Ethical Standards and Practices in Human Services and Health Care for LGBT Elders

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Abstract

Understanding and working with a population as diverse as LGBT elders is not possible without a grounding in ethics and its application to real-world problems faced by the older adults and their families. Principles of autonomy, beneficence, nonmaleficence, justice, fidelity, and veracity are critical for professionals to understand when confronting dilemmas that LGBT elders face. In this chapter, the authors use a case study to illustrate a real-world example of ethical and moral action. The purpose of this chapter is to provide a grounding in ethical principles and frameworks, as well as discuss pertinent codes of ethics, in order to make the case that an understanding of ethics is essential when dealing with the complex dilemmas that LGBT elders face.

Keywords

Autonomy · Beneficence · Nonmaleficence · Justice · Fidelity · Veracity · Codes of ethics

Overview

Understanding and working with a population as diverse as LGBT elders is not possible without a grounding in ethics and its application to real-world problems faced by the older adults and their families. Principles of autonomy, beneficence, nonmaleficence, justice, fidelity, and veracity are far more easily understood in theory than in application when professionals are confronted with dilemmas that LGBT elders face. Because of their status as a sexual minority, their historic ostracization, their fears related to outing, and vulnerabilities acquired by some as they age, it is imperative to understand and adhere to ethical principles and frameworks embedded in disciplinary codes of ethics. In this chapter, the authors use a case study to illustrate a real-world example of ethical and moral action.

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Learning Objectives

By the end of the chapter, the reader should be able to:

1. Understand basic principles of ethics.
2. Understand how ethics are applied to health and healthcare situations.
3. Understand ethical codes for law, social work, and medicine as they apply to human services and health care for LGBT elders.
4. Identify future areas for the intersection of ethics, human services, and health care for LGBT elders.

Introduction

In order to introduce and frame this section, we will start with an illustrative case, one that actually occurred (with names changed to protect confidentiality). We will refer to it and expand on it throughout the chapter.

> It was an unremarkable day at the office for Ann Fields, researcher, the only notable difference being that her hair had been cut and colored (she liked to say "clipped and dipped"). Having her hair cut always made her feel better, but likely that had more to do with the strong bond that she had forged with her hairdresser, Bill, of over 10 years. The two discussed everything, including her research work on elder abuse. Over the years, she had come to realize, as depicted in the stage play and movie, Steel Magnolias, how much intimate interaction occurred between a hairdresser and a long-time client. She had even mentioned to Bill that the next effort that she would make on raising the visibility of the issue of elder abuse would be to contact the hairstyling association in their state to see what they might be able to add on their website about the topic.
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> On that typical day at work, Bill telephoned her using her office phone (not typical). When he asked for her, he was far less jovial than he was usually. Dr. Fields, this is Bill Smock. I have a gentleman here who wants to speak with you—about possible elder abuse. Can you talk with him? He is sitting here in my chair getting his hair trimmed. Bill had her attention. And of course she had time and of course she would take the call.
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> The man explained that he thought that his mother was being exploited by his nephew, a young man who had just never been able to hold a job. The man explained that his mother would become really agitated when the nephew's name was mentioned, particularly if asked about the increasingly frequent loans that she had made to him. The man confessed that he did not want to put his nephew in jail, but that talking directly with him (and his mother) had only emboldened the nephew. And he mentioned that his mother was more than a little confused, confined to her home, and more and more relied on her wheelchair rather than her walker. And there was one more thing to add about his mother—she had come out ten years ago to the family. Really and all along, she was a lesbian.
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> Ann Fields sighed. The information seemed like a case study that she might write for her students someday, but the wrinkle was that she was not a direct services provider and that her dear friend Bill was intervening immediately and on his client's behalf. At the end of the conversation, she recommended that the man call Adult Protective Services (APS), and she provided the number for him. Then, she called an APS worker who was also a friend, and told him to be on the lookout for the report. She hoped that she had done the right things, and she also hoped that the right things would be done, whatever they turned out to be. Contextual factors would make this a more complicated case than some. And, Ann also knew that, due to confidentiality, she would not know anything more about the report.

The case above is emblematic of the very real and urgent importance of ethical and moral action. A number of these issues are at work in the case illustration above. The son's ethical and legal duty was to report the suspicion (his state was an "any person" state), and his ethical responsibility was to protect his mother from being harmed. At the point he made the call to Ann Fields, it was her moral responsibility to assist a fellow human being seeking help, and her relationship to Bill had often been one she characterized as being one of a brother and sister. At the point the son reported the suspicion to APS (if he in fact did), other ethical codes also

would come into play—those most typically of the professions of social work, law, and medicine, all of which will be discussed below. The purpose of this chapter is to provide the reader with a grounding in ethics and ethical principles and framework in order to make the case that an understanding of ethics is essential when dealing with LGBT elders. We first anchor this chapter on ethics by providing the reader with a basic understanding of ethics and its importance. Then, we discuss how human services codes of ethics and those of law and medicine both complement and confound helping LGBT elders.

What Is Ethics?

> What ought to be in a given circumstance (s).

The Oxford English Dictionary (1996) provides a simple definition of ethics as a system of moral principles or values that govern or provide rules of conduct. Ethics is the sphere within the discipline of philosophy that explores morals, values, and virtues of human conduct, not as they are but as they ought to be (Pozgar 2012). Ethics are universal principles that provide a basis to guide, regulate, prescribe, or understand behavior on both micro- (individual) and macro- (group, culture) levels. However, ethics is not law, and so does not carry legal force, and is not binding. (Darr 2011). These principles aid in making distinctions between good versus bad, right versus wrong, and in determining what may be considered acceptable or unacceptable, or what ought to be in a given circumstance. Ethics is more than feelings, or what is legal, moral, religious, socially normative, or acceptable by society. Ethics often find representation in theories and principles, some of which are presented in brief below.

