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Short Communication

Ethical Issues in Adult Patients with Acute Coronary Syndrome

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ABSTRACT

Acute Coronary Syndrome (ACS) is one of the leading causes of death and morbidity in the older population. The prevalence of ACS rises with age, and patients in their later years often have co-morbidities that necessitate a tailored strategy, which involves a thorough geriatric assessment. Ageism is a major source of concern. Some ethical dilemmas may develop in this scenario, which should be foreseen, evaluated, and resolved. To avoid futility/proportionality, clinicians will need to prioritized and distribute resources, which is not always straightforward to assess in these patients. The goal of this content is to synthesis the information on ethical problems that may occur in the management of patients with ACS who are also elderly. The four core concepts of bioethics are presented here: beneficence, non-maleficence, autonomy, and justice.

Keywords: Acute coronary syndrome; Autonomy; Morbidity

DESCRIPTION

Stereotyping, prejudice, and/or discrimination against persons or organizations based on their age are known as ageism. It encompasses any attitude, action, or institutional structure that discriminates solely on the basis of age against a person or group of people. Given that age is a poor predictor of outcome in critically sick patients, treating them solely on the basis of their age is unethical. Ageism is a widely held belief that has a negative impact on one's health. Ageism has three components that can have an impact on one's health: [1] discrimination when receiving certain treatments (unjustified do not-resuscitate orders, administration of cheaper treatments, lower quality treatments); [2] Discrimination when receiving certain treatments (unjustified do not-resuscitate orders, administration of cheaper treatments, lower quality treatments); [3] discrimination when receiving certain treatments (unjustified do not-resuscitate orders [1] Negative stereotyping; [2] Negative self-perception of ageing; and [3] negative self-perception of ageing. Psychological and behavioral mechanisms are influenced by these elements. Individual ageism may be structural (promoted by institutions) or structural (promoted by individuals) (due to assimilated negative beliefs about age). In a recent meta-analysis, both structural and individual ageism influenced health across multiple domains, with ageism being linked to a worse health outcome in 96 percent of the research examined. Exclusion from clinical trials and research investigations are examples of structural attitudes [1-3].

The term "medical futility" refers to procedures or therapies that are unlikely to help the patient. It's a common issue with ethical ramifications and issues about the ideals of non-maleficence, autonomy, and justice being upheld. Physicians are not required to administer ineffective treatment. In most cases, the term useless refers to a condition in which continued therapy is either ineffective or hopeless. It's a phrase that has anything to do with "proportionality." This refers to a treatment or operation that is likely to be more troublesome than useful and should be stopped or postponed. This last step entails weighing the benefits and dangers to patients. When interventions have a reasonable possibility of success but are not ethically acceptable, the term "possibly inappropriate" is more widely recognized [4,5].

The futility or nonproportionality of both therapies and operations must be evaluated in older individuals with heart disease. To attain this goal and balance risks and benefits, a full geriatric assessment and a multidisciplinary team decision are required; however this is not always possible in emergency situations. Physicians are not required to administer a therapy or operation that is not in the best interests of their patients. At this moment, a conflict between the autonomy of the patient and the autonomy of the physician may occur. In this instance,two concepts would be at odds: the principle of

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non-maleficence and the principle of autonomy. Patients' autonomy isn't absolute, and the other principles of beneficence, no maleficence, and justice should all play a role in resolving this problem through a collaborative decision-making process [6,7].

CONCLUSION

Patients with ACS who are elderly have a number of comorbidities that make treatment difficult. Various ethical dilemmas about ageism, priority, and futile treatment may occur during this procedure. Invasive treatment or admission to the acute care unit could be influenced by ageism in the ACS healthcare system. In this regard, physician education on the needs of the elderly patient, as well as complete geriatric assessments, functionality, and frailty, are critical for sound decision-making. Although resource allocation is complex, doctors should prioritized biological age above chronological and age should not be used as a criterion for prioritization. Finally, we should prevent futility whenever possible, but this must be done with caution because, in many circumstances, the most seriously ill individuals benefit the most from treatment. Finally, when it comes to elderly people with ACS, it's critical to work with a multidisciplinary team that can debate ethical conflicts and make the best decisions possible.

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