

Ethics and Dementia: Common yet Complex Geriatric Cases in the Inpatient Setting

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Objectives

By the end of this session, attendees should be able to:



Recognize common issues that arise in the care of patients with dementia in hospitalized settings



Identify appropriate clinical resources to address these issues



Apply appropriate concepts and strategies used in clinical ethics to these cases

Case #1

John is a 76 y/o man with a hx significant for end-stage renal disease (ESRD) on hemodialysis (HD) who was recently diagnosed with moderate-stage Lewy Body Dementia. John was just admitted to the hospital with hyperkalemia after missing his last HD appointment.

A meeting is held with family and patient. Family voices understanding of patient's poor overall prognosis. However, patient reiterates his consistent desire to receive full treatment, stating the belief that he will improve. Medical team decides to continue attempts at dialysis as to comply with John's wishes. John was felt to demonstrate "borderline" decision-making capacity with a lack of insight.

While John maintains his preference to engage with "anything that could help", he regularly refuses standard interventions (e.g., labs) and is often unable to complete attempts at dialysis as he grows agitated and confused.

Ethics is consulted in concern for complexities involving patient's borderline capacity in light of dementia, and an inability to align patient's goals with his manner of engagement.

Discuss!

Get into groups/pairs and discuss the following questions:

- 1) What clinical information would you need to assess capacity?
- 2) What ethical issues do you foresee?

Does John have capacity?

1. Can the patient communicate a consistent choice/decision? YES
2. Does the patient understand the risks, benefits, and burdens of the proposed treatment and relevant treatment alternatives, including no treatment?
SOMEWHAT
3. Can the patient personally appreciate the situation and its consequences— as it applies to the individual and their expressed values (i.e., has insight)? NO
4. Does the patient manipulate the information rationally (i.e., can reason)? SOMEWHAT



Is your patient cognitively optimized?

Delirium

Sleep deprivation

Sensory deprivation

Fear/anxiety

Untreated pain

Hunger

Delirium

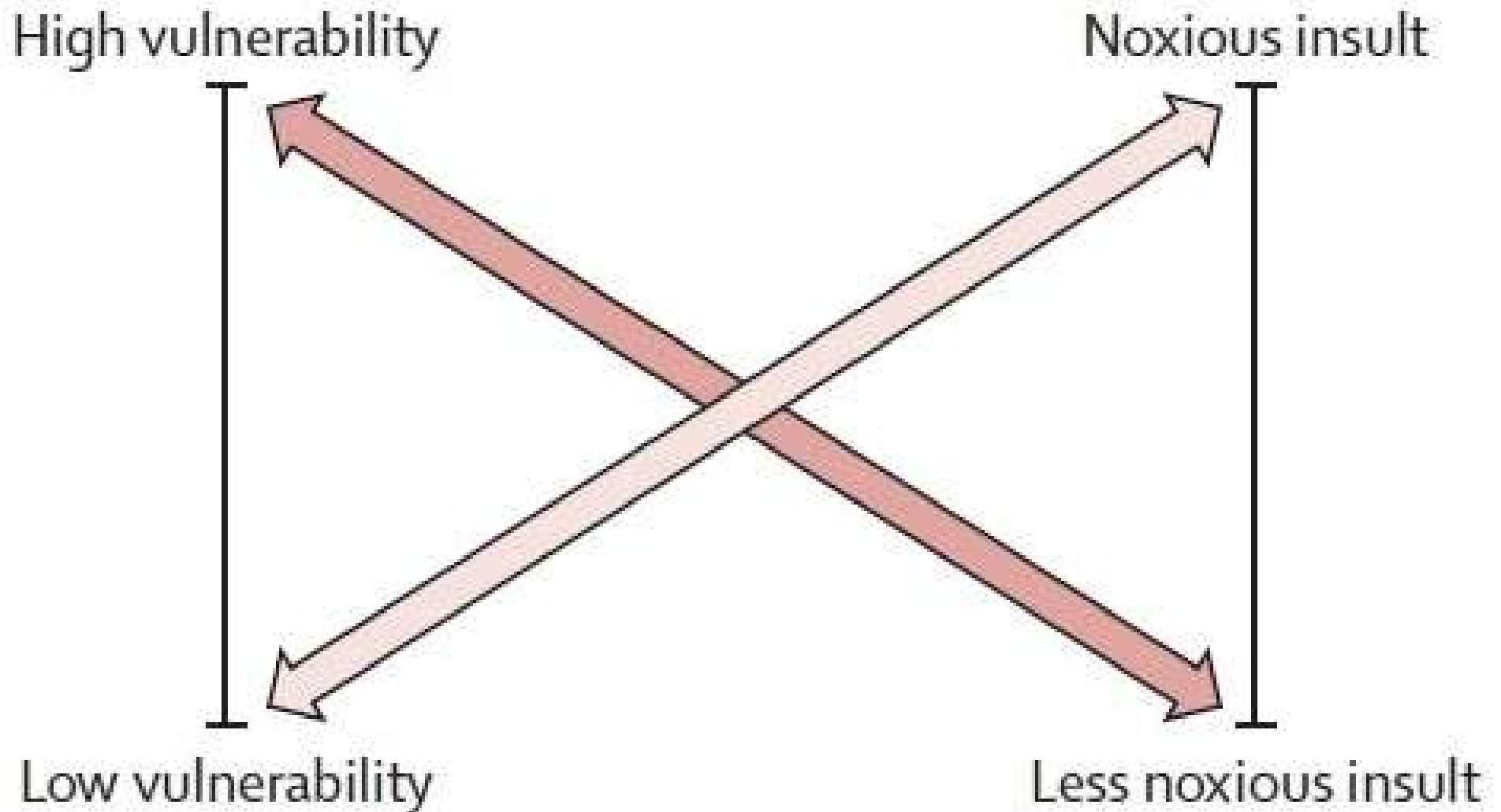
- An acute confusional state
- The active phase of cognitive injury
- Hallmark = inattention

