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Examining ethical issues that arise in providing ED/hospital care for patients experiencing elder mistreatment and approaches to address them

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ABSTRACT

Clinicians in the emergency department and hospital who treat patients experiencing elder mistreatment (EM) can expect to encounter challenging ethical dilemmas. Collaboration with ethics and EM consultation services offers teams an important opportunity to improve patient-centered outcomes and address value-based concerns when treating these patients. This article describes the role of a hospital clinical ethics consultation service and best practices for collaboration between ethics and EM consultation services. Illuminated via four case studies, the article presents several core ethical frameworks, including allowing patients the dignity of risk, considerations around a harm reduced discharge, involving abusers in surrogate decision making, and providers' experience of moral distress when dealing with patients experiencing EM. Increasing collaboration with ethics and elder mistreatment services can help teams more effectively respond to EM.

KEYWORDS

Clinical ethics; dignity of risk; elder mistreatment; harm reduction; hospital consultation service

Introduction

Elder mistreatment (EM) is a complex phenomenon that can raise challenging ethical dilemmas for professionals trying to intervene and provide care to older adults. EM, which may include physical abuse, sexual abuse, neglect, verbal/emotional/psychological abuse, and financial exploitation, can have a profound impact on an older adult's health and quality of life (Lachs & Pillemer, 2015). This mistreatment is common, with 10% of community-

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dwelling older adults and more than 20% of those living in facilities experiencing it each year (Rosen, Stern, et al., 2018). Exposure to EM may increase the risk of mortality, increases risk of depression, and can exacerbate progressing dementia (& Pillemer, 2015). Despite this, EM is dramatically under-recognized, with as few as 1 in 24 cases reported to the authorities (Rosen, Mehta-Naik, et al., 2018). The emergency department (ED) and hospital presentation is an important opportunity to identify previously unrecognized cases of EM and initiate intervention, as an encounter for an acute health issue may be the only time that an older adult experiencing EM ever leaves their home. When EM is identified or suspected in an ED or hospital, next steps are not always clear. Established response protocols do not exist, and deciding which interventions, if any, are appropriate often raises difficult ethical questions.

Recognition of the various challenges in providing optimal ED and hospital care to older adults experiencing EM led to the recent development of interdisciplinary response teams. Modeled in part on child protection teams, the first-of-its-kind ED-based Vulnerable Elder Protection Team (VEPT) was launched in 2017 in the Weill Cornell Medicine/NewYork-Presbyterian Hospital (WCM/NYP). In 2020, the University of Colorado, an international leader in child abuse pediatrics, launched their Vulnerable Elder Services, Protection, and Advocacy (VESPA) team modeled after the world-renowned Kempe Child Protection Team at Children's Hospital Colorado. The goal of these teams is to assess, treat, and improve the safety of older adults experiencing EM while also collecting forensic evidence when appropriate and working closely with community partners to help advocate for this vulnerable population. The design of the teams and their impact are described in detail elsewhere [citation from other manuscript in this special issue].

While any novel medical service or approach may encounter new challenges, elder abuse geriatrics might be expected to encounter a larger number of ethical questions than an average consult service for several reasons: 1) both the perpetration and experience of mistreatment are sensitive topics, with special considerations for confidentiality; 2) mistreatment inherently involves more than one person whose rights, interests, and wishes must be considered, and which may conflict; 3) the care of older adults who experience mistreatment requires collaboration and information-sharing among multiple medical, social, legal and other professionals, each with differing training, abilities, and perspectives. The roles and responsibilities of each professional can take on ethical importance given the other issues above. Ethical conflicts may further arise when older adults with cognitive impairment may not be able to express their desires for medical care, requiring the identification of a surrogate – who may be suspected of committing mistreatment.

Both the VEPT and VESPA have hospital ethics consultation services (Ellen Fox et al., 2022) available 24/7/365 to assist with concerns that arise in providing care to patients. Members of these ethics teams have training and

experience in working with medical teams, patients, and families to optimally address ethical dilemmas. While ethics consultations are routinely called to provide an ethical framework for clinical decisions and discharge planning when EM is suspected, the advent of VEPT and VESPA has enabled early, robust identification of cases, reliable access to vital information, and highly valued collaboration.

