Core Ethical Issues in Clinical Work with Older People

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Disclaimer

- The information in this seminar is provided only for general educational purposes. The presenter is not in the role of clinical consultant.
- Laws and codes of practice differ from one jurisdiction to another.
- Therefore, the information in this seminar should not be interpreted as direction or guidance from the presenter in the care of specific patients.
- Clinical and ethical decisions are the sole purview of the treating clinician.

With My Gratitude

Because it’s Monday Night…

Q: What do you call a brain that took a shower?

A: Brain washed.

Q: What song did the hippocampus sing in the talent show?
A: “Thanks for the Memories”.

Q: What did the oligodendrocyte have for lunch?

A: A wrap.

Q: What is the amygdala?

A: I’m not sure, but for some reason, I feel strongly about it.

What is a Geropsychologist?

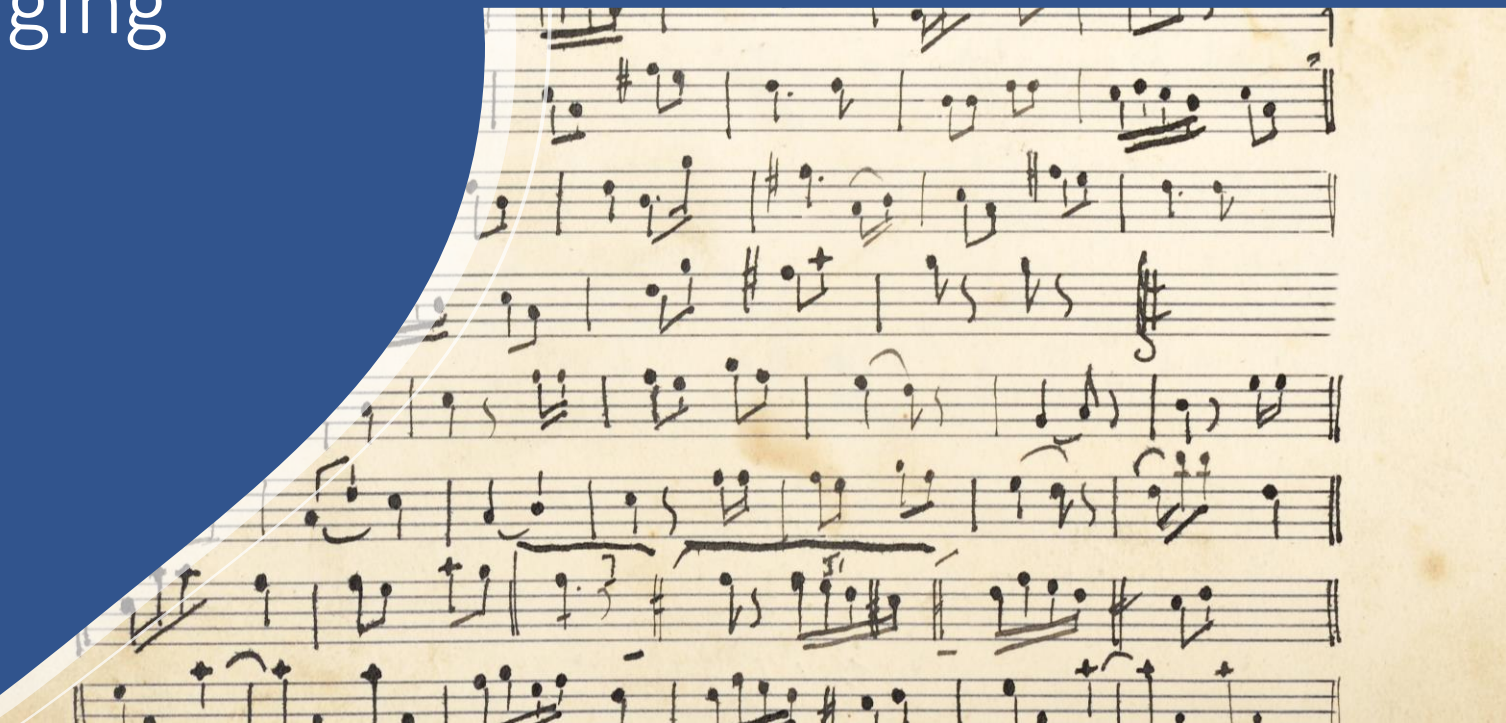
"Pikes Peak Self Assessment"

A combination of….

