The Impact of Autonomy and Financial Concerns on the Elderly at End-of-Life

University of Toledo

Guided Study: Elder Law Topic

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Introduction

Our society’s foundation is based on freedom of choice. But, where do these choices begin and end? Our society promotes individual autonomy to all people, including the elderly. Autonomous decision making is held as a caldron which frequently guides a person’s individual and ethical principles. These principles, when faced with difficult decisions, may be challenged. This is particularly true when older adults are faced with end-of-life choices. In order to make an autonomous decision one has to be in a position of control. Frequently at the end of life, this control is lost due to advanced illness, or declining cognitive function, especially when the elder has not completed an Advanced Directive. Compounding this loss is the overwhelming financial cost for care as people age. One may ask, at what point should end-of-life choices be governed by financial and economic considerations? If end-of-life choices are influenced by these factors, how would they impact patient autonomy and what would the resulting legal considerations be? Attempting to answer these questions and having an understanding of these issues is important if one is to advocate for the elderly population who are faced with these challenges.

As the number of elderly increase in our society, we are often faced with difficult ethical decisions. Many of these ethical decisions are inherent in the aging process. The literature reveals that issues related to the elderly person’s autonomy and self-determination are frequently challenged by medical practice, family, and the availability and access to financial support. Mirroring the growth of the geriatric population is the increase we see in the number of chronic illnesses. Many of these chronic illnesses require patients and families to make
difficult decisions that often have an impact on multiple aspects of their quality of life.

Additionally, patients, families, and providers of care are frequently faced with complex ethical issues which often attempt to integrate medical treatment with the patient’s personal values, autonomous decision making, and end of life decisions.

Resolving ethical issues does not always have a clear path. Patient autonomy in the elderly population is often challenged when patient choice does not coincide with family wishes, conventional medical recommendations, insurance coverage, or financial support for care. The role and actions of the individuals who care for the elderly are frequently becoming more important during these times of care. Caregivers may include a wide variety of individuals and often come from diverse backgrounds which can make decision making at end-of-life a challenge due to differing viewpoints. Decision makers at the end-of-life often include the individual patient, family, medical and legal providers.

It is important that individuals who are responsible for the care of an older person have an understanding and awareness of the ethical dilemmas faced by the geriatric population if they are to be effective advocates for the elderly. Identifying and discussing ethical situations found in the care of the elderly can have a meaningful impact on the quality of end-of-life care for this vulnerable population. One of the biggest ethical issues for people examining end-of-life care for the elderly is economics.

As reported by many sources, health care costs at the end-of-life have not diminished, they have only escalated. Experts argued for the necessity of at least discussing with patients
and families the cost of end-of-life care before making medical decisions. Some consider end-of-life care to be a societal issue and advocate that patients look beyond themselves for the greater public good. This paper will examine these issues and show that there are no easy answers.

**Growth of Geriatric Population**

It is not an exaggeration to say that our society is struggling to understand and develop a plan to meet the needs of the number of elderly people in our country. According to The Population Resource Center (2012), there will be about six million people over the age of 85 in the year 2010 and by 2050, the number of people aged 85 and older will reach a staggering 21 million. According to the CDC (2012), by 2030 the number of individuals age 65 and older will be an even more impressive number reaching 71 million. As the number of elderly in our society continues to grow, many social and ethical issues become more apparent. As a geriatric nurse practitioner, these social and ethical issues often come into consideration when making medical decisions for our elderly clients, especially as they near the end-of-life. Some individuals may consider the advancement of age a success story. Others may question whether it is really a success when you consider the personal and financial cost to both the individual and to society as a whole. Examining ethical issues related to maintaining individual autonomy and how economic considerations may influence end-of-life decisions may provide us with some answers to these questions.
Elderly and Autonomous Decision Making

One of the most pervasive concerns when speaking to an elderly individual is their desire to maintain their independence. When speaking to elderly patients, most state that they would like to remain in their own home, be able to drive their own automobiles, remain socially engaged, and be able to make their own medical decisions. In order to enhance these desires, there are several ethical and legal issues which need to be considered. One of the primary legal and ethical considerations is to promote and maintain patient autonomy whenever possible. According to Mueller, Hook, and Fleming (2004), autonomy “refers to the duty to respect persons and their rights to self-determination.” Implicit in this definition is the ability of the patient to receive adequate information from their care provider explaining their medical condition, the risks and benefits of treatment options, and expected outcome of the treatment. This is necessary in order for the patient to have a better understanding of their disease and the knowledge of how this disease might impact their daily life as well as what treatment options might be available for their condition.

