Elder Abuse and Neglect

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Introduction

Elder abuse, neglect, exploitation, and self-neglect are significant problems around the world, resulting in increased morbidity and mortality among those elders who are reported as victims [1, 2]. Because of this, physicians and other health-care workers have the duty to (1) be aware of these harmful conditions, (2) know how to identify elders in these conditions, (3) perform proper screening and assessments that are likely to reveal these problems, and (4) make the necessary interventions, including reporting to the appropriate governmental agencies. This chapter will provide definitions and give information to aid in fulfilling these duties. In addition, hypothetical cases that illustrate ethical issues and concerns medical providers may encounter will be presented.

Definitions

The conditions of abuse, neglect, exploitation, and self-neglect described in this chapter are defined by civil laws, and the remedies are designed to extricate the elder from the condition. However, the abuse, neglect, and exploitation can also amount to violations of criminal statutes where punishment for the perpetrator may

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be sought. Abuse, neglect, and exploitation refer to the acts or omissions of a person who has an ongoing relationship with and would be expected to care for the needs of the elder involved. The person who would be reasonably expected to have a duty to care for and protect the elder is usually referred to as a caretaker or caregiver. When the caretaker abuses the elder or neglects the needs of the elder they are expected to support, they are referred to as a perpetrator.

The actions of the caretaker are what create that expectation. For example, the son or daughter of an elder who is estranged and refuses to handle that elder's finances or help care for them in any way is not a caretaker. However, if that offspring handles some aspects of the elder's care, especially handling the elder's finances, he or she creates an expectation that they will also make sure that the elder has enough help during the day, gets food, is kept safe, and that other needs are met. Facility owners and employees of facilities where the elder resident lives are considered caretakers and have an expected duty of care and protection for their elderly residents.

The definition of an elder varies among jurisdictions, but is usually someone 60–65 years or older. Persons who are 60 or 65 are a diverse group and certainly not uniformly unable to take care of themselves independently in the community. A vulnerable elder might be defined as one who is unable to self-care and self-protect because of functional disabilities which often include one of a cognitive nature [3].

Elder abuse includes physical abuse, psychological abuse, sexual abuse, and financial exploitation by a caretaker as above described. Elder neglect refers to situations where the caretaker does not take care of the needs of the elder. Financial exploitation refers to a caretaker appropriating an elder's resources for the use of the caretaker without the consent of the elder. In situations where consent is required, such as sex with the elder or use of the elder's resources, the consent is not valid if it is not freely and knowingly made by an elder who is able to make the decision to consent. If the will of the elder is overcome by another person, undue influence or coercion may have been exerted and the consent may not have been valid.

Situations of self-neglect are those where the person is unable to provide for their own needs, yet does not have another person who has a duty to provide the support and protection needed. There is no identified caretaker in these cases. Self-neglect referred to here is not voluntary self-neglect. This self-neglector has not chosen to neglect their needs. Instead, they may not have the insight to realize that they are unable to meet their own needs and their failure to thrive in their environment is not intended [4].

At times, it can be difficult to identify with certainty a case of elder abuse, neglect, or self-neglect. In some families, shouting at each other may be a normal, long-standing behavior yet considered psychological abuse by an observer. In cases of alleged self-neglect, there may be varying cultural expectations for cleanliness of the person or clothing. Some families or individuals tolerate more clutter and dirt than others. Also, some persons with full mental capacity may choose to live in conditions thought to be intolerable to others. Therefore, a determination of the presence of a state of elder abuse, neglect, and self-neglect can be subjective. When considering possible elder abuse, neglect, or self-neglect, cultural and personal preferences of the elder should be noticed and honored in support of autonomy.

Reporting to Governmental Agencies and Other Interventions

All jurisdictions in the United States, and in many developed nations around the world, have agencies that are mandated to protect their elderly and vulnerable adult populations. The agencies that deal with community-dwelling elders are usually called Adult Protective Services agencies in the United States. The agency is set up to receive reports of suspected elder abuse, neglect, exploitation, and self-neglect and investigate them. The agency then offers services to the victims which are designed to ameliorate the condition of concern [5]. These jurisdictions also have Long-Term Care Ombudsman programs. These programs take complaints regarding persons in long-term care facilities and help mediate problems or direct the complaints toward the appropriate state agency that regulates that facility [6].