Starting in 2021, these EM response teams, members of which have been collaborating since 2014, conducted an annual 2-day in-person meeting to learn from each other, share information, ensure process and data collection standardization, confer about barriers and strategies, discuss challenging cases, and provide support for this difficult work. Ethical challenges raised in these cases were a key topic of discussion at the second of these consensus conferences, which was conducted in New York City on the Weill Cornell campus from September 28–29, 2022. Attendees included members of both VEPT and VESPA. Other attendees included senior ED and hospital social workers and leadership from the New York City Elder Abuse Center (NYCEAC). For the discussion of ethics, members of the hospital clinical ethics consultation services from each institution participated in a discussion of cases seen and approaches to the ethical challenges faced commonly at both institutions.

This article describes some of the roles of hospital clinical ethics consultation teams regarding EM; delineates best practices for hospital clinical ethics consultation services and EM response team collaboration; presents core ethical frameworks that arise frequently in hospital-based cases of EM, as exemplified by four patient scenarios; and summarizes the substance of the consensus reached around each case during the convening. We hope this will start the conversation about how to optimally approach the ethical issues raised in providing acute care for patients who experience EM.

Role of hospital clinical ethics consultation services

The Joint Commission, the regulatory agency overseeing credentialing of hospitals, requires that every accredited hospital "develops and implements a process that allows staff, [patients], and families to address ethical issues or issues prone to conflict" (Commission, 2023). This has been operationalized in most hospital settings in the form of an ethics consult service or ethics committee made up of bioethicists, and health care professionals, including physicians, nurses, social workers, and chaplains. A recent survey found that 81% of US hospitals have an ethics consultation service (Fox et al., 2022).

The role of an ethics consultation service is not to make a decision for the team but to educate and facilitate conversation about the ethical factors involved, resulting in an ethical framework to guide clinical decision making. Ethics teams provide a mechanism to discuss and help the health care team work through ethical challenges that arise in the hospital setting. In

addition to helping stakeholders arrive at a range of ethically justified options, the role of the ethics team also includes mediation and consensus building among stakeholders with different perspectives while centering decision making on the patient. Ethics consultation can help to ensure that the patient's culture and values are understood and respected and that the medical providers' concerns and intentions are also validated. Conversations can help medical providers to recognize the power they hold in the provider–patient relationship, acknowledge other systemic factors impacting patients, and help providers navigate their ethical responsibility to act in a way that most closely reflects the core values of the patient. Ethics experts are not available 24/7. We hope this manuscript will provide providers practicing in these environments a basic approach that can be utilized until these teams become available.

Best practices for collaboration between elder mistreatment teams and hospital clinical ethics teams

There are many ethical issues that arise in EM cases, and strong collaboration between EM teams and hospital clinical ethics teams is critical. Both VEPT and VESPA teams have engaged their ethics teams consistently and have identified some best practices for collaboration with medical providers.

First, we recommend early consultation with the ethics team when possible. Cases are often complex and unfold over time. Involving the ethics team early in admission can provide appropriate context and help provider teams care for what can be exceptionally long and morally distressing cases. Members of the ethics team are embedded in the hospital and can use their knowledge of the hospital system and previous complicated cases to help the primary team determine appropriate next steps.

Second, ethical consultation is not synonymous with legal advice; it is important to recognize when cases require legal consultation and to begin this process early as well. Collaborative meetings between the EM consult team, ethics, legal, and the primary team can help clarify nuances and allow all parties to understand the complexity of these cases. In addition to case-by-case involvement, VESPA has found it useful to hold quarterly meetings with ethics and legal teams to discuss systems issues and gaps in policy proactively. It is important in these meetings to understand whether the legal team is representing the interests of the hospital, patient, or both. The interests of the hospital and the patient may not always be aligned, and making the role of the legal team clear is essential.