Over the last several years, landmark legal cases have been brought before the courts that specifically challenged a patient’s autonomy when they made the choice to either forgo medical treatment or asked that treatment be withheld or withdrawn. One of the first cases brought before the courts that tested “autonomy in medical decision making” was the case of Kathleen Farrell, a 37 year old woman from Toms River, New Jersey who was diagnosed with amyotrophic lateral sclerosis (ALS), Lou Gehrig’s disease. This case was a bit different from the
well publicized case of Karen Ann Quinlan, which was brought before the courts in 1976, because Kathleen Farrell was found by the court to be competent to refuse medical treatment whereas Karen Ann Quinlan was in a persistent vegetative state at the time of her court case. Once a person is found to be competent, most courts would argue that they have the right to refuse or discontinue life-sustaining treatments, even if their wishes do not correspond to others as long as their means to an end was legal (McGowan, 2011). According to Pawl (2007), legal scholars have supported competent adults in their pursuit of autonomous decision making, based on their right to be free from unwarranted medical interventions, even if the intervention was meant to keep them alive.

It has been argued that a person’s ability to make their own decisions about the type of medical care they will receive is a fundamental right given to each person under our Constitution. This right shifts the decision making ability away from the historically paternalistic view of the doctor patient relationship to a more patient centered approach (Parker, Erlbaum-Zur, Chichin, 2008). In the Farrell case, the plaintiff’s husband filed an application seeking to be appointed the guardian ad litem for his wife and was seeking permission to remove her from the respirator that was keeping her alive.

At first glance, this case may appear to be an assisted suicide. But, in fact, it is really about the patient’s ability to make an autonomous decision to be disconnected from the machinery that is keeping her alive. As the disease progressed, Mrs. Farrell’s body began to deteriorate as she lost the ability to use her arms, legs, and control of her body below her head.
In 1983, Mrs. Farrell had a tracheotomy tube inserted into her throat because she was no longer able to breathe without the assistance of a ventilator. While the disease process continued, Mrs. Farrell’s cognitive function remained intact and she was able to communicate her wish to be disconnected from her medically necessary equipment to her husband, sons, parents, and sister.

The court did order a competency evaluation by a court appointed psychologist and a court appointed attorney. Mrs. Farrell’s responses to this evaluation were found to be valid and not a result of depression or any other cognitively declining condition. When asked why she wanted the ventilator removed, Mrs. Farrell responded “I am tired of suffering.” In this landmark case, the court found that “Mrs. Farrell clearly fits the legal definition of being competent, both in a general sense and regarding whether she is competent to make a decision to decline life sustaining treatment.” With regards to her ability to make an autonomous decision, the NJ Superior Court found that “every human being of adult years and sound mind has a right to determine what shall be done with his own body. A competent adult person ...has the right to decline to have any medical treatment initiated or continued.” *In re Farrell, 212 N.J. Super. 294; 514 A.2d 1342 (1986).*

Previously, patients often relied on their personal physician to “make the best choice” for them in deciding their plan of care. Currently we have seen a shift in the decision making power taking it from the physician and giving it to the patient. Mrs. Farrell’s case is an example of this transition. During the case proceedings, the New Jersey Superior Court further
examined whether, in deciding Mrs. Farrell’s case, there were any state interests which would outweigh Mrs. Farrell’s rights to terminate her medical care in order to preserve her right to self-determination, privacy, and bodily integrity. In reviewing the facts of this case, the court also considered whether Mrs. Farrell’s decision would have a negative impact on others, outside of her family. Since Mrs. Farrell was deemed competent, and because no other parties were protesting her right to withdraw from this medical treatment, the court found that she was within her Constitutional rights to self determination and could not be forced to continue with a treatment that she did not want, even with the knowledge that she would ultimately die. While Mrs. Farrell ultimately won her court case, much of this stress could have been eliminated if she had prepared an Advanced Directive.