In almost all jurisdictions, health-care workers are mandated to report concerns of elder abuse, neglect, or self-neglect to the appropriate governmental agency. In addition, there is often a criminal penalty possible if there is a failure to report as required. Once the case is reported to APS, or another responsible agency when the suspected victim is a facility resident, the governmental agency will perform the subsequent detailed investigation. The health-care worker is protected from liability for reporting so long as they are acting in good faith. In situations where the victim is suspected of being at risk for immediate harm, the police should also be contacted.

The types of protective services offered may include assisting the elder in finding another place to live, arranging for provider services (a provider is usually a non-licensed helper who assists with activities of daily living), helping to ensure an acceptable living environment by cleaning or doing home repairs, or taking the elder to a clinic for medical evaluation. These protective services may be rejected if the elder has the capacity to refuse the intervention. If the agency believes that the elder does not have the capacity to refuse the intervention, the government may seek to have the elder evaluated by a physician and ask a court to force the intervention if the elder is found to lack that capacity [7].

Since adults are generally presumed to have the capacity to make their own decisions, their decisions to reject services, live in poor conditions, or allow others to use their resources are usually respected. This is supported by the ethical principle of autonomy which respects the right of competent adults to make their own decisions. However, if the government through the courts determines that the elder does not have the capacity to make their own decisions regarding their care and protection, the government will interfere with the autonomy or liberty of the elder. This interference should only be to the extent that it is the least restrictive alternative to meet the elder's care and safety needs [8]. For example, an elder that is found to be in a state of self-neglect in their home may be lacking the capacity to refuse interventions. However, if a relative is able to supply the support needed, the agency will not pursue a declaration of incapacity by a court and the appointment of a guardian.

Statistics of Elder Abuse and Neglect

It is estimated that 2–10 % of the community-dwelling elderly population in this country are subjected to elder abuse, neglect, exploitation, or self-neglect at any time [1]. The cases reported to adult protective services are less than what actually occur, and it is thought that the reported cases are only the tip of the iceberg [3, 9]. Elder abuse, neglect, exploitation, and self-neglect are major public health problems with a large impact on the well-being of the elders affected.

Morbidity and Mortality

Elders who are reported to Adult Protective Services are at increased morbidity and mortality risk [2, 10]. The elder may be injured, emotionally distressed, and not getting their basic needs for food, shelter, and medical care met. All forms of elder abuse, exploitation, neglect, and self-neglect can have severe consequences for the physical and emotional well-being of an elderly person who often does not have much physical or financial reserve [11].

Risk Factors

Some characteristics of the elder that place them more at risk for being the victim of elder abuse, neglect, financial exploitation, and self-neglect are cognitive impairment, disability in self-care functions, depression, and social isolation [1, 9, 11–17]. Characteristics of a caregiver or a facility that are associated with an increased risk of elder abuse or neglect are financial dependence on the elder, caregiver mental illness, caregiver drug or alcohol abuse, and caregiver overburden or staffing shortages [1, 15, 18].

Red Flags

Some indicators that an elderly person may be in a state of elder abuse, neglect, financial exploitation, or self-neglect include fear of the caretaker; injuries in unusual locations or that are inadequately explained; dehydration, malnutrition, or wounds that can best be explained by neglect or abuse; medical conditions or medication effects that are poorly monitored or addressed; an elder that should have money for what they need, but is now unable to afford food, bills, utilities, and medications; and transfers of property by those with a doubtful ability to consent to the transfer [11, 19, 20].

Screening and Assessment

Due to the severe impact on the victim of elder abuse, neglect, financial exploitation, and self-neglect, screening for these conditions is suggested as the duty of medical providers by multiple health-care organizations including the American

Medical Association [21, 22]. It is suggested that the elder be questioned alone using questions such as whether or not they feel safe where they live, who prepares their meals, and who handles their checkbook [18].

A comprehensive history and physical examination including a cognitive and functional assessment should be done. This, along with consideration of risk factors and red flags, enables the medical provider to form a suspicion of whether the elder is in a state of abuse, neglect, financial exploitation, or self-neglect [3, 23–25]. Checking the information gathered against observations and reports of credible persons who have knowledge of the elder and their situation is often necessary.