- Geriatric Clinical Psychology
- Geriatric Behavioral Medicine
- Gerontology
- Geriatric Neuropsychology
- History

Two Orienting Points

First, Geriatrics is both the art and science of managing complexity.



Second, diversity is the sine qua non.

What, then, is Ethics?

Definition: National Center for Ethics in Health Care/U.S. Department of Veterans Affairs (2015)

- Ethics: "the discipline that considers what is right or what should be done in the face of uncertainty or conflict about values. Ethics involves making reflective judgments about the optimal decision or action among ethically justifiable options."

- The older person's well-being is the "true north" of ethical decision-making with older people.

Ethics: The Wisdom of Yogi Berra

- ***"When you come to a fork in the road, take it."***

  It's often complex; there's no clear route to take.

- ***"It ain't over till it's over."***

  Ethical decision making is an evolving process, it's ok to change your mind.

- ***"It's like déjà vu all over again."***

  Question "ethical scripts".

More from Yogi Berra….

- ***"You can observe a lot by just watching."***

  Vicarious learning counts, make ethics a part of every case, learn to listen.

- ***"Baseball is 90% mental and the other half is physical."***

  These are demanding decisions; this is hard work.

- ***"Congratulations. I knew the record would stand until it was broken."***

  Standards and rules change over time.

- ***"He hits from both sides of the plate. He's amphibious."***

  There's no single set of ethical principles. Diversity is an asset. Flexibility is vital.

And Still More from Yogi Berra…

- ***"Pair up in threes."***

  Ethical decision making takes place in a relational context.

- ***"It ain't the heat, it's the humility."***

  Be humble. Be self-reflective.

- ***"If the world were perfect, it wouldn't be."***

  We do the best we can in hard situations. The resolution is usually not a perfect one.

Ethical Drift

- A gradual, insidious erosion of ethical standards leading to unethical behavior.
- Standards and behavior can go down lashed together like Capt. Ahab and Moby Dick.
- The Lesson of Milgram: Someone does not have to be innately bad to engage in unethical behavior.
- It can occur in any setting/discipline.
- We are all vulnerable.
- Others may see it in us, but we do not.

Foundational Principles in Ethical Reasoning with Older People: The Same but Different

Clinical and Ethical Reasoning with Older People: The Same but Different

- Older adults know more about some things than we do.
- Older adults have longer histories.
- Older people live in unique social and environmental circumstances.
- Older adults are a very diverse population, and their personhood must be framed in the window of their historical cohort.
- Older adults are working through what can be thought of as the most challenging lifespan developmental phase.
- We are not playing on a level field; systemic biases include those affecting older people.

Clinical and Ethical Reasoning with Older People: The Same but Different (Feinsod et al. 2005)

1). Beneficence

Do right ("good") by the person (age changes some definitions of this, "good" may not be easy).

Do what is medically helpful.

2). Non-maleficence

Avoid harm (again, age changes some definitions of this).

Withhold diagnostic work-up or treatment when intervention is unlikely to result in meaningful life/well-being.

Clinical and Ethical Reasoning with Older People: The Same but Different

3). Autonomy: The capacity to exercise self-determination and authenticity.

4). Confidentiality: Maintaining the person's privacy, including in cases of interdisciplinary care and alternate decision makers.

5). Safety:

a). Physical
b). Emotional
c). Existential
d). Material
e). Relational

Clinical and Ethical Reasoning with Older People: The Same but Different

6). Dignity: Degradation of one degrades the others.

a). Universal: Pertains to all human beings to the same extent; cannot be lost.

b). Merit: Depends on social rank/position. It is very unevenly distributed among people. It exists in degrees, and it can come and go.

c). Moral Stature: The result of the moral deeds of the subject. It can be reduced or lost through immoral deeds. It is a dignity of degree and also unevenly distributed.

d). Identity: Refers to the integrity of the person's body and mind. Often depends on the person's self-image. It can come and go, the result of the actions of others and as a result of changes in our body and mind.

Clinical and Ethical Reasoning with Older People: The Same but Different

7). Futility of Treatment

Treatment should be consistent with the person's (clinically realistic) goals.

Assess each case individually to determine whether treatment would be beneficial.

Avoid interventions that would not benefit the person and/or prolong suffering.

Clinical and Ethical Reasoning with Older People: The Same but Different

8). Informed Consent and Assent

A person has the inherent right of self-determination, via consent or assent.