~~“Do you know where you are right now?”~~

“Tell me the months of the year backwards”

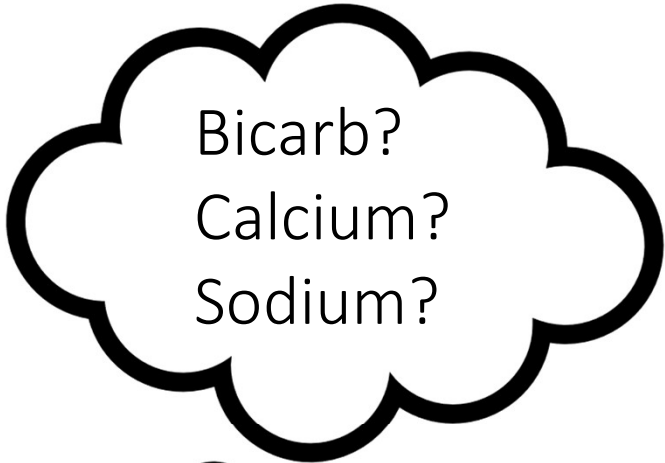
Validated tools: Ultra-Brief Confusion Assessment Method (UB-CAM),
3-Minute Diagnostic Confusion Assessment Method (3D-CAM),
4 A's test (4-AT)

Delirium and the vulnerable brain




Case #1

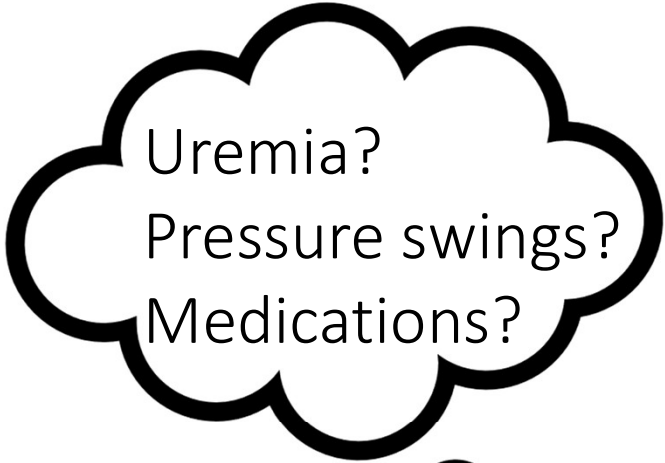
John is a 76 yo man with a hx significant for end-stage renal disease (ESRD) on hemodialysis (HD) who was recently diagnosed with moderate-stage Lewy Body Dementia. John was just admitted to the hospital with hyperkalemia after missing his last HD appointment.




