/terveyskirjasto/tk.koti?p_haku=hoitotahto&p_artikkeli=dlk00809
Palliative (symptomatic) care of (imminently) dying patients. Current Care guideline. www.kaypahoito.fi

An example of defining the treatment strategy for a severely ill elderly patient:

- 1) A doctor who knows the patient and is in charge of his or her care shall take and record the patient's complete medical history, paying particular attention to the onset, progression and prognosis of any severe illnesses.
- 2) The doctor shall evaluate how the elderly patient can be expected to recover after a sudden illness, and what his or her subsequent quality of life would be.
- 3) It shall be determined if the patient has issued or wishes to issue an oral or written advance directive, and his or her opinions about the best outline of care shall be heard. If the patient has issued no written advance directive and his or her opinions cannot be determined, the matter shall be discussed with the people closest to the patient.
- 4) The current situation, the treatment procedures to be considered at the time or in the event that the situation worsens, and the risks and potential benefits of the treatment procedures shall be discussed with the patient or with the people closest to him or her.
- 5) An outline of care shall be determined after thorough contemplation. Matters often needing to be resolved include antimicrobial therapy, hydration and nutrition, possible referral to specialist or intensive care, provision of support to the patient in a difficult period of life, and assessment and treatment of pain.
- 6) The outline of care agreed upon shall be noted down in the patient's medical records documents with brief and clear justifications to ensure the availability of these instructions in emergencies and also for other treatment institutions as necessary.
- 7) If the patient's condition changes dramatically, the treatment strategy shall be reconsidered and a new assessment appended to the patient's medical records.

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**The National Advisory Board on Health Care Ethics (ETENE)
Ministry of Social Affairs and Health**

Kirkkokatu 14, Helsinki
PO Box 33, FI-00023 Government
Telephone +358 (0) 9 160 01
Telefax +358 (0) 9 160 74312

General Secretary Ritva Halila
E-mail ritva.halila@stm.fi
Telephone +358 (0) 9 160 73834

Secretary Nina Lindqvist
E-mail nina.lindqvist@stm.fi
Telephone +358 (0) 9 160 74357

E-mail etene@stm.fi
Internet www.etene.org