Ethical Principles as Applied to Elder Abuse, Neglect, and Self-neglect

The dominant model of bioethics has been described as a method of problem solving based on principles. Primarily these principles are autonomy, beneficence, and distributive justice. In cases of elder abuse, neglect, exploitation, and self-neglect, the tension between the principles of autonomy and beneficence is central. At times distributive justice may be a principle that is part of the analysis, but this would normally be overshadowed by the other principles in the setting of elder abuse or neglect. Social and cultural norms, as well as legal rights and responsibilities rooted in public policy, help to give detail to what autonomy and beneficence require in specific cases [26]. Legal concepts and rules such as informed consent, presumption of the capacity of adults to make decisions, governmental use of the least restrictive alternative, duty to report suspected abuse, and the responsibilities of health-care providers to patients shape how our society interprets the principles of autonomy and beneficence and what weight each may be given in specific circumstances.

Hypothetical Cases

We will now discuss some hypothetical cases that illustrate ethical issues that arise in cases of elder abuse, neglect, exploitation, and self-neglect. These cases are based upon a mixture of different situations encountered. In one hypothetical case, the medical providers involved exercised their duties to the elder, and, in the second case presented, a different set of medical providers did not perform as well.

First Case

A 68-year-old woman who previously ambulated in her trailer using a walker was hospitalized following a fall. During the hospitalization, she was determined to have a urinary tract infection which was treated and she was subsequently

discharged back to her trailer in July. The trailer was extremely dilapidated. There were holes in the walls and floor. Dirt and cobwebs were all over the home. After that hospital stay, the woman was unable to get around the trailer on her own and was lying on a mattress next to a large metal sheet that covered a hole in the floor. In August, a doctor and a home health company visited and found that the woman was unable to get up for toileting, food, or water. She was dependent on her daughter who lived there with her. The daughter was about 30 years old and would leave daily for a part-time job. It appeared that the daughter was intellectually disabled. Both the mother and the daughter used the funds from the mother's social security check.

Adult protective services became involved and found that the mother resisted any provider or cleanup assistance in the home. She did not want to be moved out of her home despite the fact that the trailer was not habitable and too dilapidated to repair. The woman tried to move across the room and ended up face down on the metal sheet covering the hole in the floor. She stayed there for a week, despite the daughter coming in and out of the trailer during that time. The daughter did not call for help to get the mother up off of the floor. On the next visit by adult protective services, an ambulance was called. The ambulance took the elderly lady to the hospital where she was kept for over a week and received antibiotics for another urinary tract infection. When she was medically improved, the patient insisted on returning to her trailer. The hospital personnel believed that she was able to make her own decisions. Again at home, she was not taking any medications prescribed, was bedbound, was refusing provider services, and again was dependent upon her intellectually disabled daughter for care.

In April, a geriatric physician with experience in evaluating the various forms of abuse and neglect was brought to the home by adult protective services to assess the ability of this woman to choose to stay there. Despite the conditions remaining the same, the mother insisted that she was doing well, getting her needs met, and not in danger. When the physician was introduced to the mother, the physician explained that he was there to evaluate her and make a report to adult protective services. The woman agreed to let the physician ask questions and examine her.

It was learned that the mother had two older children who had been removed and adopted by her sister-in-law. Her husband had been dead for about 20 years, which is how long she and her daughter had been living in the trailer. She said that her sister-in-law spies on her and arranged to have her kept for a prolonged time during her last hospital stay. She said that she had not seen her sister-in-law for many years, but that the sister-in-law continues to watch her and cause her trouble.

Her person and clothing were dirty, her teeth were rotting, and she was lying on her back on the bed, unable to move about well enough to retrieve a spoon that she was laying on. Her short-term recall was good. She had trouble with simple math problems and was wrong on the date and year. She did not seem to have delirium, which is a state of acute confusion and considered a medical emergency.

Issues Raised

There is a presumption in our culture and law that an adult has the capacity to live independently without supervision. Although various types of dementia are more frequently encountered in older populations, to presume that a person in advanced age is incapable of living in the community without supervision is inappropriate, and an example of the prejudice referred to as ageism. Respect for the autonomy of elders requires that we not deem them unable to make their own decisions without good reason.