Ethical Theories. There are a variety of theories that provide a range of ethical perspectives. Often they detail parameters for actions that are considered ethical and provide a premise for doing so. For instance, normative ethics focuses on moral standards of human behavior—that which is good and right (Summers 2009), communicative ethics focuses on the importance of negotiation and communication in ethical conflict resolution (Moody 1992), utilitarian theories emphasize the greater good for all, consequential theories, on the other hand, focus on outcomes and context (situational ethics), while ethical relativism considers the impact of different cultures on notions of what is morally right or wrong (Pozgar 2012).

Ethical principles. Ethics can also be looked at in terms of principles distilled from various theories to help inform and guide ethical conduct and behavior. Principlism, as an ethical framework, provides a universal set of principles or rules of conduct most commonly recognized in general discourses of ethics, namely beneficence, nonmaleficence, justice, and autonomy (Beauchamp and Childress 2012). Simply put, *beneficence* exhorts us to do good to others, *nonmaleficence* urges against doing harm to others, and while *justice* reminds us of the importance of fairness in distributive justice, *respect for autonomy* focuses on self-determination and requires us to recognize and acknowledge the right of individuals (and groups) to make their own choices and decisions (Pozgar 2012; Beauchamp and Childress 2012) (see Table 34.1).

These principles have been applied to the field of aging, although some have voiced reservations about issues of interpretation and application (Moody 1992; Polivka and Moody 2001). Holstein and Mitzen (2001) and Holstein et al. (2011) argue that principlism fails to consider the heterogeneity of older adults, while others have argued that strict or rigid applications of these principles may result in undesirable results. For example, an overemphasis on nonmaleficence may lead to paternalism, thereby limiting freedom of action for competent older adults, and upholding autonomy may detract from recognizing the importance and responsibilities of membership in social and collective networks (Polivka and Moody 2001; Holstein and Mitzen 2001; Holstein et al. 2011). Thus, these perceived limitations of using principlism, including the emphasis on individuals to the detriment of community, neglect or nonconsideration of factors such as context, circumstance, and agents to which it is applied, and its

Table 34.1 Ethical theories, proponents, and premises

Theory/approach	Proponent(s)	Premise	Focus
Utilitarianism	Jeremy Bentham, John Stuart Mill	Ethical actions provide the greatest balance of good than evil	Utility and consequences
Rights approach	Immanuel Kant	Ethical actions protect individual dignity and freedom of choice	Self-determination; individual rights
Deontology	Kant, Descartes, Calvinists	Ethical actions comply with divine command	Duty and right by God's law
Fairness and justice approach	Aristotle	Ethical actions are fair and equal for all	Consistency; equal distribution of benefits and burdens
Common good approach	Plato, Aristotle, Cicero, John Rawls	Ethical actions serve the common good	Interconnectedness of individual and communal good
Virtue ethics	Aristotle, Thomas Aquinas	Ethical actions are virtuous	Virtuousness (e.g., prudence, compassion, integrity, honesty, courage)

tendency to view relationships as adversarial because of its origins in law and philosophy, have led to the exploration and development of alternative frameworks more suited to addressing aging (Hofland 2001). These frameworks are presented below; what they share in common is the focus placed on the perspectives of agents, subjects, and context in the consideration of ethics (see Table 34.2).

In addition to the creation of alternative frameworks, other avenues have been explored for a more meaningful interpretation and application of ethics in aging. For instance, other principles, such as honesty, integrity, compassion, caring, and privacy, are of particular resonance when dealing with older adults and can be used as tools to guide ethical action and decision-making. Finally, principlism still has relevance, in as much as the principles of beneficence, nonmaleficence, justice, and autonomy are evaluated, interpreted, and applied with due consideration for how well they can be manipulated or adapted to address aging issues meaningfully. For instance, a consideration of what constitutes ethical standards and practices relating to LGBT elders must consider their personal and group history and experience as it relates to sexual orientation and/or gender identity, and the implications for the provision of care and other services.

Table 34.2 Ethical frameworks

Framework	Premise	Focus
Phenomenology	Ethics should consider shared experience, understanding, and meaning	Perspectives of participants themselves
Hermeneutics	Ethics should respect diversity of experiences and relativity of ethical situations	Meaning and validation
Narrative ethics	Ethics should consider more facts of the case	Experience, dimensions of meaning as well as facts
Virtue ethics	Virtuous character leads to ethical acts	Moral character, not actions performed
Ethics of care	Caring for others as human activity, based on action and practice, not rules	Care that is attentive, responsible, competent, and responsiveness

Sources Hofland (2001), Tronto (1993)

Why Ethics Is Important for Working with LGBT Elders

Understanding ethics as applied to elders, particularly the LGBT elder population, is important for a number of reasons (i.e., decision-making, habilitation, resource allocation, dementia, end of life), which are discussed below. Older LGBT adults represent a special population highly deserving of ethical considerations and treatment. The aging population, of which LGBT elders are a part, presents unique and confounding ethical challenges for healthcare and human services professionals. The complexities of an aging society include ethical considerations heretofore historically unheard of as recently as the 1900s when the average US life expectancy was age 47, to today, when it is 76 (World Health Organization 2014). Several domains pertinent to aging LGBT individuals warrant ethical attention.