Bicarb?
Calcium?
Sodium?



A black outline of a human head in profile, facing right, with a thought bubble above it. The thought bubble is connected to the head by three small circles of increasing size.



Uremia?
Pressure swings?
Medications?



A black outline of a human head in profile, facing left, with a thought bubble above it. The thought bubble is connected to the head by three small circles of increasing size.

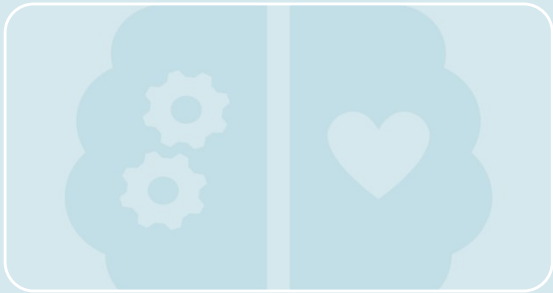
Suggested workflow

1. Part of the admission H&P: establish a baseline
 - a. What can this person do for themselves?
 - b. 4-AT, UB-CAM and/or 3D-CAM on admission
2. Assume reduced capacity will present, especially in a higher-risk patient
3. Identify surrogate decision maker during the day
4. Create contingency plan in afternoon, before signout to night team
 - a. Anticipate possible symptom triggers for agitation
 - b. Consider melatonin or pain medications to improve sleep
 - c. If sundowning likely, consider encouraging a short early afternoon nap

Are there circumstances that would better enable optimal decision-making?



When the patient isn't at their baseline in the hospital



Can cognitive recovery occur in the timeframe necessary?



If not, what evidence is there of prior goals of care?



How do we help surrogates make decisions the patient would agree with?

Takeaways from Case #1

- Identify delirium using a validated test as early as possible during the patient's hospitalization
- Address modifiable risk factors for delirium and other threats to optimized decision-making early and aggressively
- Do not presume decision-making capacity exists in a delirious patient
- When decision-making capacity is unclear or cognition is not at baseline, check for previous goals of care conversations and involve the patient's surrogate

Case #2

Mrs. Smith is an 82 y/o woman with mild dementia who is brought to the ER by ambulance after she fell in her home and called 911.

Mrs. Smith wants to discharge home, but the team feels this would be unsafe, given the patient's home is in "disarray" and has no working appliances. They instead recommend she be discharged to a care facility.

She has no next of kin or loved ones left, and she is adamantly against placement, sharing statements like: "Whenever I die, it will be on my terms and on my turf. You cannot take that away from me just because I am old and you think you know better than me."

Ethics is consulted on concern for unsafe discharge for patient with unclear capacity.

Discuss!

Get into groups/pairs and discuss the following questions:

