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Elder Self-Neglect — How Can a Physician Help?

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Mr. L is a 96-year-old widower with critical aortic stenosis and mild cognitive impairment who had become increasingly short of breath and exhausted over the course of several weeks and needed 3 hours to get dressed the day of admission. A concerned neighbor brought him to the hospital. He is not a candidate for aortic valve replacement owing to poor functional status and coexisting conditions, and after several days of gentle diuresis can barely walk across the room. At the request of the primary care physician, his son flies in for a family meeting to discuss discharge options. Mr. L has always insisted on living alone in his apartment.

Asked what is most important to him, Mr. L declares, “I want to leave my apartment feet first. I’m going home.” His son, who visits once a month, is very concerned about his father’s ability to care for himself. He notes that his father’s house is cluttered and contains piles of rotting food and even rat feces. Though Mr. L admits that he has fallen several times and worries about breaking a hip, he insists, “I can take care of myself. I’ve been doing it my whole life.” He rejects the idea of “strangers” coming into his house.

The primary care physician is unsure how to proceed: he wants to respect Mr. L’s choices if they’re informed and he’s mentally competent, but he worries that Mr. L is in serious danger at home and feels obligated to prevent harm. How can the physician respond to these countervailing professional imperatives?

Clinicians often expend considerable effort caring for elders who neglect their own needs and well-being, only to see their careful plans fall through. Home care teams cannot help if they are not allowed in the house. Reimbursement for physician house calls is low. Geriatric care managers, though extremely helpful, bill privately on a fee-for-service basis, not through Medicare or Medicaid, limiting their availability to the very poor. Clinicians are legally required to report patients to adult protective services, but they can be more helpful if they also have the knowledge and skills to aid their patients directly. (Moreover, unlike child protective services, adult protective services agencies have little enforcement power and cannot enter patients’ homes uninvited.)

We propose four practical approaches to the clinical care of self-neglecting patients. First, clinicians can avoid setting too high a threshold for safety. Second, physicians can try to

persuade patients to accept interventions that further their goal of remaining in their homes. Third, physicians can most effectively help patients meet their goal of aging in place by going into their home. Finally, clinicians can work with patients and their caregivers to develop plans for worst-case scenarios.

As many as 1 in 10 older adults self-neglect, and rates are higher among black Americans and the poor.¹ This rate will probably increase as the population ages, because American families have become smaller and more geographically dispersed. U.S. adults 50 to 74 years of age provide the majority of informal caregiving to adults 85 years of age or older, and the ratio between the two groups is decreasing (see graph).² Elder self-neglect has serious consequences, including increased rates of hospitalization, nursing home placement, and mortality.^{3–5}

Although cognitive impairment is common among self-neglecting elders, many such people do not have moderate or severe dementia and so are not considered legally incompetent to make health care decisions. A geropsychologist or geropsychiatrist can help in evaluating legal competency. When a court rules a patient incompetent, the clinical decision is easier: we do not allow patients who clearly cannot make informed decisions for themselves to make dangerous or highly risky choices. But self-neglecting patients with cognitive impairment or mild dementia fall into a gray zone. These patients, such as Mr. L, challenge clinicians because they have some capacity to make decisions but cannot adequately care for themselves. Clinicians feel stuck between competing ethical concerns — respecting their patient's preferences and protecting the patient from harm.

In the United States, we place tremendous value on people's right to make medical and social choices that jeopardize their safety; *Climbing Magazine*, the primary rock-climbing periodical, has an obituary section. Overriding a competent patient's informed choices "for his own good" violates a patient's dignity and autonomy. It is unfair — and raises concerns about ageism — to substantially raise the safety threshold solely on the basis of age. Moreover, safety is not the paramount goal for many elderly people and should not be seen as the sole criterion for decisions about their future. Clinicians might be guided instead by the principles of harm reduction, a concept that aims for incremental gains toward improved health and well-being. For example, Mr. L's apartment does not need to be entirely clear of clutter. Rather, father and son might together create pathways through the piles between the most important areas of the home. Danger to third parties must be considered, however, and if neighbors are at risk from the fire hazard or rodents, then clinicians must notify the fire department or public health authorities.

Clinicians can use persuasion in their conversations with self-neglecting patients to help them meet shared goals — in this case, remaining safely at home. By demonstrating a sincere understanding of Mr. L's goals, and aligning himself with them, the physician can build trust. The physician can say, "I agree that it's really important to keep you in your home. I also understand that you don't like being in the hospital. Let's talk about what we can do so you can get home." By clearly understanding Mr. L's reluctance to accept outside help, the physician can align himself with the patient in favor of remaining at home rather than accepting institutionalization. He might ask, "Can you tell me what concerns you have

about letting someone come into your home to help you?” and, “Is there anything that would make someone coming into your home acceptable to you?”

A home visit by the physician may effectively address the patient’s reluctance to allow strangers into the home. At a home visit, the doctor may be able to leverage his relationship with Mr. L to introduce him to members of a home care team. With Medicare penalties for readmissions, it would be prudent for health care organizations to provide incentives to physicians to make home visits in such cases. The physician might also be able to persuade Mr. L to allow neighbors or perhaps volunteers from a charity organization to help provide needed assistance at home. Adjustments can be made: if Mr. L does not want Meals on Wheels delivery people to enter his home, for example, perhaps they could leave the food outside. Perhaps Mr. L’s son could put a garbage can with scented liners next to the microwave oven, and a neighbor could be enlisted to help empty the garbage weekly.

A final key aspect of the care of neglected elders is creating plans for the worst-case scenarios. The physician might say to Mr. L, “I want to help you prepare in case things don’t go as well as we hope. What if you fell, broke your hip, and needed 24-hour care? How you would want your care to proceed?” Such advance care planning is a natural next step after the immediate care plan has been put in place. If Mr. L’s goal is to remain at home for the rest of his life, even as his condition declines and in spite of the risk of serious harms such as hip fracture, hospice may be an appropriate intervention that aligns with his goal.

Although there is no single answer that applies to all self-neglecting older adults, these approaches may help physicians find the combination of creativity and pragmatism that lies at the heart of good geriatric care.

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Figure.

Oldest Old Support Ratio.

Data are the ratio of the number of adults 50 to 75 years of age to the number 85 years of age or older. Data are from Robine et al.² and the U.S. Census Bureau.