When an elderly person seems to be making decisions and taking actions that result in a failure to provide for their own care or protection, beneficence requires some action on the part of the medical provider and government agency charged with the protection of elders. The capacity of the elder to take care of themselves without supervision needs to be evaluated. To care for themselves and protect themselves, the elder must be able to both make and carry out decisions regarding their needs and safety [27, 28]. In Texas, where the lady in this case lives, a person is deemed to be incapacitated and unable to take care of themselves without supervision to the extent that they are "substantially unable to: provide food, clothing, or shelter for himself or herself; care for the person's own physical health; or manage the person's own financial affairs" [29]. To make decisions about these needs, they must be able to (1) understand and remember relevant information, (2) appreciate their circumstances, (3) reason about options, and (4) make choices [30]. Then they need to be able to carry out their decisions, which requires a cognitive ability called executive function. Executive function allows a person to plan, monitor circumstances, and make goal-directed adjustments in behavior [27, 28].

It may be that the elder is actually able to make a choice to not have their needs met and to not be protected from harm. If that is the case, autonomy would predominate in the balance with beneficence, and our respect for autonomy would require that the government not interfere. People are allowed to make inadvisable decisions.

In the case of this 68-year-old woman, there was no indication that she actually wanted to have her needs neglected. She did not appreciate that that was the case. Her ability to make decisions was impaired because she could not appreciate her circumstances. Without the ability to make decisions about her needs and protection, she could be found to be incapacitated by an appropriate court. The autonomy rights of the woman could no longer be fully exercised by her secondary to her dementia and psychotic delusions. In this situation, the duty of the governmental agency and medical provider was to become more protective. Beneficence toward the elderly person required the consideration of a need for government imposed supervision if the needs of the elder could not be provided for otherwise. As discussed previously in this chapter, the least restrictive alternative must be employed by the government. In this case, a declaration of mental incapacity was made and a guardian was appointed because this was required to meet the needs of the elderly person.

Second Case

A 94-year-old woman lived alone in her home in the city, having been widowed 20 years before. In the neighborhood where she lived, she owned her own home plus seven other properties which provided rental income. She also received a small social security check. Most of her family and friends had passed away. She still maintained contact with her two middle-aged nephews in town and an elderly cousin who lived in another city. These were her closest living relatives. One nephew, who we will call Carl, had been named previously as her agent through a durable power of attorney for health care and a durable power of attorney for her estate. The other nephew and a cousin were named as alternate agents in these documents. One day she was found on the floor in her home and was taken to the hospital where she was treated for pneumonia. She was confused and unable to make her own decisions. Carl started making treatment decisions and handling financial affairs on her behalf.

The lady remained debilitated after the hospital stay and transitioned to a skilled nursing facility. Although she received therapy in the skilled nursing unit, she was still unable to live independently. She was confused and dependent on others for assistance with transfers, walking, grooming, bathing, toileting, and dressing. She was not qualified for government funded nursing home care because her assets exceeded the limits required to qualify. Her nephew Carl arranged for her transfer to a small unlicensed personal care home that would use less of her funds than a nursing home. The owner had one other resident and had no special training in taking care of frail elders.

Once there, the aunt did not like the care she was receiving and complained to the two other family members with whom she was still in contact. Carl instructed the owner of the home to only allow visitors when he or the owner could be present. The lady's other nephew and cousin subsequently found it difficult to visit the patient and soon began visiting less frequently. They noted that she seemed sedated whenever they saw her.

A nurse practitioner and physician team made occasional visits to the personal care home. The patient was developing pressure sores. The owner was asked to have the woman repositioned often to prevent prolonged pressure on vulnerable areas on the patient's body such as her sacrum, hips, and heals. However, the caretakers at the home were not able to reposition her as often as needed. In addition, the home was not taking the necessary time to help her eat and drink. This resulted in weight loss, malnutrition, and weakness. By late November, the nurse practitioner was expressing alarm at the condition of the patient and reported that she was in danger of dying. She informed both the physician she worked with and Carl that the patient needed to go to the hospital. Carl rejected this idea. Home health started visiting the aunt in late December and noted that the wounds were large, painful, and draining pus. The home health nurse recommended that the aunt be sent to the hospital. Again the nephew refused to allow a transfer to the hospital, insisting that she be taken care of in the home. At one point he mentioned that his aunt was old and just needed to pass on. Carl was in favor of enrolling her in a hospice program to be carried out at the home.