A person has the right to consent and a right to refuse diagnostic work-up or treatment. This includes protection from unwanted hands-on care, medication, food/fluids, attendance at activities, therapies, etc.

A person has the right to be educated on the pros and cons of a medical decision.

Although a person or healthcare proxy may request care in excess of what is considered good medicine, individual autonomy should not violate the principle of beneficence and force physicians to go beyond appropriate medical intervention.

Clinical and Ethical Reasoning with Older People: The Same but Different

9). Utilitarianism

Autonomy ceases when a person's request breaks the law or jeopardizes public health or safety (e.g., smoking in one's room in a facility, unsafe driving), or the person's safety (e.g. accidental medication mismanagement).

10). Truth Telling

Tell the truth versus offering incomplete statements of encouragement.

Communicate an honest estimate of prognosis.

11). Justice

Distribute resources and treatment in an equitable manner.

Use objective decision-making processes, not emotional/subjective ones.

Ethics in Residential and Long-Term Care

The Lay of the Land

- People are embedded in micro-level informal (loved ones) and formal (staff) relationships.
- As a person's needs get more complicated, even more staff/disciplines can be involved in day-to-day decision making in care.
- Somewhere in all of this are the person and their loved ones. Who is the patient?
- Decision-making also occurs in the context of intersecting macro-level influences.
- Due to this complexity, uncertainty and conflict about values are bound to happen.
- However, facilities are not legally required to have a mechanism to resolve ethical issues.

Not a Hospital. Not a warehouse. Rather, a Home.

" 'Culture change' is the common name given to the national movement for the transformation of older adult services, based on person-directed values and practices where the voices of elders and those working most closely with them are solicited, respected and honored. Core person-directed values are relationship, choice, dignity, respect, self-determination and purposeful living."

-The Pioneer Network

www.pioneernetwork.net

Key Regulations: Consent/Assent
US 42 CFR 483.10(c) F-552

- The resident has the right to be informed of, and participate in, his or her treatment, including:
  - The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.
  - The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.
  - The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

Key Regulations: Consent/Assent
US 42 CFR 483.10(c) F-553

The person also has:

- The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.
- The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.
- The right to be informed, in advance, of changes to the plan of care.
- The right to receive the services and/or items included in the plan of care.
- The right to see the care plan, including the right to sign after significant changes to the plan of care.

Key Regulations: Consent/Assent
US 42 CFR 483.10(c)

The planning process must:

- Facilitate the inclusion of the resident and/or resident representative.
- Include an assessment of the resident's strengths and needs.
- Incorporate the resident's personal and cultural preferences in developing goals of care.

Consent: Common Scenarios

- Consent for psychological services vs. global consent to care.
- Gaining assent even with consent of healthcare proxy.
- Refusal to follow medical advice (e.g. diet texture, AMA d/c, etc.).
- Being asked to provide new services (e.g. statement of capacity) that are outside of ongoing services (e.g. psychotherapy).
- Gaining consent for consultation.
- Being present in interdisciplinary meetings for cases in which the psychologist is not involved.
- Providing ancillary services to family/loved ones.
- “Customer Service” referrals

Key Regulations: Confidentiality/Privacy

Centers for Medicare/Medicaid Services
"Your Rights and Protections as a Nursing Home Resident"

- All HIPPA standards apply.
- Privacy is a universal right. The role of guarding it belongs to the facility/staff.
- Also, the person has a right to:

  a). To keep and use personal belongings and property as long as they don't interfere with the rights/health/safety of others.

  b). To have private visits.

  c). To make and get private phone calls.

  d). To have privacy in sending and getting mail and email.

  e). To have the facility protect personal property from theft.

Confidentiality/Privacy: Common Scenarios

- Communicating with families/loved ones.
- Communicating with interdisciplinary treatment teams.
- Navigating a shared medical record and documenting sensitive issues.
- Navigating shared living spaces (especially for those with motor limits).
- Mandated reporting/imminent risk.
- Regularly encountering residents outside of clinical contacts.
- Residents with limited understanding of/will to protect their own privacy.
- Residents wishing to engage in intimate relations with a partner.
- Electronic monitoring.
- Use of legal pornography.

Roles: Common Scenarios

- Being asked to provide services to the resident by a third party.
- Being asked to provide services to multiple residents with conflicting circumstances.
- Provider vs. Evaluator.
- Being asked by the facility for an opinion that runs counter to the resident's goals/wishes.
- Being asked to provide support services for staff.
- Alternate decision-makers who do not follow the person's wishes.
- Other staff functioning outside of scope.