Third, EM consult teams can bring important data, collateral, and context to the case discussion that informs the ethical considerations discussed. It is often helpful for the EM consult team to help teams understand the capabilities and limitations of Adult Protective Services (APS), law enforcement, and

other community agencies. EM consult teams also readily highlight the psychology and sociology of family mistreatment that can help inform these discussions.

Fourth, it can be exceptionally helpful to include ethics team members who are comfortable around or familiar with family violence. Some members of the Weill Cornell ethics team are also clinical psychologists, and the Colorado ethics team has worked with the campus child protection team (the Kempe Center) for decades, providing these groups with background and understanding of family violence. If your institution does not have ethics team members familiar with family violence, or a dedicated EM team, reaching out to programs that do can be immensely helpful in the early days of a program to ease discomfort and provide helpful suggestions. There is a large network of child protection teams who are familiar with violence in the hospital setting and can be a great resource (Society, 2023).

Finally, engaging the ethics team in moral distress rounds or case debriefs can be very helpful. Often EM teams absorb substantial moral distress from the providers they interact with and significant trauma from patients and their loved ones. This is exacerbated by the lack of resources available in many of the cases that are seen. Moral distress mitigation rounds and case debriefs can help facilitate these conversations, allow providers to feel supported, assess whether challenges have been appropriately addressed or whether anything got lost in the day-to-day care of patients, and can provide the EM team space to explain what can be done and what is out of their control (Morley & Shashidhara, 2020). These activities can be conducted with the EM and ethics team alone or with the multidisciplinary team caring for the patient; both have advantages and disadvantages.

Core ethical frameworks and case studies

Here, we present some core ethical frameworks in response to ethical issues that frequently arise when caring for cases of EM in the ED and hospital. These cases were presented during the VEPT/VESPA convening. We have simplified each case to highlight the primary ethical issue and altered each to protect confidentiality and privacy of the patient and families involved.

Cases 1 & 2: dignity of risk and a harm reduced discharge

Ethical framework

Planning for the discharge of a patient, and where they should live after hospitalization or rehab, can be a complex decision. It becomes even more

complex in the context of mistreatment and often requires a number of ethical considerations.

A key ethical concept in the context of discharge planning is the *dignity of risk*, that a seemingly unsafe decision can still serve a valid need in an autonomous patient (Marsh & Kelly, 2018; Mukherjee, 2015). An important part of being human is weighing decisions and making choices that may involve risk. Therefore, it is important for medical teams to proceed cautiously if they are considering denying patients the human right of independent decision making. That said, older adults are often at risk of cognitive and medical conditions that impact medical decision making. Therefore, evaluating a patient's decision-making capacity often plays a significant role in the EM team's assessment.

Medical decision-making capacity involves the ability of a patient to understand the benefits and risks of a treatment and its alternatives; understand how that applies to them and their situation; and express a consistent choice (Barstow et al., 2018). Broadly, ethical questions often arise when providers are assessing whether the patient has the capacity to participate in decision making. Generally, if a patient can understand and verbalize the benefits and risks of a certain decision, the applicability to their situation, and state their preference consistently over a period of time, they are determined to have the capacity and right to make that specific medical decision, regardless of the potential harms. Older adults are more prone to conditions like dementia and delirium that can impact decision-making capacity, and indeed, dementia is a risk factor for being victimized (Lachs & Pillemer, 2004; Lachs et al., 1997). Hearing loss, speech difficulties, language differences, varying levels of health care literacy, or low levels or primary education can make capacity evaluations particularly challenging and often requires someone experienced in working with adults with varying abilities to accurately assess a person's decision-making capacity. EM consultation services and ethics consultants must therefore educate teams about these barriers in capacity evaluations and remind them that capacity can often be restored and is decision-, context- and time-specific. Furthermore, the higher the stakes of the decision in terms of encroachment on patient autonomy (such as placement in a facility, or establishment of a guardian), the more care is required in the capacity evaluation process. It can be helpful to have multiple providers assess capacity, over several time points, and discuss findings as a team. While ethics teams generally do not conduct the capacity assessment, they can offer guidance to the medical providers in both procedural and substantive aspects of this critically important process (Huberman, in press). EM teams may choose to do these capacity assessments themselves or partner with psychiatrists or psychologists. It is also important to note that these assessments should be limited to the decisions necessary for medical treatment such as assignment

of a medical decision maker, discharge planning, and goals of care rather than a comprehensive assessment of decision making.