Issues Raised

In this case, the patient had provided for a surrogate to manage her affairs and make medical decisions in case she was unable to do so. Designating a surrogate to make her decisions was an exercise of her autonomy and should have been honored. However, the role of surrogate was not appropriately carried out and, as a result, her autonomy was ultimately not respected.

The powers of the agent appointed through power of attorney documents are defined and restricted by the terms of the documents creating them. These powers are also limited by the laws that authorize the creation of this agency relationship. For example, in Texas, the statute that provides for the durable power of attorney for health care allows it to be revoked by even a confused patient. In the case of both the durable power of attorney for health care and the durable power of attorney for finances, the agent is required to act as a fiduciary with respect to the principal. Also, in situations where the law establishes a surrogate for the incapacitated elderly person in the absence of a document appointing an agent, it is required that the surrogate act as a fiduciary for the person represented. This means that Carl was required to carry out the wishes of his aunt if he knew what she would want in the situation and, if he did not know what she would want, he was required to act in her best interests. These documents, as well as other advance directive instruments such as directives to physicians, are meant to promote the autonomy of the principal (patient) on whose behalf they are written. In this case, there is no indication that the patient would have wanted to be kept in a facility where her needs would be neglected. In the case of Carl, he violated his fiduciary duty to his aunt and was therefore potentially subject to removal as her agent [31–33].

The health-care providers were aware that this patient was residing in a personal care home that was not equipped to meet her needs. They also noted that she was suffering, not being cared for appropriately, and that the nephew stated that she should just pass away. Perhaps the medical team did not realize that the instructions of the nephew should be challenged when he was not acting in the best interests of his aunt.

When the medical providers had reason to believe that the patient was not getting her needs met, they were obligated by law to report the situation to adult protective services [34]. Even if they did not have the legal mandate to report, they had an ethical obligation to respect the interests of their patient to be treated humanely and have her needs addressed. The aunt's autonomy was being disregarded in the most fundamental way. Her right to life was being challenged. The level of disregard for her needs demonstrated by her surrogate (Carl) might have been a criminal offence and require a report to the police.

Enrollment of the patient in hospice would help make it seem that the death was expected and natural. However, even without the involvement of hospice, when an elder dies there is a lowered scrutiny regarding the cause of death being unnatural. The police, medical examiner, first responders, and hospital personnel are less likely to suspect unnatural causes of death, such as abuse or neglect, when the deceased is

elderly [11]. Certain circumstances, wounds, or lab results may trigger a suspicion of unnatural death. Education regarding those red flags is important for those who investigate the deaths of elders. Medical providers are in a good position to distinguish the effects of normal aging and illness from the effects of neglect and abuse [1]. The most important indicator of abuse and neglect may be that the condition of the patient may not fit with the story given by the caretaker. For example, the caregiver may report that the elder stopped eating and drinking 2 days before yet the sodium is extremely high at 156 or the caregiver says that the patient developed some pressure sores over a week when the wounds are obviously a few months old.

Did ageism play a role in this disregard for the autonomy of the patient presented in this case? Ageism is, according to the Merriam-Webster dictionary, "prejudice or discrimination against a particular age-group and especially the elderly" [35]. Common prejudices against the elderly include the beliefs that (1) they are confused and cannot make their own decisions, (2) what they say is not reliable, (3) they cannot manage their own affairs, and (4) they do not have a good quality of life. Did the people taking care of the patient see her as a person with a right to autonomy or did they assume that her age precluded autonomy?

Medical providers sometimes depend on a facility, or a group of facilities, for referrals of patients, director fees, or other financial benefits. If the medical provider notices that one or more of the patients in the facility are not getting their needs met and this situation is not remedied by discussions with the appropriate persons, the physician has a duty to report the situation to the agency which licenses and regulates the facility in that jurisdiction. In situations like our hypothetical case where the facility is not licensed, APS might be the appropriate agency. In most jurisdictions, the health-care provider is required to report elder abuse, neglect, or self-neglect whether they have a physician-patient relationship with the patient or not. Any real or perceived duty toward the facility is overridden by the duty to obey the law and protect vulnerable elders. Beneficence requires this pursuit of the interests of the patient, not the facility.