Importance of creating an Advanced Directive:

While most people who deal with the elderly would support their right to autonomous decision making, especially when dealing with an illness for which there was no cure and the quality of life was greatly diminished, there have been other medical situations which have not been so easily decided. The courts have been given the responsibility to help decide the fate of several individuals who were deemed to be “incompetent” to make their own medical decisions. In many of these cases, the patient in question was without an Advanced Directive. An Advanced Directive is defined as a legal document through which “the process of preparing for likely scenarios near the end of life, that usually includes assessment of and dialog about a person’s understanding of their medical history, condition, values, preferences for care and
treatment, and personal and family resources, takes place. These advanced directives are usually made orally or in writing by a mentally competent adult stating how they wish to be treated should they, at some stage in the future, lose mental capacity” (Yeun-Sin Jeong, S., Higgins, I., McMillan, M., 2010). Over the last thirty years, we have seen several of these cases brought into the limelight as the court system was forced to deliberate the fate of the dependent person in end-of-life decisions.

One of the responsibilities of medical and legal professionals who interact and work with older adults is to initiate the discussion of end-of-life choices and to advise them to create an Advanced Directive. Helping the individual understand the importance of this document is crucial to helping them maintain their autonomy and decision making power when they are most vulnerable. Many older individuals do not have a clear understanding of the benefits of having an Advanced Directive. When recommending that someone create an Advanced Directive it is important to explain what the instrument does and when it is used.

Some patients hold the erroneous belief that by creating the Advanced Directive while they are still competent, they will immediately lose control over their medical affairs. It is helpful to explain that an additional benefit of creating an Advanced Directive while they are competent gives them the opportunity to express to their family what they want in terms of invasive, costly medical care should they become incapacitated. However, not all costly and invasive medical care occurs at the end-of-life. Unfortunately, many people develop chronic,
long-term illnesses over their lifetime that results in the need for extended, and expensive supportive health care.

**Impact of Chronic Illness at End-of-Life:**

One of the biggest challenges in the care of older people is the development of a chronic, long-term illness. It is unfortunate that nearly all elderly individuals develop some type of chronic illness as they age. While we have been able to cure many of the infectious diseases that previously killed people at an early age, chronic illnesses like diabetes, coronary artery disease, stroke, chronic obstructive pulmonary disease, osteoporosis, and dementia, continue to rise as people age. Regardless of the type of chronic illness a person has, one common denominator among them all is the high cost of care. As medical advances developed treatments for many of these chronic illnesses that led to the prolongation of life, society as a whole did not consider the consequences of these successes. When considering options for care, the decisions becomes more complicated as elderly individuals, families, and clinicians are trying to do what they feel is correct.

As people live longer with these chronic illnesses, the legal system has not really been able to keep pace with medical advancement. Over the last several decades several legal cases have been brought before the courts reflecting the uncharted waters inherent in end-of-life choices. As mentioned previously, patient autonomy is a virtue supported by both our Constitution and legal systems. Because our society holds autonomy in such high esteem, we have seen the challenge in the judicial system of patients either requesting or refusing
prescribed treatments for particular medical conditions. In fact, even social media has gotten into the mix with movies such as “My Sister’s Keeper” and “Johnny Q” both of whose plots revolved around medical/ethical decision making. While there is no question that the social and psychological impact of end-of-life choices are difficult, an overwhelming consideration that often influences patient and family choice is the significant cost of this care.

Financial Implications of End-Of-Life Care:

While people are living longer, who is baring the financial burden of care? The ethical and social consideration that goes into answering these questions has been reflected in many round table discussions around the world. Journal articles, books, and scholarly endeavors have researched and debated the question of who should pay for the care of the elderly, particularly as those costs pertain to end-of-life care and end-of-life stage.

Crippen and Barnato (2011) propose that we look at not only how our country spends money at the end-of-life, but also at the period of time in an older person’s life which they call the “end of life stage.” The authors propose that when you consider how we spend money in this country, we will see how we really earmark our spending to the two life extremes, our children and our elderly. In the middle adult years, much of our salary goes to pay for taxes that support the school systems which our children attend and Social Security and Medicare which is to be used by the elderly. The authors go on to say that this outlay of money is really disproportionate with the elderly receiving more in the form of Medicare and Social Security income than our children receive in the form of subsidized education. In theory, the children
that we initially support will eventually become our financial supporters as they enter the labor force as young adults. However, after reading much of the literature, we know that this concept may not come to fruition because there are increasing numbers of older people today, and more projected for the future, than there are young people entering into the labor force.