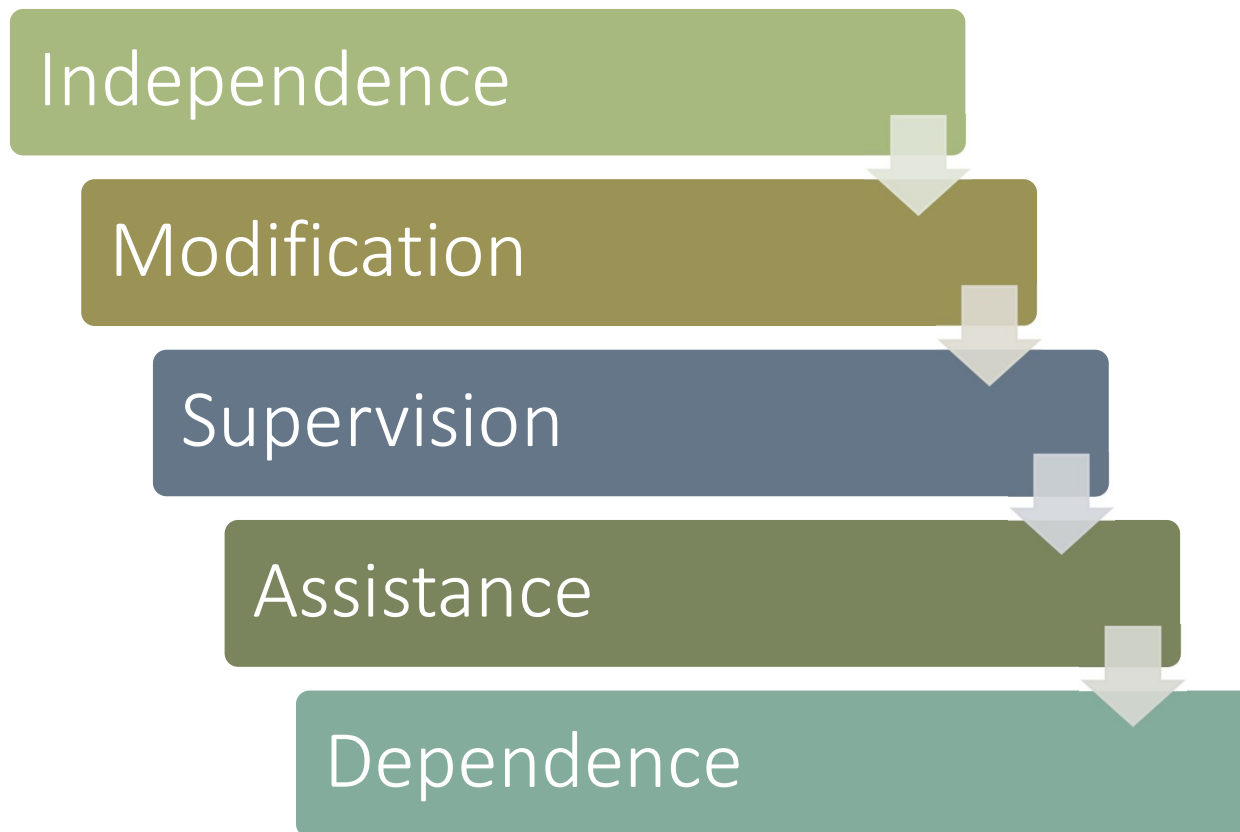
- 1) Should we facilitate Mrs. Smith's discharge back to her home or should we pursue placement in a facility?
- 2) What ethical principles or values are motivating your train of thought?
- 3) What clinical information would you need to make this decision?

FAST Stage	Description	Cognitive age
3	Mild dementia	Adolescent
4	Mild-moderate dementia	8-12 years old
5	Moderate dementia	5-7 years old
6a	Moderate dementia	5 years old
6b-c	Moderate-severe	4 years old
6d	Moderate-severe	3 years old
6e	Moderate-severe	2 years old
7a-e	Severe dementia	18 months-newborn
7f	End-stage dementia	4-12 weeks

Stages of dementia

Source: Hartford HealthCare Center for Healthy Aging

Functional assessment



IADLs

Finances
Medications
Transportation
Shopping
Cleaning
Cooking
Using the phone

ADLs

Dressing
Grooming
Bathing
Toileting
Transferring
Ambulating
Eating

Assessing function

Collateral history

EMT notes

Home health notes

Chart history

Family

Friends

Neighbors

Assessment

Occupational therapy (inpatient)

Home health nurse or OT

Assent

vs.

Consent

Willingness/agreement

Informed decision-making

“Going along”

“Deciding”

