How do Autonomy, Dignity and Justice Look Like in Aging Context?

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Abstract

The aim of this paper is to describe the problems of autonomy, dignity and justice that medical professionals experience with elderly patients. Method: Both literature review and philosophical reflection, ethical case analysis have been used. There is a gap between the theory and practice with the application of the principle of respect for autonomy. This is possible because in bioethics the principle is based only on I. Kant’s second formulation of the categorical imperative. So in practice a patient is understood as being autonomous or non-autonomous. He can make responsible decision for himself or he cannot make such decisions. It is like there is nothing in the middle. Contrary to the theoretical framework patients with dementia show us that there is actually something in the middle. The change that occurs in the decision-making capacity requires revising our understanding about autonomy as well as our concepts of dignity. Does the patient with dementia lose his dignity with the development of the disease? Justice is often related to resource allocation issues in medical practice. One of the most difficult questions here is whether limiting health care for elderly patients is consistent with the current understanding of justice? Do we owe something to elderly patients? People change through time so their values change as well. Despite being older than other patients, elderly patients need more complex moral care. Their values may not change through time and medical professionals should be prepared to understand them and explain the values in life.

Keywords: autonomy, dignity, justice, elderly patients, values

INTRODUCTION

In bioethics we have imperatives which aim to govern professional behavior, i.e. professional ethical codes are imperatives that all medical professionals must follow and obey. If medical professionals do not follow the code it will be ineffective. Yet, following those imperatives is not always an easy task. I would like to propose a clear understanding of imperatives so that the ideas of autonomy, dignity and justice could easily be understood and applied in medical practice.

What is “Imperative”?

The Oxford dictionary provides us with the following definition of the word “imperative”:

1. Adjective
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a. **Of vital importance; crucial:** “Immediate action was imperative”. [with clause]: *it is imperative that standards are maintained*.

b. **Giving an authoritative command; peremptory:** “The bell pealed again, a final imperative call”.
   
i. In grammar is used for denoting the **mood** of a verb that expresses a command or exhortation, i.e. “Come here!”.

2. **Noun**
   
a. **An essential or urgent thing:** “Free movement of labour was an economic imperative”.
   
i. A factor or influence making something necessary: “The biological imperatives which guide male and female behavior.”

b. **Grammar:** A **verb** or **phrase** in the imperative mood.
   
i. *(the imperative)* The imperative mood [5].

Those are good understanding of the word “imperative” and now we have solid base from which we can develop our work.

A much more complex **philosophical** understanding of imperatives could be found in Immanuel Kant’s *Groundwork for the Metaphysics of Morals*. He writes: The representation of an objective principle, insofar as it is necessitating for a [human] will, is called a ‘command’ (of reason), and the formula of the command is called an imperative [4]. As you can see the will that every human being poses is vital for understanding and following imperatives. But before we continue with more complex philosophical characteristics of imperatives let’s try to keep it simple and summarize everything in a simple explanation: “Imperatives” are a must. So, every given command is considered an imperative and we must execute it.

Let’s see what the characteristics of imperatives are. According to Kant all imperatives are expressed through *an ought* which indicates a relationship between an objective law (of reason) and human will which on the other hand is subjective in its nature. The latter is not always governed or determined by objective law [4]. Not all things appear to us as something good. Kant defines *practical good* as something which determines the will by means of representations of reason – not subjective causes but objective principles [4]. By “objective” Kant mean’s all grounds that are valid for every human being as such. Therefore, all objective principles are valid for every human being. Due to the fact that human will is subjective by its nature it cannot be only determined by and follow only objective principles.

The second characteristic of imperatives is that they are formulas that determine actions of human will. The aim of the action is of importance to determine whether the imperative is **hypothetical** or **categorical**. Hypothetical imperatives, as Kant describes them, represent practical necessity of possible action of attaining something that one wills (or could be willed) [4]. Categorical imperatives represent action as objectively necessary for itself, without any reference to any other end [4].