Decision-Making. Competent elders are often capable of making decisions for themselves, even until the end of their lives. However, their ability to make decisions for themselves can become compromised due to such reasons as medication interactions, chronic illness, dementia, general weakness, or all of the previous reasons in combination. Also, because of vulnerabilities that some elders experience at the end of their lives, they may be the focus of unhealthy dependencies by their care providers (formal or informal) and so may become the unwitting victims of undue influence (Nerenberg 2000) when making decisions.

For elders who are competent and who wish to authorize another individual to make decisions for their health care, finances, or both, a power of attorney (POA) document must be executed, while the older adult still has the capacity to make decisions (see Chap. 22). Such a document executed under undue influence or when an older adult no longer possesses the capacity to make decisions is not a legally executed or binding document. In addition, should an older adult fail to appoint a surrogate or become incompetent without executing a POA, many states have a statutorily established order of surrogacy, which usually begins with the spouse of the elder, followed by a son or daughter and continuing to next of kin. This designation can be particularly problematic for older LGBT persons, since the law in many states does not recognize the marital status of a same-sex partner. Due to divided acceptance of an elder coming out, some family members are estranged and so may be very poor surrogates for the incapacitated elder. Also, the isolation that some older LGBT persons experience may make surrogate decision-making even more challenging, because his or her wishes for health care and service acceptance may not be discernable or followed. This situation would be particularly difficult should an LGBT elder require that a guardianship be initiated due to his or her incapacity (Teaster et al. 2010).

The emphasis on autonomy to the exclusion of other ethical principles (Holstein and Mitzen 2001; Holstein et al. 2011) is one not as deeply held in other countries (and actually, not by all older adults) as it is in the USA. Some countries have far different approaches toward treating persons who are dying or persons who are suffering from a terminal illness. For example, Moody (2001) describes the conundrum faced when a US-based and indoctrinated medical team faces the wishes of an Asian family concerning the issue of veracity. The US team wants to tell the old Asian mother that she has terminal cancer, but the family members, acting within the value system of their culture, want to withhold this information.

Habilitation. Unlike the majority of their younger counterparts, older adults live in both community and facility settings, and many will live in both at some point in their lives (Congressional Budget Office 2013). The meaning of place and where an elder identifies his or her home reflects important ethical concepts of belonging, respect for persons, autonomy, and justice (Beauchamp and Childress 2012; Holstein and Mitzen 2001). For many adults, the home in which they intended to live for the remainder of their days may become inappropriate for them: Upkeep or house payments may become too expensive, the neighborhood is no longer safe,

the elder is no longer able to traverse stairs, and little accommodation is possible, or the elder experiences dementia and cannot attend to activities of daily living or instrumental activities of daily living. Making decisions concerning one's habilitation is life-altering and may be irreversible, a situation different from when they were a younger adult.

One of the most wrenching decisions that many families face is whether or not to have an elder leave his or her home and move to either an assisted-living facility (if resources allow it) or a nursing home (synonymous with death for some elders) (Kane and Caplan 1990; Powers 2003). Bed availability and quality of care are ongoing concerns for care provision in nursing homes (see, generally, Web sites for the Centers for Medicare and Medicaid Services and National Consumer Voice for Quality Long-Term Care). For LGBT elders, there is an added concern, which is that of being outed in a care environment that may be inhospitable to him or her. Some facilities have staff members who are vicious and abusive, and some such facilities, which may provide excellent and loving care, may be the only one available within a huge radius, as is often the case in rural areas. Here, ethical dilemmas revolve around limiting freedoms to protect and preserve safety. This aspiration may not be realized if the care environment does not welcome LGBT elders (see Chaps. 16, 17, 25, and 28).

Resource Allocation. Resource allocation is yet another arena in which ethics informs how healthcare providers and service professionals treat the needs of LGBT elders. Even though approximately 20 % of the population will be composed of older adults, policy tends to lag both scholarship and demographic realities. In addition, uncomfortable questions arise as to deservingness. Whose interests have primacy? Young children? Adolescents? Young or old LGBT persons? Gay or straight? The allocation of resources is usually not so blatantly black or white. More often than not, simmering below the surface are issues of who gets what, when, and where. When resources are scarce, these issues become even more heated. Guns or butter, or in another interpretation, guns or canes, is a frequently debated issue, particularly at the national level. Ethical issues of justice (Callahan 1995; Moody 1992; Rawls 2009) come to bear when resources are allocated. As an example, a goal of the 2010 Affordable Care Act has been to widen healthcare coverage for persons who have heretofore been unable to access it. Questions concerning the fairness of compelling persons to purchase health care, despite hardship, strike at the bedrock principle of autonomy, one fiercely guarded in the USA.

In addition to this, the allocation of healthcare resources is the developing conundrum concerning access to technology (Lesnoff-Caravaglia 1999). Perhaps nowhere in the USA is the digital divide more keenly felt than that which divides generations coupled with those who are well off and those who are not. As an illustration, LGBT elders with the ability to teleconnect via some form of computer (e.g., laptop, mobile phone, iPad) with others are thus able to reduce isolation and its effect on health and well-being. Elders who are able to live in homes that are becoming increasingly "smart" may be able to reduce injuries at rates far higher than their poorer and older counterparts. Also, elders with means are able to afford better assistive devices such as canes, walkers, mobile scooters, and the like far more easily than elders who have limited means to acquire them.