Special Topics

Special Topic: Autonomy

- A definition: Older people's rights to make decisions without being influenced by others.
- It is a primary human right that is protected by universal declarations and conventions.
- Diverse people perceive autonomy differently and its meaning can also vary in time and context.
- It is linked to older people's opportunities to govern themselves. , i.e. opportunities must be sought after.
- It's not just what we offer, it's how it is received.

Autonomy

- Data has identified that perceived autonomy led to increased quality of life and satisfaction with daily routines in residential care.
- It has also been associated with improved health and well-being.
- And, it resulted in organizational benefits, e.g. increased staff retention.
- Autonomy is often diminished among older adults who are directed by the decisions of family, guardians, and staff.
- Physical and cognitive limitations are also inherently disempowering, especially in a residential setting.
- It is not uncommon to structure daily life around rigid care routines, meals, and other activities.
- Institutional policies around a shared environment also take a necessary toll.

Their Voice: An Integrative Review

Moilanen, T. et al. 2021. Older people's perceived autonomy in residential care: An integrative review. Nursg Ethics, 28 (3): 414-434.

- Autonomy was defined as:
  - Exercising own free will.
  - Ability to make independent choices without domination or suppression.

- Specific decisions identified were:
  - Nutrition
  - Rest and sleep
  - Outdoor activities
  - Hygiene including clothing
  - Social activities and visitors
  - Money
  - Décor in their room

An Integrative Review

- Autonomy was considered as a sign of respect, dignity, and value as an individual.
- Older people said that their autonomy promoted their well-being, subjective vitality, and mental health.
- Specifically, it decreased stress levels, depression, and apathy.
- Those who were satisfied with their autonomy were more active day to day at the care facility (a concrete catalyst for better health).
- Limited autonomy led to feelings of confinement and frustration.
- Staffing levels are a major help or hindrance to autonomy.

An Integrative Review

Enhancing Or Degrading Autonomy:

- Openings for expressing their own opinions and exercising their rights helped.
- Maintaining reasonable independence, while accepting medical/functional status, helped.
- There is an inverse relationship between degree of dependence and ***perceived*** autonomy.
- There is a direct relationship between degree of dependence and degree of paternalism directed at the person.
- Decreased functional abilities limit physical opportunities, but not their inner freedom to think or react.
- They felt that they could keep their autonomy as long as they retained sufficient intellectual skills for decision-making.

An Integrative Review

The Role of Significant Others

- Relatives influenced their autonomy, but they preferred to make their own decisions, which they expected their relatives to respect.
- Some involved their relatives in decision-making and shared the burden of decision-making, especially when their capacity declined.
- Others preferred to leave any decisions to their relatives, but they expected them to promote and protect their rights.

Special Topic: Sexual Consent

Capacity Basics: Quick Review

1). An awareness of the relevant issues.

2). The ability to rationally consider available options and the risks/benefits associated.

3). The ability to evidence a reasoned choice that is consistent with well being and values, in the person-environment setting.

4). The ability to express a preference or choice.

In residential care, the rights/autonomy of the resident may be overlooked in favor of eliminating any harm or potential problems (e.g., lawsuit, family issues, prohibitive staff attitudes). Capacity can be overlooked.

Sexual Consent: Position Statement from the Society for Post-Acute and Long-Term Medicine

2016 White Paper: "Capacity for Sexual Consent in Dementia in Long-Term Care" (www.paltc.org)

- In the US, all persons who have reached the age of consent (varying by state from 16-18 y/o) have the right to consensual sexual activity.
- People are presumed to have the capacity to consent, unless there is specific evidence otherwise.
- All people have the right not to be the target of unconsented-to sexual behavior.
- People living in residential care have a right to appropriate accommodation for consensual sexual relationships.

Sexual Consent

- Ageist myths and stereotypes suggest that older adults are asexual.
- Decisions to support/prohibit intimacy may be influenced by family and/or nursing home staff attitudes/fears.
- In a survey of facility staff and administrators, discussion about sexual consent often reflected gendered social norms - men are predators (“dirty old man”) and women need protection (“sweet”).
- A reliance on reporting, disregarding private space, and steering residents away from each other, was noted.
- The result is an environment of surveillance that discourages sexual (and other) rights.

