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Ethical Considerations in the Treatment of Geriatric Patients

by Hugh Pates, Ph.D.

I have had the opportunity to treat geriatric patients in skilled nursing facilities (SNF) for the past 15 years of my 40-plus career as a practicing clinical psychologist. In the course of my experience, I have encountered ethical dilemmas that have led me to make subtle and significant changes in my practice of therapy with this group of patients.

My goal in writing this article is to highlight some of the common considerations in working with patients in SNFs, and my suggestions for how to address them.

Confidentiality

As any practicing clinician knows, confidentiality is the cornerstone of the therapeutic relationship, and is strictly maintained (with the usual legal limitations) in general clinical practice at all times. The SNF, however, is powered by a team of professionals, all of whom play vital roles in a patient's care. Confidentiality, in such settings, are between the patient (and his or her family) and a team of healthcare professionals, rather than a single therapist.

Before any discussion about confidentiality is broached, I always like to gauge whether the patient has the competence for talk therapy, often with the aid of a Mini Mental Status Exam (MMSE). I then ask the patient to sign a waiver of confidentiality to allow me to communicate with medical personnel associated with the patient's care and "others" as needed. "Others" generally include appropriate family members and/or conservators. Consultations of this nature are necessary in order to improve the medical care of the patient, and to also help family members understand what is going on with their loved one and assuage any fears or doubts they may have.

The most striking difference in keeping records of therapy sessions (in the form of progress notes) when working with patients in SNFs is that any professional involved in their care has access to them. This makes a team approach to a patient's care seamless. Both these practices are clearly different among therapy patients in SNFs than those in a typical, outpatient/community practice.

Suitability for Talk Therapy

Sensory impairment (particularly hearing) or cognitive impairment pose challenges for talk therapy, therefore, an evaluation of a patient's ability to participate in and profit from talk therapy is essential. These challenges tend to be present more frequently among seniors at SNFs.

When I began my work in SNFs, I was concerned about the ethics of working with someone who may not benefit from therapy; as it turned out, I have seen substantial improvements in the quality of life among numerous patients in a skilled and supportive therapeutic milieu.

The initial diagnostic interview is the ideal way to evaluate the manner in which a person is able to articulate their thoughts and goals, and recall personal historical information. This is also a good opportunity to determine the extent of hearing impairment, if any, and the modifications necessary to render talk therapy and appropriate mode of treatment. Additionally, a cognitive screen such as the MMSE is a quick and effective way to assess a patient's basic cognitive skills, attention and orientation, and short term recall and recognition. I have found that an MMSE of 18 (out of a possible 30 points) is the minimum score required to proceed with therapy.

Gift Giving

Gift exchanges, particularly accepting gifts from patients has always remained a gray area in the therapeutic relationship. However, among older patients in SNFs, distributing small gifts can serve to strengthen and enhance therapeutic alliance. Candy (when appropriate), other edibles, or flowers are usually the types of gifts that are appreciated and tend to facilitate swift positive changes in behavior patterns that in turn, can improve mood (e..g, reduced expression of anger, willingness to participate in activities, more cooperation with caregivers).

Touch

Touch, like gift exchanges, fall into that controversial, gray area in general clinical practice. However, physical touch (patting someone on the shoulder, holding a hand, or a hug) among geriatric patients, in both outpatient and inpatient (e..g, SNF) settings can be a powerful way to build the therapeutic relationship. Older adults respond more positively to interventions when they see their therapists as caring and concerned about their well-being, and gentle, caring touch when they are experiencing an emotional moment, or at the conclusion of the session goes a long way in maintaining rapport.

Personal Disclosure

I have consistently found that revealing details from my own life with geriatric patients has a hugely beneficial effect in moving therapy forward. Patients tend to become more energized, alert, and involved when they see therapists as people they can have a connection with; I share tidbits from my own life, such as escapades with my grandchildren or my interest in various athletic activities. I direct my own experiences to those they have had in the past or are currently experiencing, in order to engage them in dialogue about goals for the session at hand.

These are but a few ways in which my ethical practices differ from those pertaining to other populations I see in my practice. They are modified in the manner described in this article to engage a group of patients traditionally not open to therapy, and to enhance the effectiveness of existing, evidence-based interventions. My hope is that science catches up with the practice of therapy with geriatric older patients, a rapidly growing demographic that is underserved and less understood than any other age group of therapy patients.