Dementia. Also, unlike their younger counterparts, older adults, who are disproportionately affected by the problem, may develop a type of dementia (Binstock et al. 1992; Post 2000; Purlita and ten Have 2004). About 4–5 million people in the USA have some degree of dementia at any given time, a number expected to increase over the next few decades due to the aging of the population. Dementia affects about 1 % of people aged 60–64 years and 30–50 % of people older than 85 years. Dementia is the leading reason for placing elderly people in institutions such as nursing homes. Dementia is a serious condition that results in significant financial and human costs (Alzheimer's Association 2014). Dementias are not all alike. In the USA, 50,000–60,000 new cases of Parkinson's disease (PD) are

diagnosed each year, adding to the one million people who currently have PD (National Parkinson Foundation, n.d.), while an estimated 5.2 million Americans of all ages had Alzheimer's disease in 2014, including an estimated 5 million people aged 65 and older and approximately 200,000 individuals under the age of 65 (Alzheimer's Association 2014).

Regardless of type, cures do not yet exist, and the march of such chronic diseases is relentless. When persons become deeply forgetful (Post 2000), it is all the more important to provide respectful care to such afflicted individuals who may be unable to remember that they are lesbian or for that matter, their very name. It is in these particular positions of vulnerability that afflicted LGBT elders must be treated with dignity and respect for personhood, though many former vestiges may become unrecognizable.

End of Life. Finally, considerations of what is ethical come to bear at the terminus of a long life. This is not to say that end-of-life issues do not affect younger populations, but living to an old age involves the certainty that older adults are nearing the end of their lives, a time when the complexities that append to living a long life intersect (Ellingston and Fuller 2001; Gaventa and Coulter 2005). End of life can involve addressing real pain encountered through chronic illness and that encountered as a consequence of living. Personal pain can be acute when families and friends fail to accept the needs and wishes of an LGBT elder. Ideally, end-of-life circumstances allow for the resolution of a life that is coming to an end, one that requires special attention and care if the dying elder is LGBT. It may be very important to the elder that, despite years of friction, family conflict is confronted and resolved. Issues of religiosity and spirituality are also highly important at this time in life (see Chap. 29).

The ethical issues presented above that are germane to an aging LGBT population are not exhaustive of those that may arise. They are, however, illustrative of why an understanding of ethics is critical when healthcare and service professionals confront conundrums of aging LGBT persons. The following section explores the application of ethical principles and approaches to specific issues that such professionals encounter as well as offers suggestions for ways to approach ethical dilemmas.

Application of Ethics

Ethics can be applied in a variety of ways. Ethics can be used as rules of conduct "moral code" for individual behavior, as well as for groups such as those adopted as professional codes of ethics, as a means to determine rights, duties, and responsibilities to others as well as to inform decision-making (Pozgar 2012). Applying ethics to LGBT elders requires considering not only what rights accrue to LGBT older adults, but also what duties and responsibilities are incumbent on health and social services providers in order to effectively care and serve this population. It is also important to consider what ethical considerations need to inform optimal decision-making and how current ethical principles can be interpreted to reflect LGBT elders' reality.

Interpreting ethical principles through the LGBT perspective can help develop an ethical framework or "moral map" for caring for LGBT elders and the unique ethical dilemmas that may arise. Such applications must at the very least affirm LGBT elders, address prejudice, recognize inequalities and vulnerability, and be flexible.

One alternate framework, whose precepts provide a good starting point for application of ethics to LGBT elders, is Joan Tronto's *Ethic of Care* (1993). Care is defined as "activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which seek to interweave in a complex, life-sustaining web" (Fisher and Tronto 1990, p. 40, as cited in Tronto 1993, p. 61). According to Tronto, how we "care" for others is a human activity, and because it is an action and practice, rather than a set of rules, which is based upon a flexible standard, what constitutes good and thus ethical care reflects "the way of life, the set of

values and conditions, of the people engaged in the caring practice" (Tronto 1993, p. 61). Also, four phases of care and the correlating ethical principle have been recognized:

Phase 1: Caring about—*Attentiveness* as the ethical quality (dimension) of being able to perceive the needs of others and one self.

Phase 2: Caring for—assuming the *Responsibility* for responding to the identified need for care.

Phase 3: Caregiving—ethical requirement of *Competence* in performing the functions of care.

Phase 4: Care receiving—relates to the *Responsiveness* of recipients of care, to care received, and the ability of care to meet/address identified needs.

Applying the ethics of care to LGBT elders requires health and social services providers to become knowledgeable about the unique needs and challenges these elders face, as a necessary foundation in order to properly discern the needs to be addressed, as well as to determine the scope of responsibility. It requires competence not only with regard to the nature of work performed, but also cultural competence in issues affecting sexual orientation, gender identity, and how these may interact with aging to determine unique needs and inform appropriate interventions. Additionally, by considering the response of LGBT elders, the application of the ethics of care places the LGBT elder in the epicenter of decision-making and action, ensuring a voice in the issues that affect them, such as the efficacy of services received.

Another way to promote the application of ethical standards and practices with LGBT elders is to embed appropriate ethical principles and values in the professional codes of conduct for the different disciplines that work with LGBT elders. These codes are important because they prescribe agreed-upon standards and expectations of conduct, as well as consequences for breach, if that occurs (Pozgar 2012; Resnik 2011). Professional codes of ethics protect both providers and LGBT elders by promoting responsibility, accountability, and professionalism in service delivery. They can provide a method, lens, or perspective to guide decision-making, problem identification, and solution, as well as promote the social and moral values that they consider important (Resnik 2011). It is critical, therefore, that these codes clearly include ethical principles germane to working with LGBT elders.