Sexual Consent

- A unique area of capacity assessment.
- The nature of sexual relationships and interactions are often fluid and do not often develop in a logical or planned way.
- The decision is often made in the moment. There may not be an extended time to weigh options or consult others.
- Substitute decision-makers or guardians are rarely, if ever, appointed to an older adult specifically to make sexual decisions.
- It is one of the least-developed capacity domains in terms of assessment and diagnostic strategies.

Sexual Consent

Core Elements

1). Does the individual know the nature of the sexual activity in which they are engaging, including legality?

2). Does he or she know the risks of sexually transmitted diseases and other potential consequences?

3). Does the individual know how to tell if the partner desires the activity? And to differentiate that from their own feelings?

4). Does she or he know appropriate times and places for particular sexual activities, and with whom they are engaging in the activity?

Sexual Consent

5). Does the individual have the capacity for the reasoning process inherent to sexual consent, including an understanding of having a choice that is consistent with the individual's values and preferences?

6). Is the sexual choice being made in a manner that is free from undue influence or coercion, i.e., is it a voluntary choice? Can the person protect themself from emotional coercion?

7). Is the person aware of who is initiating sexual contact?

8). Can the person state what level of sexual intimacy would be comfortable?

10). Does the person have the capacity to say no to uninvited sexual contact? Or, withdraw consent? i.e. to say "Stop", push away, etc.

Sexual Consent

- Diminished cognition alone does not necessarily imply diminished capacity for sexual consent.
- Capacity for sexual consent in cognitive disorders should be viewed along a continuum of intimacy activities, from nonsexual touching to sexual intercourse.
- Higher degrees of intimacy and risk may require a higher threshold of capacity.
- Capacity should be evaluated in the context in which the decision takes place.
- Capacity may fluctuate depending on the situation in which the decision is made or on the individuals involved.

Special Topic: Firearms and Cognitive Disorders

- It has been found that perhaps one-third of persons with cognitive disorder and who live with caregivers have access to guns at home.
- However, in one survey only 5% of caregivers said a health care practitioner had ever asked about this issue.
- Why?

  Guidelines about discussing firearm access with persons who have cognitive disorders mostly rely on common sense; the research base is low.

  It is an uncomfortable topic for providers.

Firearms and Cognitive Disorders: “The Five L’s”

- Ask: “Is there a gun in the home?”

- If so, is it:
  - Loaded?
  - Locked?
  - Are there Little children in the home?
  - Is the person Low?
  - Is the person Learned?

Firearms and Cognitive Disorders

- Know your state's laws concerning when it is appropriate to have firearms removed from the home (e.g. “red flag laws”).
- Know whom to ask for help when intervention is needed: Family members, the police, or Adult Protective Services.
- Acquire knowledge from a gun safety course. This may eliminate some apprehension and boost confidence in intervention.
- Engage firearm-owning persons with cognitive disorder early/proactively in planning for future firearm transfer. It respects autonomy while also ensuring safety.
- As with other safety topics (such as driving) use of a firearm agreement may help prompt and document decisions.

Special Topic: Driving

The Person's Perspective:

- Loss of independence.
- Loss of dignity ("Mom, can you drive me to the mall?").
- Loss of roles.
- Threat to masculinity/femininity.
- Proxy indicator that underlying disease (of whatever nature) is advancing.
- Becoming isolated, literally and existentially.
- Depression.

Driving

The Perspective of Loved Ones:

- Fear of harm to someone.
- Fear of lawsuits.
- Don’t want to hurt the person’s feelings.
- Excuse the problem, or “co-pilot”.
- She/he/they rely on the person to drive.
- She/he/they will need support from healthcare providers, to avoid the “she won’t let me” dynamic.
- Your word counts more than you may realize.

Driving

For Providers:

- Importance of open communication.
- Autonomy in decision-making.
- Advanced planning to connect people with resources.
- Acknowledge the significance of relationships.
- Importance of providing support for the impact of cessation on identity and emotional wellbeing.
- Benefit of individualizing supportive approaches.

Driving

"Physician's Plan for Older Drivers' Safety" :

- **Screen** for red flags such as medical illnesses and medications that may impair driving safety.
- **Ask** about new-onset impaired driving behaviors.
- **Assess** driving-related functional skills in those patients who are at increased risk for unsafe driving.
- **Treat** any underlying causes of functional decline.
- **Refer** patients who require a driving evaluation and/or adaptive training to a driver rehabilitation specialist.
- **Counsel** patients on safe driving behavior, driving restrictions, driving cessation, and/or alternate transportation options as needed.
- **Follow-up** with patients who should adjust their driving to determine if they have made changes and evaluate those who stop driving for signs of depression and social isolation.