Victims of abuse, especially when abuse is chronic and embedded within family systems, can view their situation differently than health care providers might. It is important to recognize that patients may prioritize family, being home, protecting the alleged abuser, and helping others in their family more than their own personal safety. For example, a woman whose child experienced physical abuse by her husband, may, in later life, choose to protect that son when he is the perpetrator of violence against her, or a grandparent whose child is physically abusive to them may choose to return home in order to help protect their grandchildren. It is not uncommon for people experiencing domestic violence or other forms of mistreatment to want to return to the same living situation. Health care providers must be cautious to evaluate decision-making capacity without their own values for safety impacting their assessment. This highlights the tension between patient autonomy and clinicians' notions of safety (Drane & Coulehan, 1995). Patient autonomy often extends well beyond the clinical contexts and incorporates aspects of life that provide meaning and existential purpose. Whether it is choosing to stay in an abusive relationship, refusing to accept help, or remaining in an unsafe home with deep emotional attachment, people's priorities are often not reducible to only their health and safety.

A safety-focused perspective may influence the providers' determination of capacity. Clinicians' impression that a patient may be underplaying the risks of a certain decision could lead to a determination of lack of capacity. Providers often need to explore the discrepancy between the patient's and the team's understanding of risks and fill in factual or perceptual gaps. Understanding a patient's value system could help teams consider whether the patient or surrogate is adequately reasoning within the patient's unique value system. If it is determined that the patient has capacity, it is not the provider's responsibility to stop them from making what they perceive to be a "bad" decision.

Teams should try to elicit to the extent possible the patients' reasoning for wanting to make a choice that the care team finds worrisome. This is core to the preservation of dignity, which is often taken unfairly from older adults due to systemic ageism and the drive to protect a vulnerable population. This can be particularly harmful for an older adult who has experienced mistreatment as their autonomy and dignity have already been violated through the abuse itself. Understanding the patient's values can help mitigate the team's estimation of the risks of discharge, as well as contextualize how the decision may be central to the patient's identity.

Ethics consultants can help teams consider a harm reduction model (Marlatt, 1998). The primacy of safety can bias those involved in the care of the patient toward solutions that *maximize* safety rather than the "safe enough" less restrictive options. For example, increasing oversight by a third

party might not be as "safe" as forcibly separating the patient from the abuser; however, this intervention offers a reasonable chance that the patient's autonomy can be upheld with lowered risk. The principle of proportionality requires that risk be *weighed* against other concerns rather than eliminated altogether. The harm reduction approach respects the reality that there are many kinds of harms. Determinations of which option may be in the patient's best interest while trying to minimize risk to the patient requires the care team to respond to the patient's authentic priorities.

Surely, some situations may truly be unsafe to a degree that could override the patient's choice when capacity is compromised. Memory units and other restrictive settings for older adults exist for a reason, and placement in such facilities can be ethically supported when no other option is feasible or reasonable. The role of ethics consultants is to challenge care teams as to whether facility placement is truly the right choice when considering the uniqueness of each person.

Similarly, there may be situations in which the impact on the larger community must be taken into consideration. Mistreatment often impacts other victims, family members, and the community at large (Steinmetz & Straus, 1974). For instance, hoarding behaviors may endanger other community members, particularly in multiunit housing, and therefore have an impact beyond the patient for whom we are caring (Frost et al., 2000). On the other hand, teams must be careful to avoid holding hospitalized patients to a higher standard than those residing in the community. As has been made clearer than ever in the context of the recent pandemic, the personal values of any given individual may be in tension with public health interests. Resolving such dilemmas requires input from a range of stakeholders and is perfectly suited for ethics and EM consult teams to collaboratively assist clinicians in their interventions or to advocate on behalf of their patients.