Codes of Ethics

In order to provide guidance for elevating members' behavior and to instill confidence (both within and outside the organization), various disciplines as well as government and professional organizations have developed and subsequently adopted codes of ethics that guide the conduct of professional behavior (Plant 2001). Most codes of ethics, also called codes of conduct, explicate an organization's values, mission, and vision. Additionally and typically grounded in the ethical principles and frameworks delineated earlier in this chapter, an organization's code of ethics provides direction to its members on appropriate standards of conduct, including how to adhere to them (Adams et al. 2001). Most mature professions have developed codes of ethics or conduct (e.g., social work, law, medicine, gerontology). Such guidance is critical for the complex situations that can arise when working with older members of a sexual minority. Below, we return to our case study earlier and discuss codes of ethics for social work, law, medicine, and gerontology, highlighting how they might guide members' treatment of LGBT elders.

> The man who sat in the chair of the beauty salon did, in fact, make a report to Adult Protective Services. The report was logged in the state system, and an APS worker was assigned to investigate the case. The APS worker had a Master's of Social Work and belonged to the National Association for Social Work.

Code of Ethics for Social Work. According to the preamble of the Code of Ethics for Social

Work, promulgated by the National Association of Social Work (NASW) (2008),

> The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

The preamble of the code stresses that the profession should promote social justice and social change with and on behalf of clients whom they serve. The code stipulates that the term "clients" is used inclusively and refers to "individuals, families, groups, organizations, and communities" and that "social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice." Core values of the NASW include service, social justice, dignity and worth of persons, importance of human relationships, integrity, and competence.

Most pertinent to clients who are LGBT is Section 1 of the code, "Social Workers' Ethical Responsibilities to Clients." Subsections within Section 1 include social workers' commitment to clients, respect for clients' self-determination, informed consent, professional competence, cultural competence and social diversity, conflict of interests, privacy and confidentiality, access to records, sexual relationships, physical contact, sexual harassment, derogatory language, payment for services, clients who lack decision-making capacity, and interruption and termination of services. Particularly salient for social workers who are addressing the needs of older LGBT clients is the guidance that the code provides on self-determination and cultural competency, which defer to the ethical principles of autonomy, nonmaleficence, and justice. According to the Section 1.02 on self-determination,

> Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

Goals for LGBT elders may be to remain in the home as long as possible, to direct their own health care, or to discontinue life support in the event that medical treatment is deemed futile. An elderly LGBT person's self-determination may have to be limited, for example, if the older adult were determined to be self-neglecting (see Chap. 16).

Also highly important for working with older LGBT clients is Section 1.05, i.e., Cultural Competence and Social Diversity. The section directs social workers to "understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures." Further, "social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability."

Section 1.05 includes the strongest admonition of the code to respect and understand the particular needs and situations of older LGBT clients, tenets that reflect the ethical principles of beneficence and nonmaleficence, as well as the ethics of care discussed earlier. It is notable that the code was revised in 2008 to specifically mention sex, sexual orientation, gender identify, and expression (NASW).

> Upon investigation of the report to APS, the social worker assigned to the case substantiated it for physical abuse and financial exploitation by the nephew. It had not taken the older woman long to admit that her nephew had been threatening to out her in the intimate assisted living facility in which she was currently living. The woman was adamant that she wanted the exploitation to end (she never quite admitted that the bruises on her arms were the result of his striking her) but that she did not want her nephew to go to jail. But the social worker knew that exploiting an elder was a crime

as was physical abuse. She referred the case to the local commonwealth's attorney.

Code of Ethics for Law. The American Bar Association's (ABA) rules of professional conduct for members of the legal profession are codified in Model Rules of Professional Conduct, adopted by the ABA House of Delegates in 1983. Commonly known as Model Rules, this code has nationwide application and has been modified and adopted by most states as the format for state-level disciplinary codes or rules of professional conduct, with the exception of the state of California (ABA 1983). The nature and extent of a lawyer's professional responsibility are delineated in the preamble and scope of the Model Rules of Professional Conduct. The preamble emphasizes that the Model Rules provide a framework to guide practitioners in the ethical practice of the law and a basis for disciplinary action against those who fail to comply with the prohibitions and obligations imposed.

According to Sections 1 and 2 of the preamble, a lawyer has multiple responsibilities—"as a member of the legal profession, is a representative of clients, an officer of the legal system and a public citizen having special responsibility for the quality of justice." It also spells out clearly, the various capacities in and through which the lawyer acts a representative of his/her client(s):

> [2] As a representative of clients, a lawyer performs various functions. As advisor, a lawyer provides a client with an informed understanding of the client's legal rights and obligations and explains their practical implications. As advocate, a lawyer zealously asserts the client's position under the rules of the adversary system. As negotiator, a lawyer seeks a result advantageous to the client but consistent with requirements of honest dealings with others. As an evaluator, a lawyer acts by examining a client's legal affairs and reporting about them to the client or to others.

Thus, a lawyer's functions and roles include advising, advocacy, negotiation, evaluation, and reporting as clients' needs and circumstances dictate. In addition, the preamble indicates that a lawyer may serve as "third-party neutral" in dispute resolutions without a representational role to parties involved. Section 4 requires that lawyers perform these functions with competence, promptness, and diligence. These roles and performance requirements are pertinent and useful considerations when dealing with allegations or reports of elder mistreatment (see earlier discussions in Chap. 16).