While discussing cost for care, Crippen and Barnato (2011) also postulate that the expenditures that people make for end-of-life care are not nearly as costly as the treatment of long term chronic illnesses that are prevalent in the elderly. They note that the average Medicare patient in the top quarter of spending has five chronic diseases, sees multiple physicians, and is on multiple medications (Crippen, Barnato, 2011). The authors also state that “it is not increases in end-of-life spending that is driving up the cost of health care, but overall health care costs propelled by the increase in chronic disease, technology to detect and treat it, and in the costs of treating patients with multiple chronic illnesses” (Crippen, Barnato, 2011). While we know that chronic illnesses are costly to society, as well as the individual, the concern over expenditures at the end-of-life care has also been brought into question.

According to Donley and Danis (2011), “Over the last twenty five years, the percentage of Medicare payments attributed to the care of patients at the end of life has remained stable at around 25% which shows how little progress has been made in containing these costs.” These authors present a rather different plan to help reduce these costs. They suggest that practitioners who treat the elderly have direct discussions with their patients at the onset of their illnesses regarding the cost of treatment and care which is shared by the population
The Impact of Autonomy and Financial Concerns on the Elderly at End-of-Life

through taxes and insurance premiums, and the individual themselves during their time of illness.

The authors argue that by presenting this information to the patient, their autonomy is being preserved as well as allowing them to consider the costs of various treatments that they may incur. They further postulate that by discussing costs at the onset of their chronic illness, the patient would have the opportunity to incorporate financial considerations into their end-of-life health care planning (Donley, Danis, 2011). This idea is interesting when you think of the number of people, some of whom are not elderly, that have chronic illnesses. It seems that the authors are suggesting that once a person is diagnosed with a chronic illness, the practitioner should begin having end-of-life discussions with them in order for them to consider their end-of-life choices both from a personal as well as financial viewpoint. Given the rise in health care spending, perhaps the authors feel justified in making this recommendation.

In examining health care costs, the authors noted that the Congressional Budget Office projected that the total US spending on health care would reach 25% of the gross domestic product by the year 2025, 37% by 2050, and 49% by 2082 (Donley, Danis, 2011). The cost of medical care continues to rise greater than people’s ability to pay. In 2009, 21% of Americans reported that they were having difficulty paying for necessary health care (Donley, Danis, 2011). The authors also noted that of people with chronic illnesses, 30% had challenges paying medical bills, 16% used up all their personal savings, and unfortunately, 5% went bankrupt (Donley, Danis, 2011). Donley and Danis (2011) report that in a study of patients specifically
identified as being terminally ill, 17-28% reported spending 10% or more of their income on health care costs outside of insurance premiums. Further statistics point to the fact that a large percentage of terminally ill patients and or their families had to find other means to finance medical care, such as taking out a personal loan, mortgage, or using up all of their personal savings. Given these statistics, is it any wonder that patients at end-of-life, be it from a chronic or acute terminal illness, may become depressed?

Considering the high cost of end-of-life care, Donley and Danis propose that practitioners can act as conduits for cost cutting measures by speaking with and influencing patients in the types of diagnostic and therapeutic interventions they chose at end-of-life. Ones initial reaction to this concept may be shock and disbelief because on first impression it may seem very paternalistic and on the verge of being inappropriate. However, their point was not to make the patient chose a specific treatment plan, but rather to consider the cost and potential outcome of a particular treatment. What the authors are saying is that practitioners are in a position that can strongly influence how scare resource dollars are spent.

The authors propose that some practitioners may be aided in this process of dissuasion by the guidelines and policies set down by their institution with regards to who can and cannot have access to certain tests and procedures either because of short supplies or institutional allocations. Secondly, some patients are not considered candidates for certain procedures based on medical practice guidelines. And finally, some practitioners may dissuade a patient from a particular test or treatment based on their clinical knowledge when the previous two
reasons do not apply. Donley and Danis (2011) believe that due to the practitioner’s influence and power over health care expenditures, they may be in a very persuasive position to discuss the costs of treatments and decisions that are presented to patients.