We present here two cases that involved a discharge plan that seemed "unsafe" to the medical team and involved a great deal of risk but was true to the patient's cultural values.

Case 1: hoarding disorder and loyalty to pets

An 88-year-old woman presented to the hospital multiple times due to abusive interactions with her son and episodes of illness requiring urgent medical care. The patient lived alone with her cats and experienced hoarding disorder, which contributed significantly to her multiple presentations for injury and illness. She would intermittently allow her son to stay with her until the situation escalated to a physically abusive incident. The most severe of these incidents resulted in the police department providing her with an order of protection against her son and led to another hospitalization. Her capacity waxed and waned during this hospitalization depending on her clinical status, but at the time of discharge

she was felt to have the capacity to refuse the recommendation of discharge to an alternate location and wanted to return home. Despite safety concerns around the hoarding and that she may allow her abusive son back into her life, the patient continued to refuse offers for relocation and insisted on returning home, citing her cats as the main comfort in her life and wanting to return to care for them.

Ethical questions and analysis

- How does the principle of dignity of risk apply to this patient?

This patient had a clear value of remaining in her home with her cats that was stated over multiple presentations to the medical system. While the medical team understood that she valued her cats' well-being over her own and was making a decision that might risk her life, being in her home with her pets was clearly her primary motivation in life and was critically important to her above the threat of her son harming her or living in a hoarded home. All adults who have the capacity have the right to make decisions that health care providers would not themselves make, even if the decisions seem to be "bad." Significant dignity results from being able to make such decisions, and this dignity should not be removed simply because a patient has reached older adulthood. In this scenario, it was important for the medical teams to lean on this framework to support them in making the determination that the patient had capacity.

– What was the providers' role in reducing future harm?

In addition to the hoarding disorder, which presented a significant risk to this patient's health and well-being, there was ongoing physical violence from her only support person. The police department provided her with an order of protection, which can be a helpful tool in protecting patients, but only when the victim consistently and routinely enforces it, which most victims are hesitant to do. The health care teams helped the patient come up with her own patient-driven safety plan to help reduce the risk of harm and revictimization while also honoring the patient's self-determination. The medical team supplemented discharge with as many home-based wrap-around services as possible, such as referrals for home-care, APS, check-ins from her building management and the police department, and a life alert button. Ultimately, ensuring patients are connected to community and medical care in a patient-centered way will help reduce the risk of harm.

The team's discussion with the ethics consultant and EM response teams also addressed concerns around how the patient's hoarding behaviors may have impacted the safety of her neighbors. The teams worked with the patient and APS to plan for a deep cleaning upon arrival to her home.

Case 2: homelessness as a culture

A 74-year-old man was found on the side of the road; he was dehydrated and attempting to defecate on the curb. Paramedics were called and transferred him to the hospital due to confusion and medical needs. The admitting medical team found that the patient's son had recently decided to discharge him from a long-term care facility, and the facility reported concerns for financial exploitation by the son. The EM response team spoke to the son as well as the patient's daughter who lived out of state. Both reported that their father had always enjoyed being unhoused and not tied down to any one address. For over 20 years, he enjoyed sleeping outside and being able to walk anywhere he wanted. The son reported that he and his father typically lived together when the weather becomes colder, and he was currently preparing to find them more permanent housing for the coming winter months. He understood that his father now had some newly developed cognitive impairment, but the patient had always made it back to the son in the past, and he did not want to deprive his father of the walks and freedom he had always enjoyed.

Ethical questions and analysis

- How does the principle of the dignity of risk apply to this patient?

This case brought up complicated feelings for medical teams around autonomy and respect for prior decision making and values. The patient had clear cognitive impairment, and providers were suspicious that the son may not have been a trustworthy surrogate, given reports of financial exploitation. Health care providers value stable housing as it is linked to better health outcomes and most health care providers view being housed as the preferred state of being. At the same time, many patients choose to live unhoused, as this patient had for many years. In this case, there was a long discussion with the ethics team around weighing the patient's autonomy and identity against the providers' obligation to maximize safety for this patient with impaired capacity, as for most patients this would be deemed an unsafe discharge. Given the collateral history from multiple sources, in addition to the son, that confirmed that this patient had chosen to be unhoused over many years, the discussion was able to focus on how to respect his autonomy as safely as possible.