ABA core values for professional conduct address client–lawyer relationships, the roles of lawyers as counselor/advisor and advocate, as well as transactions with nonclients. For instance, Rules 1.1, 1.3, and 1.6 and Rule address values of competence, diligence, and confidentiality, respectively, in client–lawyer relationships:

> Rule 1.1 Competence: A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.
>
> Rule 1.3 Diligence: A lawyer shall act with reasonable diligence and promptness in representing a client.

As stated earlier, these values are pertinent when dealing with LGBT elder clients. Competence requires that a lawyer be culturally competent in LGBT issues, including knowledge and awareness of the history of prejudice and stigma, attitudes of clients themselves as well as others to issues of sexual orientation or gender identity, and how these impact the experience of clients or issues at stake. Also, the potential to reduce or ameliorate harm suffered by LGBT elder clients through prompt and timely action is anchored on the capacity to act with diligence and recognition of the need and benefits from doing so.

Because of the history of prejudice and stigma that LGBT people endure as a result of sexual orientation and/or gender identity, the value placed on confidentiality of information in client–lawyer relationships is critical. Subject to exceptions in subsection (b), such as the protection from harm or death, and commission of crimes or fraud, Rule 1.6 (a) provides that,

> A lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or the disclosure is permitted by paragraph (b).

Further, subsection (c), which requires that

> A lawyer shall make reasonable efforts to prevent the inadvertent or unauthorized disclosure of, or unauthorized access to, information relating to the representation of a client.

is also germane to protecting LGBT privacy interests, especially in light of the fears of persecution, discrimination, backlash, and other undesirable consequences following disclosure of sexual orientation or gender identity often harbored by LGBT elders. For instance, research indicating that such fears are significant contributors to nondisclosure of LGBT status in health care encounters (Durso and Meyer 2012; Fredriksen-Goldsen et al. 2011).

The value of communication also addressed in Model Rules is important because it works in tandem with confidentiality and informed consent, both of which are tied to the ethical principle of *autonomy*. Appropriate, timely, honest, open, and clear communication is necessary in order to serve LGBT elder clients because it facilitates decision-making and enhances trust and understanding in the client–lawyer relationship.

Model Rules also provide guidance for dealing with clients with diminished capacity, which may be relevant in some cases involving LGBT elders with increased levels of vulnerability due for instance to cognition, or other circumstance. Rule 1.14 states,

> (a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.
> (b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.

The goal of protection can be linked to the ethical principle of *nonmaleficence* (i.e., do no harm). This section also provides that a lawyer may disclose or reveal information about the client whether it is necessary to protect the client's interests. This is potentially a useful safeguard that may be necessary in effecting communication with and informed action by other stakeholders or professionals such as social workers, healthcare providers, and/or criminal justice system on behalf of the client.

Model Rules also provide guidance in terms of the roles that a lawyer might play in relation to an LGBT elder client and how to execute these ethically. These roles help shape goals of behavior when working with LGBT elders on issues, such as elder mistreatment. As advisor, in Rule 2.1, lawyers are required to "exercise independent professional judgment and render candid advice" and to consider beyond the law, "other considerations such as moral, economic, social and political factors that may be relevant to the client's situation." Again, this is pertinent when dealing with LGBT elders because their sexual identity and/or gender identity reflect and impact moral, social, and political realities of the day with implications for both these LGBT elders and society in general. Counselor and advocate are two other roles addressed in Model Rules. The conduct of either role can bear on the ethical principle of *autonomy and respect for persons*, because they require considerations of the rights to self-determination of LGBT elders, to make choices and decisions. They also reflect the duty of truth-telling and fidelity to clients (Darr 2011). As counselor, emphasis is placed on the ethical responsibility to obtain informed consent and to protect client's interests (Rule 2.3/4). In the role of advocate (Rule 3), lawyers are required to exhibit the values of candor, fairness, and truthfulness and to act in good faith in the interests of the client. In order to do so effectively, again the importance of LGBT cultural competence (sensitivity, knowledge, and awareness) cannot be overstated.

Finally, the Model Rules also recognize a duty of lawyers for public service, such as through provision of *pro bono* services to those of limited

means. This reflects the ethical principle of beneficence (do good) as well as *justice* (fairness). According to Rule 6, lawyers should provide services—at free or reduced rates "to persons of limited means" (6.2); or "to individuals, groups or organizations seeking to secure or protect civil rights, civil liberties or public rights… where the payment of standard legal fees would significantly deplete the organization's economic resources or would be otherwise inappropriate" (6.1). Because the life experiences of LGBT elders often reflect a curtailment of their rights and result in socioeconomic disparities in later life, the provisions of Rule 6 are of particular salience to this population, by assuring extending access to legal representation, regardless of financial wherewithal to do so.

Although the Model Rules of Professional Conduct do not specifically mention issues of sexual orientation or gender identity, the espoused core values lend themselves to the ethical treatment of LGBT elders by detailing acceptable behaviors in client–lawyer relationships, as well as expectations and responsibilities to act as advisor/counselor and advocate in service to all clients. Appropriate service in these roles requires at the very least a willingness to understand the challenges facing LGBT elders, LGBT cultural competence, and collaboration with other caregivers, stakeholders, or professions as necessary to assure the interests of LGBT elder clients.