So imperatives say which actions are possible but they cannot always tell us which action would be good because one cannot always will to follow objective principles which is essential for doing a good actions. One can will to do something bad or at least not good.

In *Groundwork for the Metaphysics of Morals* Kant offers three formulas of categorical imperatives (or moral laws). If an action follows the categorical imperative it would always be good action.
The formulas are:

1. **The Formula of Universal Law (FUL)**: “Act only in accordance with that maxim through which you can at the same time will that it become a universal law” (G 4:421; cf. G 4:402).
   
a. **The Formula of Law of Nature (FLN)**: “So act as if the maxim of your action were to become through your will a universal law of nature” (G 4:421; cf. G 4:436).

2. **The Formula of Humanity as End in Itself (FH)**: “Act so that you use humanity, as much in your own person as in the person of every other, always at the same time as end and never merely as means” (G 4:429; cf. G 4:436).

3. **Formula of Autonomy (FA)**: “the idea of the will of every rational being as a will giving universal law” (G 4:431; cf. G 4:432) or “Not to choose otherwise than so that the maxims of one’s choice are at the same time comprehended with it in the same volition as universal law” (G 4:440; cf. G 4:432, 434, 438).
   

In contemporary bioethics the second formulation is very popular. It lies in the ground of the principle of *respect for autonomy* of Beauchamp and Childress [1]. To put it simple, medical professionals must respect the responsible decisions of every autonomous patient. Following this imperative seems easy at first glance, especially when you see that this categorical imperative has practical manifestation in ethical codes and declarations, e.g. International Code of Medical Ethics, Declaration of Lisbon [8, 9]. Yet, this idea is not that easy to comprehend when it comes down to elderly patients and respecting their autonomy. In my opinion, the problem lies in not fully applying Kant’s categorical imperatives.

The idea of respect for autonomy managed to get popular because of Kant’s first imperative: “Act only in accordance with that maxim through which you can at the same time will that it become a universal law” [4]. In the second half of the 20th century medical professionals got around the idea of patients autonomy and they started to integrate it in medical practice. In other words, medical professionals willed the idea of patient’s autonomy. Later, little by little patients got educated and they also started to will the idea of autonomy and started to demand respect from physicians towards their wishes, privacy and body.

With the development of medicine respecting patient’s autonomy has got harder. Even though, World Medical Association (WMA) and World Health Organization (WHO) created different statements for different moral problems not all countries follow those statements by the book, i.e. countries around the world create their own legislation in accordance with the WMA’s or the WHO’s ideas but differences can be found on national level as well. Thus for medical professionals it is really hard to comprehend and follow this vast network of moral and legal imperatives. Another reason for this is the fact that by possessing free will humans may not choose which moral or legal law to follow but they can choose to follow any other course of action as well no matter if it is moral or not.

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1 The idea for the abbreviations of the different formulas is Allen W. Wood’s.
JUSTICE

Justice as a problem in aging ethics is related to resources and their equal and just allocation. This is the economical and ethical part of the problem and if we could illustrate this problem with a line this line would be so long that we would not be able to see the beginning of it nor the end of it. In the beginning of this line lies “the real problem” in aging ethics: “What is it that we want medicine to do for us as we age?” [2]

Daniel Callahan is just one of all professionals in bioethics who proposed an answer to this question. He developed the idea of “full biography”. Yet, I would like to focus onto one of his early ideas – natural life span. The reason why Callahan does not support the idea that elderly patients must receive more resources than young patients is that most of the times the resources are used to expand old patients’ life time. According to his opinion, the goal of medicine should be to improve the quality of life of elderly patients not to extend it. No matter how much we invest in medical development we just cannot change human nature – people will always get older and die. For Callahan medicine should stop treating aging and dying (because of age) as medical problem. Longer life does not mean good quality life. He points out that lots of young patients die because of different diseases; medicine could invest in their treatment and provide only the necessary for the elderly so that they could have a sense of meaning and significance of their stage of life [2].