- What does harm reduction look like in this case?

It was determined that allowing the patient to return to his prior living situation with his son was aligned with his core values. The medical team worked with the patient's son and daughter to help find safer housing for the coming winter months and also provided additional education to the son about caring for someone with progressive cognitive impairment.

Case 3 & 4: abusers' involvement in surrogate decision making and provider distress

The following discussion centers around two cases that highlight how provider moral distress can arise during patient care when the available surrogate is the likely abuser, and how ethics teams can assist in addressing provider bias for these distressing cases.

Ethical framework

Our teams have commonly seen concerns that arise when the surrogate decision maker's behavior is in question and there are allegations of abuse that have been either made or substantiated. A particularly ethically challenging aspect of the issue is that surrogates may simultaneously display harmful and supportive behaviors. EM and ethics teams may help reframe for providers that a surrogate's role is not easily reducible to an "appropriate" or "inappropriate" duality. People are not inherently "good" or "bad" and can display both helpful and unhelpful behaviors toward patients simultaneously (Fins & Huberman, 2020).

There are situations in which a surrogate may raise red flags but may concurrently be able to provide very important information about the patient's values that can inform the direction of care. A person suspected of perpetrating EM may be in the best position to not only contribute information but to also make some decisions, when properly supported (Fins & Huberman, 2020). The role of the decision maker is to speak to what the patient's values and choices would be to the best of their knowledge. Often those closest to the patient, who are most likely to know their preferences, are also those who perpetuate mistreatment. There are other times, more specific to cases of domestic violence, when a surrogate may display harmful behavior, but the patient repeatedly states a preference for keeping the surrogate involved. Ethics and EM teams may assist clinical teams in better understanding the psychology of intimate partner violence to help determine how to honor the values and choices of a person with impaired capacity. However, that must be balanced with the consideration about whether a decision maker is making decisions for their own secondary gain. For example, someone may choose to keep a patient at home who requires a higher level of care than home can allow because they would not be able to afford to continue to live at home without the financial benefits of the patient remaining there.

Ethics and EM teams help mitigate provider bias when their clinical training might otherwise compel them to treat the patient by eliminating the problematic surrogate's role altogether. Teams may be tempted to immediately turn to another person on the surrogate hierarchy to make high-stakes clinical or discharge decisions for an incapacitated person when the individual closest to

the patient is suspected of EM. Ethics consultants can remind clinical teams that all potential surrogates must have their decisions held to the same ethical standards, specifically responding to the wishes, priorities, and interests of the patient. Honoring and involving a previously appointed Medical Durable Power of Attorney (MDPOA) also upholds patient autonomy. In general, individuals can maintain their role as surrogate decision makers unless they are making decisions that are not in the best interest of the patient. If it is necessary to turn to a previously uninvolved person to serve as surrogate, teams must take care to ensure that the person closest to the patient is unable to serve within ethical parameters and that the less involved individual is able to meet the ethical standard. Ethics and EM teams can help mediate conversations between clinical teams and surrogates when the different parties are viewing the situation through different value systems, centering the conversation on what option going forward seems most aligned with the patient's priorities and values. Ethics and EM teams can also help facilitate conversations with hospital legal teams in particularly complex situations.

There are limits to surrogate choices and to their ability to maintain this role. A surrogate who poses serious, direct risks to the patients, such as physical violence, unfettered exploitation, or destructive emotional abuse, may be unable to serve in any capacity as a decision maker. Indeed, there are times when conversations with APS or law enforcement lead to a recommendation to limit the role of a previously appointed decision maker. In many circumstances, however, the universal complexity of human relations carries over into the patient-surrogate relationship. It is therefore important to try to address the situation whenever possible, rather than eliminate the problematic surrogate's role altogether.