American Medical Association, *Physicians' Guide to Assessing and Counseling Older Drivers, 4th ed. 2019*

Driving

Specific Approaches (a priori):

- Begin the conversation as soon as possible and involve loved ones (with consent).
- Frame it as “When, not if”, as it will be for all of us some day.
- Involve the person in planning and decision-making (e.g. alternate transportation) .
- Appeal to the person's sense of responsibility to self and others, personalize it, talk about legacy, talk about values.
- Appeal to the practical benefits (e.g. save money).
- Use a “No Driving Contract” (i.e. Alz Assoc, NHTSA, AARP, etc.).
- Consider: How able is the family to intervene? How does the family relate? Are they in agreement? Not?

Driving

Specific Approaches (in vivo):

- Be patient and firm. Demonstrate understanding and empathy. Return to information discussed a priori.
- Suggest that a respected family authority figure or family attorney reinforce the message about not driving.
- Ask additional providers to advise the person not to drive.
- Suggest a family conference with multiple providers. Depending on the person/circumstances, this may be more effective than trying to persuade the person not to drive by yourself.
- Ask the person's physician to write a prescription/statement stating that the person must not drive. Physicians can have a unique role as an authority figure, especially with older people.
- If the conversation does not go well, do not blame yourself. The disease can impair insight and judgment, and cause mood and personality changes, as you know.
- Depending on jurisdiction/professional setting and individual facts of the case, a mandated report to the DMV, police, and/or Adult Protection Services may be necessary.

Alzheimer's Association.org (accessed 27 JUL 20)

Ageism

"Um…we don't use that term".

“Age-Ism: Another Form of Bigotry”

-Robert N. Butler, M.D. (1969)

“Malcolm X, the Kerner Commission Report and a variety of other persons, events, and materials have made the concept of racism familiar. Social class discrimination also needs no introduction. However, we may soon have to consider very seriously a form of bigotry we now tend to overlook: age discrimination or age-ism, prejudice by one age group toward other age groups. If such bias exists, might it not be especially evident in America; a society that has traditionally valued pragmatism, action, power, and the vigor of youth over contemplation, reflection, experience, and the wisdom of age?”

"Since the adoption of the first APA Resolution on Ageism in 2002, there has been a wealth of empirical evidence documenting that ageism, including negative self-perceptions, are associated with a host of negative psychological and physical outcomes in older adults and societal impacts across health care, employment, education and training, and policy settings."

American Psychological Association Resolution on Ageism (2020)

"Ageism is one of the last socially accepted prejudices."

American Psychological Association (2023)

Kirsten Weir

"Monitor on Psychology"

vol 54 (2), p. 36

Age is not the Adversary. Ageism Is.

- Ageism: Stereotyping, prejudice, and discrimination against people based on their age (older or younger).
- Like other prejudices, it starts forming early in life. And it spans nations and cultures.
- Ageism directed toward older adults has empirically demonstrated negative impacts on their health and well-being.
- Societal ageism has been reinforced by COVID.

First, Do No Harm

In other words, ageism harms people.

a). Being the target of ageism increases risk for mortality, poor functional health, slower recovery from illness, mental health complications, older adult abuse, etc.

b). Ageism among healthcare practitioners, at all levels and among all disciplines, creates risk for sub-standard care.

c). Ageism creates risk for social exclusion and existential harm, including the loss of the will to live.

d). “Double Jeopardy” : when age, gender, and/or cultural background combine to create synergistic, adverse effects.

Double Jeopardy

"Older Black Americans during COVID-19: Race and Age Double Jeopardy"

Chatters, L. et al. (2020). Older Black Americans during COVID-19: Race and age double jeopardy. Hlth Educ and Behav, 47(6): 855-860.

"…current information on COVID-19 morbidity and mortality profiles for older Black adults. These data indicate that Black people and older adults are the two most impacted groups. Consequently, older Black adults are doubly impacted and at particularly high risk for disease and death. "

“Dementia-ism”

“…the dominant view of dementia is grounded in a ‘tragedy discourse,’ which emphasizes the loss of both ability and identity and this view directly harms people living with dementia above and beyond the effects of the pathology of any disease. “

-Reed, Carson, & Gibb, AMA Jn Ethics, 2017

* It harms the rest of us, too.

What Has this Person to Tell Us?