> The local commonwealth's attorney reviewed the report in front of him, as well as the notes he had made during his conversation with the social worker. Cognizant of his ethical role as counsellor and advocate, he wanted to be sure that he left no stone unturned in dealing with the matter. However, from past experience and anecdotal conversations with other colleagues, he knew that he would need more information before he could determine how to proceed, for example what extra issues did the question of sexual orientation create, which should be considered, and how to establish evidence of the physical abuse alleged. He recalled a recent article written by a physician about the forensics of physical abuse and mental health concerns in vulnerable adults. He wondered if there was any benefit to speaking to a health care provider as he prepared to work on this case.

Code of Ethics for Medicine. The American Medical Association's (AMA) Code of Medical Ethics provides nine ethical statements that constitute the professional code of ethics for physicians. The first professional code of ethics for physicians was adopted at the inception of the AMA in 1847 (Darr 2011). Since then, it has undergone a number of revisions as recently as 2001 (AMA 2015). According to its preamble, this code that sets the standards of honorable conduct or behavior for physicians was designed primarily for the protection of patients and requires that

> As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self.

A review of the nine ethical statements that make up the Code of Medical Ethics (the Code) reveals the following core values—competence, compassion, respect for human dignity and rights, honesty, confidentiality, respect for the law, professionalism, and duty to patients and wider community. Of particular relevance here, Principle I requires that—

> A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

The requirement of competence and compassion in providing care touches on the ethical principal of respect for persons and autonomy. Competence also requires that the physician seeks knowledge and resources necessary to support the provision of compassionate and appropriate care to LGBT elders. In addition, Principle IV emphasizes the importance of respect for patient rights, thus ensuring the protection of privacy and confidentiality—important considerations when dealing with LGBT elders as stated earlier. The ethical responsibility to seek LGBT cultural competence finds support in Principle V, which states that—

> A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and

> the public, obtain consultation, and use the talents of other health professionals when indicated.

As stated earlier (see Chap. 20), provider awareness and sensitivity improves disclosure in health encounters and enhances outcomes (Lambda Legal 2010; Durso and Meyer 2012; The Joint Commission 2011). Compliance with Principle V also encourages collaboration with other service and care providers, or working in multidisciplinary teams, which augur well for care. The code recognizes the physician responsibility to improve community and public health (Principle VII). This responsibility to "do good" in a broader level can serve as the impetus for encouraging more rigorous participation of physicians in efforts to identify and address elder mistreatment generally and within the LGBT community.

Finally, Principles VIII and IX contain the following provisions:

> VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
> IX. A physician shall support access to medical care for all people.

Taken together, these principles have ramifications for physician behavior in the care of LGBT elders. It requires that the well-being of LGBT elder patients be the key consideration in healthcare encounters. To ensure this, the needs and challenges faced by LGBT elders and barriers to quality care, including access to care, must be addressed. It requires recognition of the moral or ethical context of care, for instance the need to balance autonomy with protection, or beneficence with nonmaleficence; the understanding that care requires a holistic approach that combines medical and social factors and thus, the value in seeking out those outside the medical community who are in positions to provide insight and assistance.

> The doctor to whom the case was referred was helping a gerontologist at the university in town (Dr. Ann Fields, a Fellow of the Gerontological Society of America) conduct a National Institute of Justice funded study on testing theories and outcomes of elder abuse. He had agreed to put out some flyers describing the study in his office and to mention it to patients for whom he thought and understood that the study was appropriate. He passed the information on to his recovering patient. He always liked helping with the research endeavor though his clinical practice took nearly all the time and focus he had.

Code of Ethics for the Gerontological Society of America. A Code of Ethics for members of the Gerontological Society of America (GSA) was developed by members of the Research, Education, and Practice Committee and approved by GSA Council 2002. Its stated purpose is to guide "professional behavior for the members of the Gerontological Society of America," who are directed to conduct themselves in a manner consistent with the statements set out in the Code (GSA 2002). The intention of the Code is to "promote discussion and provide general guidelines for ethically responsible decisions" (GSA 2002). The statement applies, but is not limited, to members' relationships with "research subjects, colleagues, students, employees and society at large as we carry out our aging related work" (GSA). Pertinent to the research alluded to above is the following set of statements.

> To those we study we owe disclosure of our research goals, methods, and sponsorship. The participation of people in our research activities shall only be on a voluntary basis and only on research projects approved by an appropriate institutional review board. We shall provide a means through our research activities and in subsequent publications and reports to maintain the confidentiality of those we study. The people we study and their proxies must be made aware of the likely limits of confidentiality and must not be promised a greater degree of confidentiality than can be realistically expected under current legal circumstances in our respective nations. We shall, within the limits of our knowledge, disclose any significant risks or limits of possible benefits to those we study.

Other statements from GSA's code direct members to respect the dignity, integrity, and worth of individuals, families, and communities touched by members' activities, which would include LGBT elders involved in the research endeavor and concepts addressing the ethical principles of autonomy, beneficence, and fidelity. Additional topics addressed under the code are appropriate treatment of colleagues and factual

reporting of research findings (reflects the principle of veracity), nondiscriminatory access to education, accurate and timely reporting of qualifications, and adherence to the responsibility of communicating and advancing and communicating an understanding of human aging to the society at large (GSA 2002).

Included in the codes for the professions described above, although not explicitly stated but certainly implied, is how professionals should treat LGBT elders. Such treatment can involve juggling the values of many professions, which can even be conflicting at times. Another persistent conflict mentioned above arises about the professions' primacy placed on autonomy, one that can be at loggerheads with the directive to do no harm or to simply do good. A thorough understanding of ethical frameworks and principles is essential to resolve such challenging dilemmas.