On the surface this tactic may seem like a rational approach to a social problem, but at the base of this discussion, it appears to be a paternalistic approach to rationing of health care with the practitioner holding all the power and the patient being left powerless, which is extremely unethical. The authors admit to their idea as being a form of “bedside rationing without informing the patient.” However, they rationalize this approach as being the counterpoint for the practitioner who simply opts for the most effective, most modern, and often the most expensive treatment (Donley and Danis, 2011). But, ultimately, who pays? In most cases everyone pays either through their taxes, insurance policies, or out of pocket.

Considering medical costs, Donley and Danis (2011) argue that each person should help to reduce medical expenditures by being more selective about which medical procedures they use. This argument is based on the idea of considering what is best for society as a whole, rather than what is good for the individual. This is particularly poignant for the dying patient. They are arguing that before a practitioner recommends a particular procedure or treatment for a dying patient, that the patient should consider their choices and what the cost will be to society. They point out that as individuals consider how their actions and choices will impact the burgeoning medical costs in our society, by forgoing expensive and most likely unhelpful
medical procedures, the individual will be providing for the greater good rather than acting in a self-serving manner (Donley, Danis, 2011).

Decision making at the end-of-life is made more difficult for some because of financial concerns of affordability of care. Donley and Danis (2011) contend that by discussing the costs of medical treatment at the end of life, it gives the patient time to address any financial concerns that they may have and helps them to make decisions regarding plans of care. The authors feel that by discussing the financial concerns of treatment with the dying patient, they are in fact promoting autonomy in decision making and are better able to support the patient’s choices and are able to offer patients treatments that they are more likely to adhere to because they can afford them.

Dying patients are faced with many complex issues. Many of the issues are tied to finances. By discussing financial cost of care with a dying patient from the inception of the illness, the practitioner is allowing the patient to have some control over how their dollars are spent. While not totally supportive of the authors opinion, there may be value in discussing cost of treatment with a patient who may like to have the freedom to use his/her money in another manner, say going on a trip, or buying a new car for his/her family. For individuals who may not have health insurance, or other means of payment for their medical care, even daily costs of living may be a hardship for them. Having financial discussions with their care provider about end-of-life treatments may allow them to choose how they want to spend what money they have available for basic necessities rather than for futile costly treatment. Given the enormity
of the decisions that are taking place at end-of-life, one consideration that needs to be addressed is the amount of influence a care provider may have on a patient or family during this period and to what extent trust in the physician comes into play when making decisions to continue or forgo costly treatment.

**Trust in the Physician and End-of-Life Decisions:**

The issue of trust in the physician may be considered when discussing the choices a dying patient may have at the end-of-life. Anderson and Dedrik (1990) developed the Trust in Physician Scale which has been used to measure the interpersonal trust between the physician and patient. This eleven item, self administered questionnaire measures three areas of trust: physician dependability, confidence in the physician’s knowledge and skills, and confidentiality and reliability of information received from the physician (Anderson, Dedrik, 1990).

While not directly discussed in the article by Donley and Danis, the theme was mentioned when they related the results of a qualitative research study done in California (Donley, Danis, 2011). This study revealed that when physicians make medical decisions that are influenced by cost, yet patients have indicated a desire to be reassured that cost was not the only or primary consideration in their physicians’ decision. Although not specific to the elderly, this study does indicate that patients do follow the recommendations of their physicians when it comes to treatment options indicating a certain level of trust in the physician.
Thom, et al (1999) using a revised version of the Trust in Physician Scale reported that older patients, greater than age 55, had significantly more trust in their physician than younger patients. Based on these results, it may be postulated that some individuals do make end-of-life decisions based on their physician recommendations, particularly if cost has played a factor in their discussions. Given the results of Thom’s study, some might conclude that some elderly patients and their families will go along with whatever recommendation the physician makes because they are considered “trustworthy.” But, as we will see in the following case, that is not always the result.

The Power of Others in Decision Making at End-Of-Life:

Acknowledging that end of life care is very costly to the patient, family, and society, how do we balance the cost of care in a situation where the prognosis is very poor and there is little chance of recovery? Previously, it was stated that patients often follow the recommendations of their physician with regards to end-of-life care because they have trust that the practitioner is acting with knowledge and expertise. But, what if a patient or family does not want to follow those recommendations, even though they are made based on medical knowledge? Who is responsible for extended care and its related cost when it is the patient or family who is demanding treatment? Do practitioners hold any power in their own decision making and how does that affect cost? An example of this concern can be address by examining the case of Helga Wanglie [Source: In re the conservatorship of Helga M. Wanglie, No. PX-91-283, District Probate Division, 4th Judicial district of the County of Hennepin, State of Minnesota.].
Helga Wanglie was an active 85 year old women who had been married to her husband of more than 50 years when she fell and sustained a hip fracture in December, 1989. Over the next two years, Mrs. Wanglie’s health deteriorated as she sustained several admissions to and from hospitals and rehabilitation facilities. During one of these admissions, Mrs. Wanglie suffered from cardiopulmonary arrest and never fully recovered from this incident. From May, 1990 until July 4, 1991 when she died, her husband, Mr. Wanglie acted as her surrogate decision maker since his wife did not have an Advanced Directive. From the time of her cardiac arrest until her death, her physicians stated that Mrs. Wanglie was in a persistent vegetative state and would never recover. The ethical and legal debate that rose from this case revolved around the dispute that came between Mr. Wanglie, who wanted to maintain care, and the Hennepin County Medical Center (HCMC) who wanted to discontinue care.

It is important to note that during the initial five months of care, Mrs. Wanglie was conscious and able to make her wants and needs known. It was not until her cardiac arrest that Mr. Wanglie became her voice. In 1990 the HCMC, after gathering and hearing from the hospital ethics committee, recommended that Mrs. Wanglie stop being aggressively treated. This was based on the fact that Mrs. Wanglie had been receiving aggressive treatment since her first admission, was being sustained on a respirator, was receiving nutritional tube feedings, and was deemed to be in a persistent vegetative state by the hospital examining physicians. Mrs. Wanglie’s age and neurologic status weighed heavily on the minds of her treating physicians who felt that she really had no chance of regaining any meaningful quality of life.
Even with this prognosis, Mr. Wanglie insisted that everything possible be done for his wife. He felt that only God could take her away and that everything should be done to maintain her life. When the HCMC ethics committee first looked at this case they appeared to stall on taking any further action believing that at some point in the near future Mr. Wanglie would recognize the futility of the care that his wife was receiving and that he would consent to withdraw her from the respirator and stop further treatments. During the time of Mrs. Wanglie’s care, there were also conflicting reports from Mr. Wanglie as to what his wife would have wanted done under the circumstances first stating that he did not know her wishes, and then changing his statements expressing that she told him she would want everything done if she were ever in that position.

In early 1991 when it became apparent that neither the hospital nor Mr. Wanglie could reach a compromise, the hospital filed suit with the court to have a conservator appointed to represent Mrs. Wanglie’s medical interests. In its letter to the court the hospital stated “The hospital is seeking appointment of a conservator to represent the patient to decide whether continued treatment is appropriate. It is not directly requesting the court to discontinue treatment immediately over the objections of the family. In seeking court involvement, the hospital and its ethics committee are aware that there has never before been a case in the United States of a hospital seeking a conservator to consider non-treatment when the immediate family has strongly and unanimously objected. The major point of the hospital's current position is that the family cannot demand that physicians continue to give treatment that is not in the patient's best personal medical interest” (Cranford, 1991).
In the end, the hospital system lost and Mr. Wanglie was appointed his wife’s surrogate decision maker which allowed him to make medical decisions on her behalf. One of the interesting things about this case was that the court was not asked to determine whether Mrs. Wanglie should receive continued care, but rather who should be her guardian, her husband who wanted everything done, or the hospital who wanted to discontinue treatment. This case also demonstrates two important themes in end-of-life care: the importance of having an Advanced Directive and the high financial costs associated with long term medical care.

The HCMC system reported that up to the time of Mrs. Wanglie’s death, Medicare and her supplemental insurance company had paid over $800,000 for her care (Cranford, 1991). When we examine the cost of Mrs. Wanglie’s care several concerns come into play. In addition to the expenditures paid by Medicare and her insurance company, how do we justify the expenses paid by the family in both actual dollars and emotional costs? Unlike the Shiavo and Quinlan cases where the family wanted to withdraw treatment, this family wanted to continue to provide extensive medical care even though there was no hope of meaningful recovery. In our country, patient autonomy may be shifted to family autonomy when a person is considered incompetent to act on their own behalf. When the court system granted Mr. Wanglie permission to act as his wife’s guardian, he was given the power to act on her behalf. According to Baily (2011) “refusing to let people do things to you is one thing, but demanding that people do things for you is quite another.”
The physicians and hospital system in this case were forced to treat the patient despite their convictions that their actions were futile, invasive, and costly to the patient, family, and society. How much pressure the physicians were put under by the hospital and Medicare system to stop treatment was never revealed. The staggering financial cost associated with Mrs. Wanglie’s care was covered by all of society, not just her family. Looking at this case from an economic perspective, one can argue that the physicians were advocating for the discontinuation of care based on the appropriate use of medical resources and the expense of utilizing these resources. The physician’s autonomy in decision making and providing continued medical care was brought into question when their recommendation for termination of treatment was refused.