"I'm looking at your face to know if it's ok."

Our relationship matters.

"It is possible and probable that my mind has slipped over the edge but I have not completely lost all communication with most of reality."

I need you to know I am still here.

"Just because they are mad at you doesn't mean you did anything wrong."

I have my own opinions.

"I don't like horses."

I need you to see my perspective.

Ageism: Prevalence

"Experiences of Everyday Ageism and the Health of Older US Adults", JAMA Open Network, Jun 2022

- Survey of 2035 adults ages **50** to 80 years (1047 women, 988 men, 192 Black, 178 Hispanic, 1546 White, mean age 63 years).
- Assessed ageism along three dimensions:

  a). exposure to *ageist messages* in the form of environmental and social cues reflecting ageist prejudices and stereotypes.

  b). frequency of *ageism in interpersonal interactions*, specifically being targeted by discrimination rooted in others' assumptions and stereotypes about older adults.

  c). endorsement of *internalized ageism.*

Ageism: Prevalence

- Results: 93.4% of those surveyed reported regularly experiencing one or more forms of ageism every day.

- Internalized ageism was reported by 1664 adults (81.2%), ageist messages by1394 adults (65.2%), and interpersonal ageism by 941 adults (44.9%).

Ageism: Some Determinants

- Our own fears and exposure.
- "Threat Mitigation" (akin to Racial Threat processes), "Him/Her but not me", Ingroup/Outgroup, Keep them at a distance, Othering.
- Other emotions: "I can't fix you!", "It feels like taking care of my grandmother", "How can that be considered quality of life?".
- "Young Savior Syndrome" (akin to the notion of a "White Savior").
- Societal and Systemic Factors .

" 'They treat me like I'm old and stupid': Seniors decry health providers' age bias"

Judith Graham, Health News Florida, Oct 20, 2021

"At the end of the summer, when Stamper was hospitalized for an abdominal problem, a nurse and nursing assistant came to her room with papers for her to sign. "Oh, you can write!" Stamper said the nurse exclaimed loudly when she penned her signature. "They were so shocked that I was alert, it was insulting. They don't respect you."

"Most of the time, Bailey feels like "I'm invisible" and like she's seen as "a slug in a bed, not a real person." Only one nurse regularly talks to her and makes her feel she cares about Bailey's well-being. "Just because I'm not walking and doing anything for myself doesn't mean I'm not alive. I'm dying inside, but I'm still alive," she told me."

Reflective Practice: What Are My Biases?

Who's the oldest person you know well?

- *How old is this person?*
- *What does this person look like?*
- *How does this person communicate?*
- *How is this person's health?*
- *How does this person respond to aging?*
- *How does this person spend her/his time?*

These experiences can influence our perspective on aging (especially given our age cohort) -> how we conduct clinical care with older people -> specific clinical outcomes.