Ex. teenage patients

Ex. independent adults

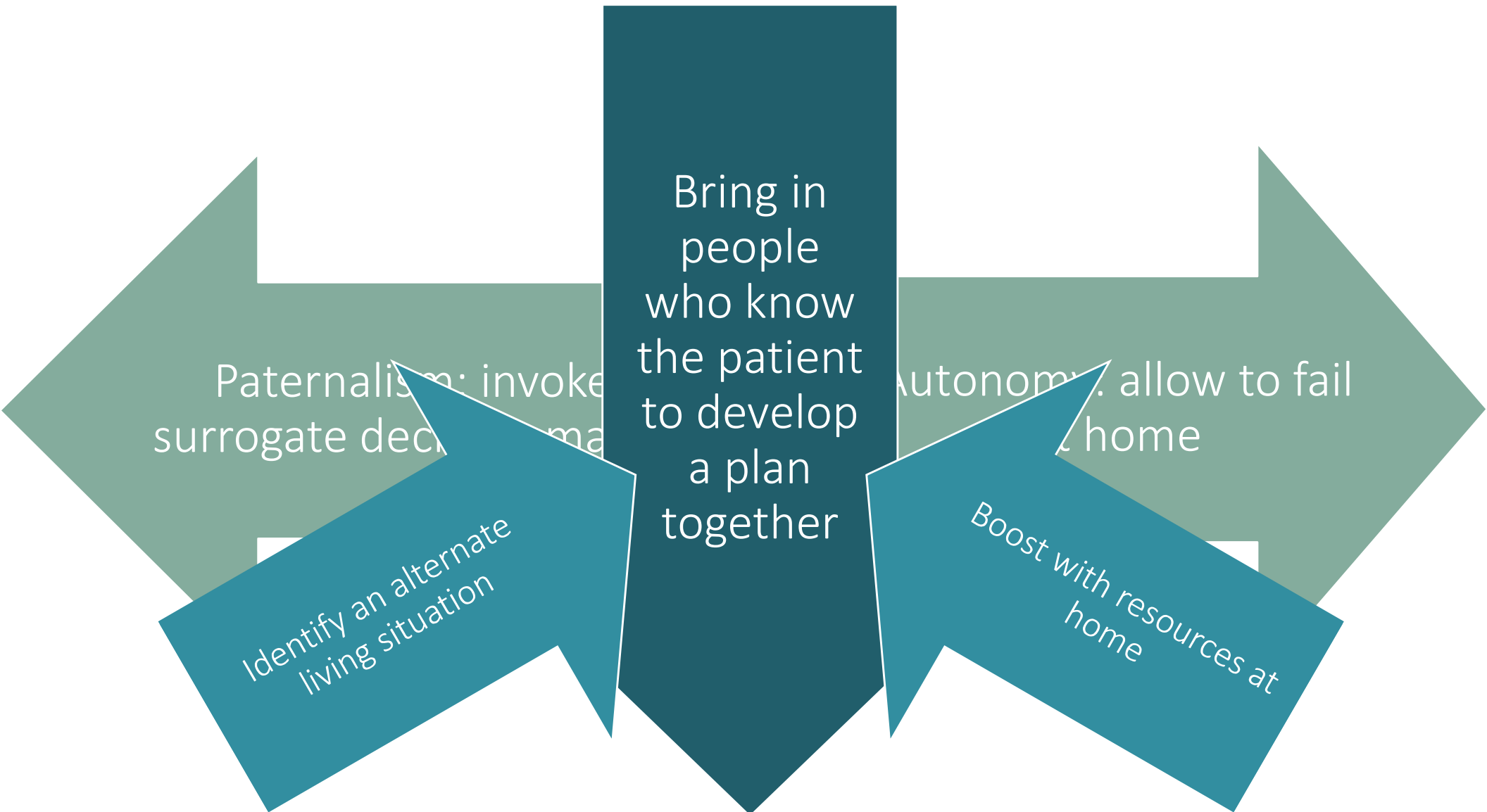
The spectrum of shared decision-making



Paternalism: invoke
surrogate decision-maker

Autonomy: allow to fail
at home

Supported decision-making



EXAMPLES OF HARM REDUCTION IN OTHER AREAS



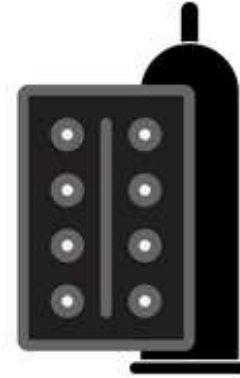
SUN
SCREEN



SEAT
BELTS



SPEED
LIMITS



BIRTH
CONTROL



CIGARETTE
FILTERS

Can we discharge
patients to unsafe
settings?

Yes!