A related but distinct concern is whether to allow potentially abusive family members to visit the patient in the hospital. If there is a clear threat to the patient or staff, the visitation may need to be limited. However, if there is no clear evidence of a threat during the hospitalization, or the visitor can be appropriately supervised, there is often great benefit to the patient and family to have loving but potentially maltreating people at the bedside. This becomes particularly important at the end of life as most often the potential abuser was also the one closest to the patient.

Case 3: longstanding cycle of violence

An 81-year-old woman with a known history of dementia presented to the hospital system several times with multiple bruises, highly concerning for physical abuse. The husband, who was her appointed health care decision maker, repeatedly made comments to staff that implied he was abusive toward her and would decline to assist her in ways that were indicated for her benefit. For example, he refused to assist her with eating, citing that "she needed to learn,"

even after reporting that he understood with dementia that she could not learn anymore. The only other family member was a son who saw no problem with his father's behavior. The medical team questioned whether the patient had capacity, in large part because she would often say that she was being hit by her husband but that she felt safe at home, which was considered contradictory. The team administered a full capacity assessment, which ultimately determined that the patient did not have the capacity to refuse alternate placement. The husband remained her decision maker.

The clinicians involved were very distressed by this case and tried to understand how they could intervene or remove the husband as a decision maker. When this was discussed with the ethics consult team and APS, it was clear that without significant evidence that the husband was not acting in her best interests in his role as a surrogate decision maker, he should not be removed from that role. Ultimately, APS and the ethics consult team felt that bar had not been met in this case. Hospital staff had refused him visitation earlier in the stay as he was verbally aggressive with staff, but this was reversed quickly, further causing staff distress.

Ethical questions and analysis

- What are special considerations clinicians need to take into account when assessing capacity in the context of long-standing intimate partner violence?

A key discussion point with the medical team assessing this patient's capacity was around the psychology of domestic violence. Providers who had not worked in this realm before could not understand how a patient could report being abused while at the same time reporting feeling safe in that environment. It was likely that this pattern had been going on for years, as evidenced by the son's response to the situation, making this the patient's reality for that entire time. Therefore, her statements of knowing she was being abused and wanting to return home where she felt safer than the hospital were not necessarily contradictory in her reality. It was important for the teams to have an understanding of the psychology of intimate partner violence in order to understand her values and more appropriately determine her capacity to participate in decision making. The patient was ultimately found to lack capacity for other reasons, but understanding her value system was critical in honoring her preferences as best as possible.

- To what extent can the abusive family member participate or be limited in decision making or visitation?

This patient had previously assigned her husband as her MDPOA. While the health care team had concerns about her overall safety and suspicions of physical abuse, these were not formally substantiated by APS or law enforcement. Furthermore, her husband was not making decisions during hospitalization that would cause immediate risk of harm. The role of EM teams is not

to investigate and/or find people "guilty." Instead, the role is to identify concerns, report them, and advocate for patients. Since law enforcement and APS did not recommend removing her husband as decision maker, and there were no concerns of his medical decisions, we continued to honor the patient's wishes of having her husband as her medical power of attorney. However, if her husband tried to make medical decisions that were potentially harmful in that moment – trying to remove her from the hospital when she was medically unstable, for example – further discussion with legal and ethics teams would have been indicated to reconsider his decision-maker status.

This case also brought up questions about visitation while in the hospital. There was significant push from staff to not allow the patient's husband in the hospital. Limiting visitation in cases where there was a clear threat to staff or patient safety is common among hospital systems. In this situation, whenever there was a direct threat to the staff, the husband was asked to leave. However, no behaviors were seen that met the threshold to limit his visitation or participation permanently throughout the entire hospitalization as he did not demonstrate behaviors that put her immediate safety at risk while she was hospitalized. Additionally, allowing the husband to visit was a means of supporting the patient's autonomy, as he was a central part of her support system.

- How can ethics teams address staff moral distress in cases where there seems to be no actionable recourse?