Thoughts, Questions, and Ideas

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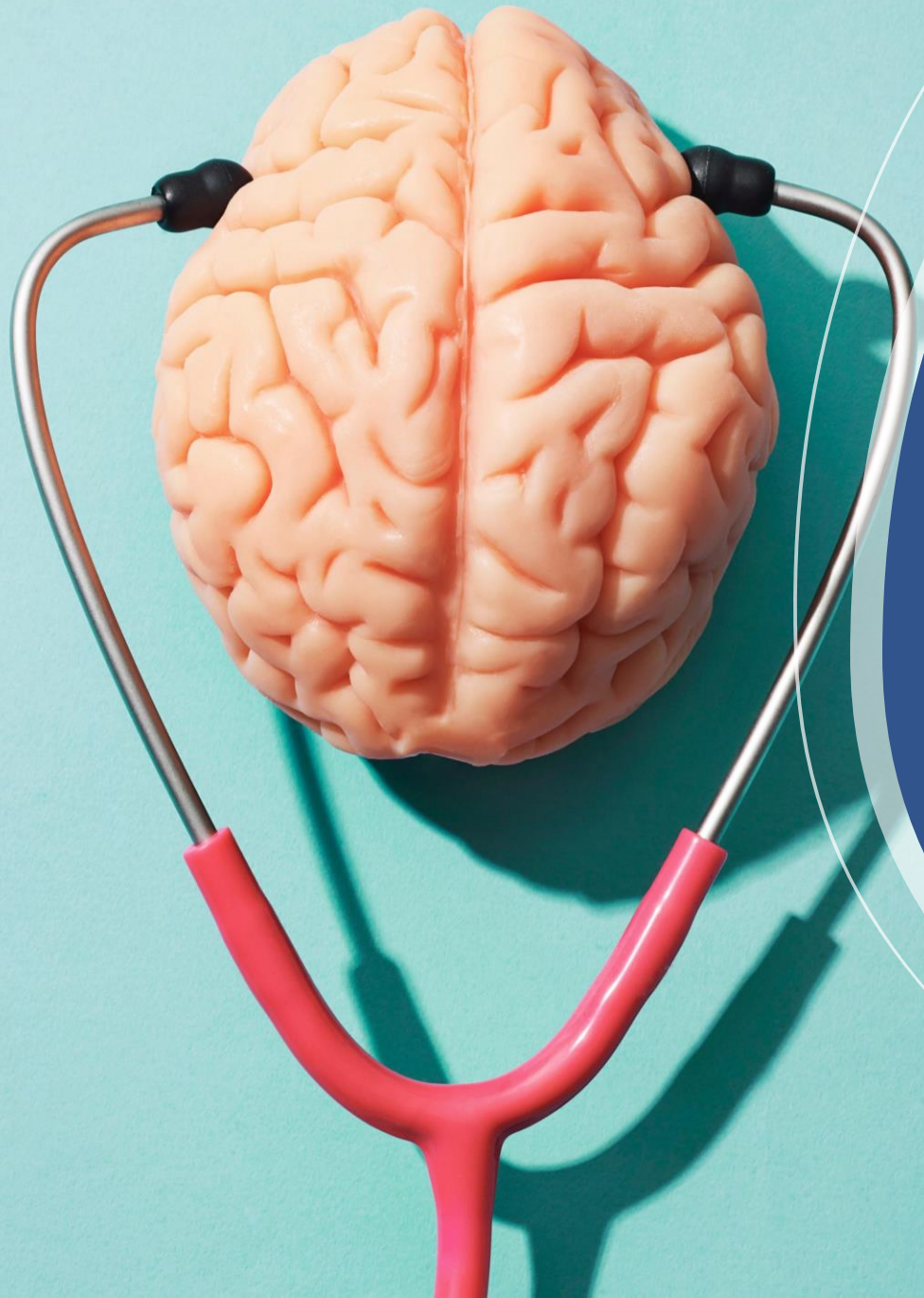

The brain is the only organ in the human body that tries to understand itself.

Resources and References

Topic Specific Resources

Sexual Consent Policy

CAPACITY FOR SEXUAL CONSENT IN DEMENTIA IN LONG-TERM CARE | AMDA | The Society for Post-Acute and Long-Term Care Medicine (paltc.org)

Sexual Consent Assessment

Sexuality Assessment: (nccdp.org)

Culture Transformation in Long Term Care

https://www.pioneernetwork.net/wp-content/uploads/2021/02/Artifacts_2.0_NH_Form_030521.pdf

Pikes Peak Geropsychology Knowledge and Skills Self-Assessment

https://coaportal.apa.org/uploads/uploads_overflow2/83DC3565_671/Pikes_Peak_Evaluation_Tool.pdf

Adult Protective Services Technical Assistance Resource Center

APS TARC - Home (acl.gov)

Topic Specific Resources

Center for Medicaid/Medicare Services, Rights and Protections for Nursing Home Residents

https://downloads.cms.gov/medicare/your_resident_rights_and_protections_section.pdf

Psychologists in Long-Term Care (PLTC) Guidelines for Psychological and Behavioral Health Services in Long-Term Care Settings

http://www.pltcweb.org/cms/uploads/documents/PLTC%20Guidelines%20for%20Psychological%20and%20Behavioral%20Health%20Services%202021.pdf

Attitudes to Ageing Questionnaire (24 item)

https://ugc.futurelearn.com/uploads/files/76/f7/76f7a255-90a0-4aa4-8ca2-a2f45de82daa/Attitudes_To_Ageing.pdf

American Psychological Association, Resolution on Ageism

www.apa.org/about/policy/resolution-ageism.pdf

Topic Specific Resources

U.S. Patient Self Determination Act

https://www.congress.gov/bill/101st-congress/house-bill/5067

Essentials of Clinical Geriatrics: Ethical Issues in the Care of Older Persons

Chapter 17. Ethical Issues in the Care of Older Persons | Essentials of Clinical Geriatrics, 7e | AccessMedicine | McGraw Hill Medical (mhmedical.com)

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