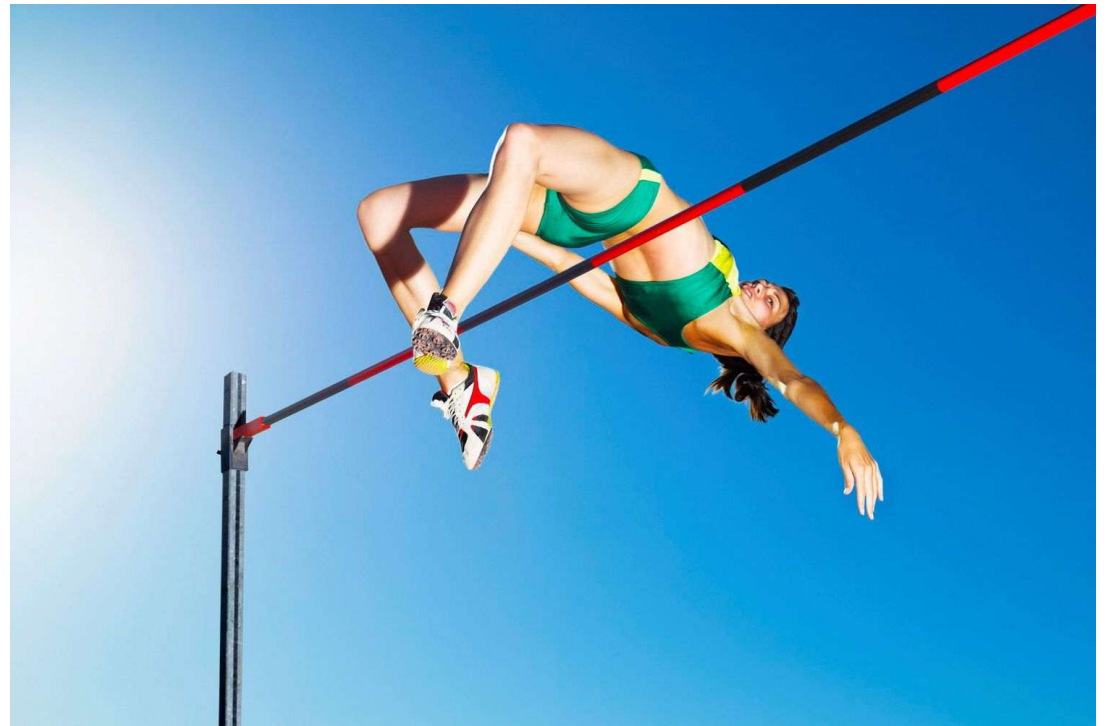
Examples of harm reduction tailored to functional needs

Cooking	Meal delivery services
Driving	Paratransit
Medication management	Pill boxes or blister packs Reminder calls Caregiver
Cleaning	Volunteer cleaning services Housekeeper
Finances	Rep payee services
Shopping	Scheduled grocery delivery Friend/neighbor taking them shopping
Telephone use	Accessibility settings



How will your patient remember your discussion?

State- appointed guardianship



Recommended reading:
American Geriatrics Society position
statement: “Making medical treatment
decisions for unrepresented older
adults”

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Sometimes it's
just not a great
situation.

We are not gods.

Takeaways from Case #2

- Supported decision-making can help us balance best interest for the patient while supporting their autonomy
- Even with patient's who might not be able to "consent", we still want to try to reach a place of assent
- Harm reduction strategies can turn a "not great situation" into a better one
- Giving up the illusion of control and making space to grieve difficult situations is a challenge for all of us

Recommended reading

Jacobsen J, Blinderman C, Alexander Cole C, Jackson V. "'I'd Recommend ...' How to Incorporate Your Recommendation Into Shared Decision Making for Patients With Serious Illness." *J Pain Symptom Manage*. 2018 Apr;55(4):1224-1230.

Largent EA, Peterson A, Karlawish J. "Supported decision making: Facilitating the self-determination of persons living with Alzheimer's and related diseases." *J Am Geriatr Soc*. 2023 Nov;71(11):3566-3573.

Marcantonio ER, "Delirium in hospitalized older adults." *NEJM* 2017 Oct; 377(15): 1456-1466.

Marcantonio ER, Ngo LH, O'Connor M, Jones RN, Crane PK, Metzger ED, Inouye SK. 3D-CAM: derivation and validation of a 3-minute diagnostic interview for CAM-defined delirium: a cross-sectional diagnostic test study. *Ann Intern Med*. 2014 Oct 21;161(8):554-61.

Sessums LL, Zembrzuska H, Jackson JL. Does this patient have medical decision-making capacity? *JAMA*. 2011 Jul 27;306(4):420-7.

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Questions?