This case brought up significant distress for staff members, including the bedside nurses, who witnessed the husband making multiple degrading comments toward both the patient and medical providers. This distress was amplified as the patient repeatedly presented to the hospital and clinic with bruises raising concerns for abuse. Upon each encounter, the calculus was revisited to assure that the patient's interests were still best served by a discharge to home. Ethics team-facilitated moral distress mitigation rounds were a helpful tool to provide space for providers to debrief about this challenging case, commiserate on the moral injury that they encountered, and brainstorm ways that the moral distress could be mitigated at the bedside, unit, and system levels.

Case 4: the only available surrogate is an abusive brother

A 77-year-old man presented to the hospital after neighbors found him outside his home. He had a known diagnosis of dementia, and his brother was his caregiver. When he presented, his core temperature was less than 90 degrees Fahrenheit. The patient remained in the hospital for many months during which time APS substantiated ongoing financial exploitation and neglect by his brother. APS recommended that the brother not be used as a surrogate due to their investigation and started to pursue guardianship. No other family could be

found who was willing to serve as a surrogate. However, before the guardianship process could be completed the patient became acutely ill. He suffered from aspiration and required significant oxygen support, placing him at risk for needing to be intubated and placed on a ventilator, a significant clinical choice particularly for someone with dementia. As no family member was able or willing to be decision maker, and the guardianship had not been completed through the court, the medical team was then left not knowing what to do regarding intubation for this patient.

Ethical questions and analysis

- To what extent can the abusive family member participate in decision making?

It was clearly recommended from APS that the brother could not serve as the sole decision maker for this patient. Guidance from the ethics team was to involve the brother in identifying the patient's core values and goals to help inform decision making while still precluding him from making final decisions. This was able to be done, and the brother was able to confirm the patient's core values of wanting to be able to enjoy food and music which guided the medical team's treatment. Fortunately, the patient's clinical status stabilized for some time, while the court's investigation located another family member who stepped in as surrogate decision maker.

Limitations

This manuscript presents an initial exploration of the respective roles of ethics and elder protection programs and their collaborative interactions. The analysis is largely based on a few selected cases and the perspectives of clinicians and ethics consultants with experience and expertise in this field. More comprehensive case studies based on larger data sets are needed to better understand how models of interdisciplinary collaboration can improve patient-centered outcomes. Each case is unique, and while we have found some general themes, it is recommended as best practice to consult with ethics and legal teams at the clinical site where a patient is being seen, to work together to determine the best solution for any one individual patient.

Conclusion

The collaborative discourse between ethics and elder protections programs offers several ways to improve patient-centered outcomes and address value-based concerns in the treatment of patients who suffer from EM. First, ethics consultation services and elder response teams can help multi-disciplinary teams consider risk in a broader context and find solutions that balance risk

mitigation with the patient's priorities and values, especially around discharge planning. Second, collaborative discussion can carve out a role for surrogates who act in ways that compromise patient interests. Rather than exclude these actors altogether, a mindful inter-disciplinary approach can see them as sources of useful information, some measure of social support, and even partners for decision making whenever their adverse influence can be successfully isolated from their role as surrogates. Third, ethics consultants can offer a value-based perspective to clinicians who are tasked with determining patient capacity. Here too, safety can be weighed against the patient's own priorities which can, in turn reveal a different rationale to decision making than what clinician's prior assumptions might include. Thus, rather than simply applying ethical principles, the role of the ethics team often involves mediation and building consensus among stakeholders with different perspectives, while centering decision- making on the patient, and addressing providers' moral distress.

Involving a clinical ethics perspective is an important and attainable resource to consider when medical teams confront difficult EM situations. Sharing information and increasing collaboration is critical to support both ethics teams and emerging older adult protection teams in responding to issues that arise for patients experiencing EM. This manuscript is intended to begin this sharing process. Additional research is needed to study the interaction between elder protection teams and ethics and offer a more detailed, evidence-based model for collaboration. We hope that recent efforts from Medicaid to fund social determinants of health assessments, and other similar initiatives, will encourage others to explore the development of these teams and work in this important area (Esch & Christopher, 2024).

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