Second Case Continued

A few weeks later, the owner of the facility called an ambulance for the patient. The aunt had become unresponsive and the owner did not want her to die in the home. She was not yet enrolled in hospice. In the hospital, the patient was found to be dehydrated, malnourished, and with over 20 pressure sores, some of which were infected. She was septic from the wounds. The nurses were alarmed at her condition, and the hospital social worker reported her case to adult protective services. The patient was treated with intravenous fluids, antibiotics, and surgical debridement of the wounds. She improved in the acute care hospital and was able to report to the social work case manager that she had not been getting fed well and was having pain from the wounds in the personal care home.

After 11 days in the hospital, she was transferred to a long-term acute care hospital for continued treatment of her wounds and infections. A month later, still in

that long-term acute care hospital, she developed fluid overload and respiratory failure. The patient's nephew Carl was still recognized as the surrogate for his aunt, and he insisted that she not be moved to the intensive care unit and resuscitated. Morphine was administered for comfort and she expired.

Issues Raised

The nurses and social work case manager in the acute care hospital recognized that the aunt had most likely been the victim of neglect and reported the case to adult protective services. The aunt communicated with the social worker there regarding not being fed well and having been in pain at the personal care home. What if in this hypothetical case the patient did not want to get her nephew in trouble and so did not want the social worker to make a report to adult protective services? Patients do have an interest in confidentiality and this should be respected. However, social workers and medical providers have an obligation to obey the law, and the law requires that suspected elder abuse be reported even if the alleged victim is not in agreement [36].

Carl was still seen as her agent when another health crisis occurred at the long-term acute care hospital. Was a report to adult protective services enough to protect this patient? Could the social worker or the medical team at the acute care hospital have done more to protect this woman from a surrogate who had not acted in her best interests? Protection of the aunt's interest in autonomy should have prompted a termination of Carl's agency and this fact should have been made evident in the medical record. In the state of Texas, a principal on a durable power of attorney for health care may terminate the agency relationship no matter what the mental state of the principal. The aunt probably needed assistance and guidance from the social worker or medical team to have a more appropriate surrogate identified and engaged. The other nephew and the cousin were not contacted to take over as alternate surrogates either. She did not get the advocacy that she needed to protect her interests.

Conclusion

Elder abuse, neglect, exploitation, and self-neglect affect up to 10 % of elders in the United States, and these problems are associated with increased morbidity and mortality. Identification of cases and intervention to reduce harm to the affected elders is an important effort. Ongoing education of health-care workers, as well as others in the community who come into contact with the potential victims, regarding these issues and appropriate interventions is needed. Balancing the principals of autonomy and beneficence is required to resolve ethical conflicts arising in the case of elder mistreatment or self-neglect. Social and cultural norms, as expressed in laws and other codes of behavior, help guide what autonomy and beneficence mean in specific cases. The goal is to respect and promote individual choice to the extent possible while protecting elders who are unable to provide self-care and self-protection.

Practice Pearls

The main duties of medical providers are to protect the interests of vulnerable elderly patients by
Knowing the statistics, morbidity, mortality, and red flags of elder abuse, neglect, financial exploitation, and self-neglect
Screening for these conditions in inpatient, outpatient, and long-term care settings
Performing appropriate assessment histories and physicals
Keeping the elder safe through appropriate interventions including reporting to appropriate governmental agencies and ensuring medical treatment
In cases of elder abuse, neglect, exploitation, and self-neglect, the tension between the principles of autonomy and beneficence is important
Autonomy should be respected and overrides the requirement that the medical provider protects or acts beneficently regarding the elder. To care for and protect themselves, the elder must be able to both make and carry out decisions about their needs and safety. To make decisions about their needs and safety, they must be able to appreciate their circumstances. They must also be able to take goal-directed action toward carrying out these decisions. The autonomy interest of the elder with capacity to take care of and protect themselves allows them to make decisions that seem unwise to others
When the elder is unable to take care of or protect themselves, and so is unable to exercise their autonomy, beneficence requires that the medical provider work with the appropriate government agencies to help protect the interests of that vulnerable elder
The autonomy interests of the vulnerable elder may be furthered by the use of advance directives such as durable powers of attorney for health care, directives to physicians, and other durable powers of attorney. The agents or surrogates established in such documents have a fiduciary duty to the elder and so are required to carry out their wishes if known and act in their best interests otherwise. When this trust is violated, the vulnerable elder may need the assistance of the medical provider to oppose the agent or surrogate. The medical provider has a duty of beneficence toward the patient, and this requires them to put the interests of the patient before the interests of the agent or a facility

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