Baily (2011) also makes reference to the importance of trust in the physician when it comes to making these difficult decisions when she states that “ordinary people do not know enough about medicine to be able to assess the meaning of symptoms and determine a treatment plan. Given their vulnerability, they need physicians to be trustworthy agents who can figure out what is wrong, help them understand what can be done about it, and then help them make good decisions given the available options.” In the Wanglie case, we see a tug of war between the decision making power of the patient’s family and that of the physician. One might ask if the physician was making a determination of treatment in this case based on cost or was it based on what they believed was best for the patient. One would hope that the decision would be based on what is best for the patient.
Although the total cost of care for Mrs. Wanglie was mentioned in the legal brief, there was no mention as to whether or not Mr. Wanglie was made aware of the expenses that had been incurred during his wife’s illness, nor was there any mention of how these expenses were paid. Since that was not mentioned, one would assume that it did not play into Mr. Wanglie’s decision to demand continued care. Taking this into consideration, we should consider whether the physician and/or hospital had an ethical duty to discuss the cost of care for Mrs. Wanglie with the family. Presuming that the family was aware of the expenses that were being incurred, and they wanted to continue with extensive medical care, we must consider the medical providers side and reflect on whether they were acting in an ethical manner when they recommend termination of treatment or were they simply attempting to stop the rise in costs associated with this type of care.

When we talk about Medicare and private insurance, we have stated that there is an endpoint to the availability of resources, or money. The question becomes, just because a patient or family wants something, should they be able to have it? Should we provide futile care regardless of the cost? Should society, who supports the Medicare or Medicaid programs through our taxes, be responsible for covering the cost in futile cases? These are questions that are yet to be answered, but it appears that society would not want to put a nail in the door to access to care strictly on the basis of payment. However, in today’s health care market, insurance companies have attempted to do just that with the implementation of requiring people to obtaining prior approval and showing medical necessity before receiving reimbursement for treatment of health related conditions (Baily, 2011).
Conclusion:

Throughout this paper we have examined two important issues related to elder health care at the end of life: patient autonomy in medical decision making and the economic impact of end-of-life care. If our society holds autonomy in such high regard, then why do some question the rights of older individuals and their families who opt for more aggressive care at the end-of-life? If autonomy is associated with power, then why do some want to strip this away from the old, chronically ill, or terminally ill patients? Perhaps it is because some people in society feel that ill, elderly people’s decisions impact their own lives by altering available services or by diminished available funds when the elderly exercise their rights to chose what type of care they want and for how long they want it.

Both health care practitioners and elder law attorneys are frequently put in the position of being advocates for the elderly. In this role it is our duty to provide care for our patients and clients, even within limited financial resources, yet our hands are frequently tied. Patients don’t really understand the limits of medical resources, nor do they really care when they are in need. Yet, under today’s health care economy, many patient procedures are put on hold or denied either due to their request not being found to be a medical necessity, or in some cases because insurance does not provide adequate coverage. But, when one talks about end-of-life care for the elderly, should more weight be placed on “medical necessity” due to increasing cost? Society understands that some treatments for dying patients are palliative, but not
curative. But even some palliative care treatments are costly. Mrs. Wanglie’s case is an example of costly, but futile care.

There are no easy answers to many of these questions, however rationing of health care to elders, especially at end-of-life, has been proposed and the theory is gaining in strength. For the elderly, cost does become a factor in accessing health care. How do we keep costs down, not just for the individual but for society as well? Callahan (2012) recommends that our philosophical time line change. He suggests that we no longer consider how long we can extend life, but rather look at improving our health within a given boundary of time. He contends that “it is the obligation of a good society to help the young to become old, but not to help the old to become indefinitely old.” Given the current fiscal and health care dilemma facing our society, perhaps his contention is correct.
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