

CORRESPONDENCE

Elder Self-Neglect: Another Ethical Dilemma for Physicians

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This correspondence responds to Joshua M. Baruth and Maria I. Lapid's "[Influence of Psychiatric Symptoms on Decisional Capacity in Treatment Refusal](#)," which appeared in the May 2017 issue, 19(5), of the AMA Journal of Ethics.

I read the recent article, "Influence of Psychiatric Symptoms on Decisional Capacity in Treatment Refusal," with great interest and applaud the clarity of the authors' analysis of the difficulties physicians face when patients refuse treatment. Baruth and Lapid effectively lay out principles to follow in that circumstance [1]. They indicate that the majority of psychiatric patients have decision-making capacity, that the impact of patients' refusal of treatment should be considered, and that physicians must avoid being paternalistic. In addition, the authors emphasize that the assessment of capacity should consider a patient's needs and express respect for a patient's autonomy and that physicians' beliefs should not unduly influence the process.

I recently took care of a 91-year-old man who had history of nonadherence in taking his antihypertensive medications and eye drops to reduce intraocular pressure. He lived alone and frequently missed appointments with his primary care physician and in the eye clinic. He had a long-standing history of glaucoma and had lost total vision in his right eye because of his self-neglect. This man consistently refused help at home, stating he was "fine," and had no close relatives or friends that could provide assistance. He was mobile and able to travel without difficulty to the hospital. He answered questions appropriately but clearly lacked the ability to care for his health responsibly.

The patient required immediate treatment in the emergency department on several occasions in the past after he missed multiple prescheduled primary care or eye clinic appointments. His medical history demonstrated an inability to adhere to prescribed medications and routine visits. He sought acute care when one of his chronic conditions worsened precipitously. On this occasion, he arrived in the emergency department complaining of four days of right eye pain, redness of the lower eyelid, and yellow discharge emanating from the corner. He stated he had not come in sooner because "I thought I would get better." The workup demonstrated right orbital abscess, necessitating his admission to the hospital for intravenous antibiotics. If the patient had been treated earlier in the walk-in clinic when the problem was less serious, oral antibiotics would have sufficed, thereby obviating the necessity for admission.

This case illustrates a growing problem among elderly patients, as lifespan is increasing and certain cognitive skills become more impaired with age [2]. Elder self-neglect is an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care [3]. Self-neglect is associated with an increased risk for all-cause mortality [3, 4] and, as the population ages, will become more common. More specifically, it is associated with an increased risk for cancer-related mortality and an increased increase in mortality resulting from endocrine or nutritional deficiencies [5]. The number of Americans over age 65 is expected to increase the burden of dementia [2].

Yet elder self-neglect is often unrecognized by clinicians [4]. If older patients suffer from self-neglect but understand the consequences of refusing aid at home or changing their living conditions, physicians face a moral dilemma. On the one hand, geriatricians or primary care clinicians might feel their patient would be better served by obtaining help from a caregiver to increase medication compliance, arrange adequate nutrition, improve hygiene, or enable activity with assistance. On the other hand, the patient-physician relationship requires respect for the patient's dignity, independence, and autonomy.

Unlike physical or psychological [mistreatment](#) by caregivers, which is a problem with a clear-cut solution since it involves responsible adults whose irresponsible actions have negative consequences for dependent persons in their care [6], self-neglect is more complex, presenting shades of gray and an ethical challenge for health care professionals. Health care professionals take on some of the responsibility of the caregiver by trying to do their best for the dependent elder, balancing the elder's wish for independence and the risks of poor self-care [6, 7]. They try to determine the extent of the patient's cognitive decline and its consequences over time, barring intervening medical illness or accidents.

Many patients with mild [cognitive impairment](#) are unable to take adequate care of themselves but, because they do not have moderate or severe dementia, maintain their legal right to make health care decisions [8]. As mentioned earlier, this situation creates a dilemma for physicians: many seem to favor patients' rights and autonomy but might be concerned about safety if the patient wishes to live independently. Geriatricians or primary care clinicians might feel their patient would be better served obtaining help from a caregiver, but overriding a competent patient's informed choices is unethical and violates the trust that has evolved over time [8]. This complex situation presents difficult legal and ethical questions for physicians concerned about both the patient's health and the patient's wish to remain independent [6-9].

Self-neglect is a chronic problem of geriatric patients, but it was not a feature of the case discussed by Baruth and Lapid, which involved a 55-year-old woman with depressive

symptomatology who refused specific aggressive treatment for stage II breast carcinoma though she had a clear understanding of the risks and benefits [1]. The authors adroitly argue that a prior or current psychiatric diagnosis should not determine judgments of decisional capacity. By contrast, this correspondence describes an older man who lives alone, has not been diagnosed with depression, and who might have worsening dementia that has not severely limited his daily functional capacity. He is not refusing a specific treatment or procedure. The dilemma for health care professionals is at what point to question the patient's right to be autonomous as his functional capacity slowly declines. At what point is he considered a "danger" to himself? The problem is made more complex when it is not possible to view a patient's living conditions or when consultation with relatives or close friends is not an option. I would like to invite Baruth and Lapid to offer advice or comments on this type of dilemma, which seems less straightforward than their interesting and informative case.

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