Summary

Any understanding of a group as diverse as are LGBT elders is bereft without a thorough understanding of ethics and its application to real-world problems. Values of autonomy, beneficence, nonmaleficence, justice, fidelity, and veracity are far more easily understood in principle than in application when confronted with the complex dilemmas faced when trying to assist LGBT elders. Due to their status as a sexual minority, their historic ostracization, their fears related to outing, and vulnerabilities acquired by some as they age, it is imperative that professionals of all stripes have a grounding in ethics and adhere to the code of ethics promulgated by their profession.

Policy Box

You have been selected to serve on the Mayoral Council for Sustainability (Sustainability Council) in your city. This is part of a broader mandate to create a sustainable and livable community for all persons. As a member of the subcommittee on health, you recently attended a health conference organized by the local Rainbow Alliance for aging LGBT. You have been working as an advocate and would like to see a more open and inclusive policy in the local health department, to help promote the delivery of quality services to all persons in the community. As a result of what you learned at the conference, you would like the policy to specifically include the growing population of LGBT elders in your community. You have decided that a good starting point would be to create a code of ethics for the local health department.

Questions

(a) How would you go about this project?
(b) What factors should you consider and what ethical principles might be relevant?
(c) Who should be involved?
(d) Create a draft policy for consideration by the subcommittee on health and leadership of the local health department.

Learning Activities (Both)

Self-Check Questions

1. What are ethical issues particular to older adults? How does being an LGBT elder increase the complexity of the issues?
2. Explain the ethical principles of autonomy, beneficence, nonmaleficence, and justice. Provide an example of when one principle contradicts another.
3. What is Tronto's ethic of care?
4. What are components of the ethical codes described above that are similar in each? Different?
5. Why is understanding ethics important for healthcare and social services professionals?

Experiential Exercises

1. Identify a social worker and discuss with him or her an experience in which he or she worked with an LGBT elder and how the social work code of ethics helped or hindered the work.
2. Explore the ethical principle that you think most important and why.
3. What is your profession's code of ethics? Explore its implications for how you will conduct your work.

Multiple-Choice Questions

1. Which of the following is not considered a universal ethical principle under principlism?
   (a) Autonomy
   (b) Beneficence
   (c) Confidentiality
   (d) Nonmaleficence
   (e) Justice
2. Which of the following statements about professional codes of ethics is *not* true?
   (a) Most professions have a code of ethics
   (b) Codes of ethics set accepted standards for behavior and practice
   (c) Codes of ethics reflect the core values of the profession
   (d) Codes of ethics have legal force/force of law
   (e) Codes of ethics provide an ethical framework for self-regulation
3. Ethics can be defined as _____
   (a) Feel good factors people should consider
   (b) System of moral principles or values that provide rules of conduct
   (c) System of legal principles or values that provide rules of conduct
   (d) Universal principles that help regulate and understand individual or group behavior
   (e) Both b and d
4. The ethical theory that focuses on moral standards of behavior and what is good and right is _____
   (a) Communicative ethics
   (b) Normative ethics
   (c) Utilitarian ethics
   (d) Consequential ethics
   (e) Ethical relativism
5. The ethical theory that focuses on the importance of negotiation in ethical conflict resolution is _____
   (a) Communicative ethics
   (b) Normative ethics
   (c) Utilitarian ethics
   (d) Consequential ethics
   (e) Ethical relativism
6. _____ is the ethical theory that emphasizes a balance of good than evil and the greater good for all.
   (a) Communicative ethics
   (b) Normative ethics
   (c) Utilitarian ethics
   (d) Consequential ethics
   (e) Ethical relativism
7. According to _____, ethics should consider the impact of different cultures or notions of what is morally right or wrong.
   (a) Communicative ethics
   (b) Normative ethics
   (c) Utilitarian ethics
   (d) Consequential ethics
   (e) Ethical relativism
8. Tronto's "Ethics of care" is an alternative ethical framework which is based on the premise that _____
   (a) Caring for others is a human activity based on action and practice and not rules
   (b) Virtuous character leads to ethical acts
   (c) Ethics should consider experience and dimensions of meaning in addition to facts
   (d) Ethics should respect diversity of experience and the relativity of ethical situations

(e) Ethics should consider shared meaning from the perspectives of participants themselves

9. Which of the following is *not* a true statement about the limitations of applying principlism to the field of aging?
   (a) It emphasizes individuals to the detriment of community
   (b) It considers the heterogeneity of older adults
   (c) It neglects such factors as context, circumstance, and agents to whom it is applied
   (d) It has a tendency to view relationships as adversarial
   (e) Strict application may result in undesirable results
10. In working with LGBT elders, health and social services professionals can apply ethics to _____
   (a) Decision-making
   (b) Habilitation
   (c) Resource allocation
   (d) All of the above
   (e) a and b only

Key

1. c
2. d
3. e
4. b
5. a
6. c
7. e
8. a
9. b
10. d

Resources

American Bar Association. Model of Model Rules of Professional Conduct. http://www.americanbar.org.

American Medical Association (AMA). Code of Medical Ethics—American Medical Association. http://www.ama-assn.org/go/codeofmedicalethics.

Centers for Medicare and Medicaid Services. http://www.cms.gov/.

National Association of Social Workers. Code of Ethics. http://www.socialworkers.org/pubs/code/code.asp.

National Adult Protective Services Association. Code of Ethics. http://www.napsa-now.org/about-napsa/code-of-ethics/.

National Consumer Voice for Quality Long-Term Care. http://theconsumervoice.org/.

Gerontological Society of America. Code of Ethics. http://www.geron.org/code-of-ethics.

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