For better or for worse

... till death do us part?

What do we do when spouses of older patients do not want them home again after discharge even though it is physically and medically safe for them to do so? Is it ageist of us to expect older couples that have been together for a long time to always be happy to remain so? Whose problem is it anyway? **Dr Yuen Cheng Looi** offers two such ethical dilemmas for further discussion.

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As healthcare workers for the elderly we come across many situations that make us uncomfortable and present awkward dilemmas, both personal and moral, that directly affect the life and well-being of those whose care is in our charge. The two following scenarios are composites of just such events.

Scenario one

A 72-year-old gentleman, who had previously been quite fit and well, had an acute bowel perforation following an elective colonoscopy to investigate anaemia. He then underwent emergency surgery, which left him with a loop colostomy. His subsequent recovery was plagued with recurrent infections. By the time he arrived in the rehabilitation unit, he had lost a great deal of weight. His mobility had deteriorated and he had occasional short-term memory lapses.

After several more weeks of physiotherapy, he reached a 'plateau' in his recovery. He was able to mobilise short distances with his zimmer frame but needed assistance washing and dressing. He was able to change his colostomy bag, albeit with some supervision. He also required a catheter because of incontinence. Prior to his admission, he had lived in a house with his wife. He was very keen to go home again. The multidisciplinary team felt that this would be possible with a full care package. His wife, however, would have to convert one of the downstairs rooms into a bedroom for him as he would not be able to manage the stairs at home. (A stair-lift was not an option because of the layout of his home.) She would also still need to supervise his changing the colostomy bag.

Unfortunately, his wife said she would 'not be able to cope' even though she did not really need to personally do any physical care for her husband. She did not want him to come home again but also did not want to tell him so herself. Several weeks of unsuccessful negotiation followed. In the end, the team had to tell the man it was probably 'safer' for him to go into residential care (to avoid causing more friction between the couple). He accepted the 'medical team's decision' and went into a residential home not long after.

Scenario two

Another man, aged 68 years old, was admitted to hospital following a fall at home. On admission, he was found to be slightly confused. He was diagnosed with a urinary tract infection and treated for it. His confusion resolved soon after. As he remained quite unsteady on his feet, he was referred to the physiotherapists. After a few more weeks in hospital, he was deemed 'as good as he

is going to get', which was slightly better than his baseline function prior to admission.

He needed only a little assistance washing and dressing, but was otherwise able to walk with a zimmer frame. He was keen to go home and was willing to accept a care package. Unfortunately, his wife did not want him home either. She informed the team she would 'not be able to cope', despite the fact she did not need to perform any physical care for him and no adjustments were required in the house. She told her husband so directly. He quietly accepted her decision and told the team he had changed his mind and would go into residential care instead. It was obvious to all that he had been coerced into this and he admitted so himself, saying, 'She doesn't want me home...'

The wife was unshakeable in her decision until the last stage in finding a residential care home was reached. Not financially well-off, his house would have to be sold to raise the necessary funds for this placement (even though this is technically illegal). This, of course, meant the wife would have to move to a smaller place herself. Faced with this, she changed her mind and 'allowed' her husband to come home as originally planned.

Discussion

Of course, we cannot truly know what these two couples' relationships had been like over the years. Nevertheless, situations such as these trigger a sense of outrage: 'How could she do that to him, especially after so many years together?' After further thought on the matter, a deeper question arises: 'Why should we have simply assumed that all older married people who have been together for a long time would always want to remain together, supporting each other through thick and thin?'

As care of the elderly physicians, we often pride ourselves on the fact that we are 'set up' to care for the 'whole person'. After all, we had multidisciplinary teams long before many other specialties realised they needed them as well. We train our juniors to ask how older patients cope at home. We define how 'independent, fit and well' a patient is by his or her need for carers, walking aids and other equipment in the home. We even have rating scales for various activities of daily living.

Sadly, we still often forget that patients, no matter how old or frail they may be, may still have significant ongoing relationships with other people that have nothing to do with their daily functional activities, but still play an important role in their lives. These other important people may be their spouse, partner, child, sibling or simply a very close friend. These relationships are often assumed to be fine and well. More often than not, a decline in the overall state of an older person or the partner puts a strain on the relationship – one that may have already been strained in the first place, or for any number of years. There may be 'significant others' who still care deeply but truly cannot cope anymore. There may be others the more cynical might say would take this as an opportunity to 'get out'.

We all know many clichés alluding to the fact that love, friendship, indifference, hate or abuse can still occur at any stage of our lives. Ageism is nonetheless still prevalent in how many of us expect older people to behave in their relationships. Yet consider how difficult it still is for elderly couples to share rooms in residential care homes. And take, for example, the shock that many still have when an older patient is diagnosed with a newly acquired sexually transmitted disease. It is also interesting to note that the National Statistics department lists marriage rates by age up to those '80 and over' but divorce rates only to the age of '60 and over' – presuming, one supposes, that older people are mostly happy to stay together.

Returning back to the scenarios described above, there are several important issues. Both men had the right to go home and there were no physical or medical reasons they should not. The houses legally belonged to them as well. They both had mental capacity and understood what was happening. One could also argue that the first man should have been told the whole truth about his wife instigating the whole matter. But would it have made any difference in the end? In the second, it did not. It might only have served to cause him more emotional hurt. In essence, the medical team's hands are tied because these men did not contest 'the decision'.

Also, as the patients' wives were not patients, they could not be 'investigated' further regarding their true motives. Indeed, even with a suggestion that one wife may have suffered from mental health problems, they could – as they do in many cases – prove very resistant to offers of psychological counselling and support for

Key points

- Many of us still have preconceived ideas of how older people should behave in their relationships with others.
- Too often, we assume that all older couples will always be happy to stay together.
- These relationships can be affected by ill health in one partner.
- We need to think more about how we can support our patients when these relationships fail, especially when they affect where and how they are going to live in the future.

themselves. Finally, there is the matter of the breakdown of these relationships. There would be long-term emotional and psychological effects for both couples to deal with long after the patients were discharged from hospital.

What do we do in cases like this? Is it even 'our' problem (because it is affecting a patient's discharge) or is it a 'personal' issue that we should leave to them to sort out themselves? Who should stand for our patients when they can no longer do so for themselves and the people who used to, no longer do? More interestingly, who do we have on our multidisciplinary teams to help mediate when dilemmas such as these arise?

Quite often, many of us would try to avoid the issue. It becomes a 'social' problem left to 'someone else' to sort. The least confrontational approach is the one often taken, though not necessarily the right one. A variety of consequences can result. Ideally, it would be useful to have someone else in the team well-versed in law, ethics and counselling to mediate in such cases. Most of us do not have any easily accessible resources in this area yet.

Is it time then to re-think the scope of our multidisciplinary teams?

What do you think?

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