So what is this natural life span? Callahan understands natural life span as: “We should think of a natural lifespan as the achievement of a life that is sufficiently long to take advantage of those opportunities life typically offers and that we ordinarily regard as its prime benefits – loving and “living”, raising a family, engaging in work that is satisfying, reading, thinking, cherishing our friends and families” [2]. All people should aim to that kind of life. But for this to be possible, there should be some kind of plan executed by the government so that resources are not wasted or directed to wrong places. Callahan strategy is:

1. [The] government has a duty, based on our collective social obligations, to help people live out a natural lifespan, but not to help medically extend life beyond that point.
2. [The] government is obliged to develop under its research subsidies, and to pay for, under its entitlement programs, only the kind and degree of life-extending technology necessary for medicine to achieve and serve the aim of a natural lifespan.
3. [B]eyond the point of a natural lifespan, government should provide only the means necessary for the relief of suffering, not those for life-extending technology [2].

So if a health system follows those principles it would allocate resources in a just way and every patient, no matter of their age, would receive “sufficient” amount of resources. Here I would like to leave the back door open for something really important when it comes to resource allocation. When speaking about resource allocation in health care, especially which type of treatment deserves more funding, we often forget that patients are different and they have different needs. So how are we supposed to prioritize different diseases? Which disease is more important and why? Probably we could come up with some combination of risk-benefit or cost-benefit analyses which are not discussed here.

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2 According to Callahan this necessary thing is relieving the patient from his/her pain and suffering.
CASE 1. How family threatens autonomy

The aim of case 1 is to describe the problem of respecting someone’s autonomy and how family members can actually disrespect personal autonomy due to paternalistic attitude.

A 75-year-old man arrives at the emergency department febrile, short of breath, and confused. Many family members accompany the patient, including his wife, his siblings, his children, and his grandchildren. The physician wants to perform an emergency lumbar puncture, which the patient’s wife and siblings are refusing. His 25-year-old granddaughter walks up with a health-care proxy form signed by the patient designating her as the proxy. She insists that you do the lumbar puncture stating that was her understanding of the patient’s wishes. The rest of the family, including the wife, refuses the lumbar puncture stating that they know the patient’s wishes better [3].

The key point here in understanding autonomy as moral problem with elderly patients and solving it is the advanced directives idea. Fisher provides us with very simple definition of advance directives. An advance directive is the method by which a patient communicates his/her wishes for his/her health care in advance of becoming unable to make decisions for himself/herself [3]. This could be done either by a health care proxy or a living will. There are differences between them and there are pros and cons for both of them. In the end their function is to express the patient’s decisions and by following those wishes the physician will represent patient’s autonomy. This idea is stated in both national and international documents, e.g. WMA Declaration of Lisbon article 4.a. If the patient is unconscious or otherwise unable to express his/her will, informed consent must be obtained whenever possible, from a legally entitled representative [8].

The problem here lies within the paternalistic attitude that the relatives of our patient have towards him. It is not a problem to follow a proxy decision. It is quite clear stated in WMA Declaration of Lisbon that if the patient is unconscious or otherwise unable to express his/her will, informed consent must be obtained whenever possible, from a legally entitled representative [8]. By following this imperative physicians would make a combination of actions. Not only that they would follow the Lisbon declaration but they will follow WMA International Code of Medical Ethics where the obligation of physicians to respect patients’ rights is stated [9]. In Kantian perspective physicians are willing to do a moral action. The problem here is how to prevent the harm towards the patient from his relatives who are suppressing his autonomy. The fact that our patient choses who will make all the decisions instead of him is by itself an autonomous act by a worthy person. So we must explain to the relatives that the patient already made up his mind and they have no moral or legal right to object it due to the fact that the health care proxy is making a decision that is in the patient’s best interest. Here we can also see that there is a problem with Kant’s second imperative. The patient’s family looks at him as a means to an end. The latter is not clear what it is but we can see that the patient’s granddaughter views our patient just as an end in itself. This is, in philosophical perspective, harm done towards the patient’s autonomy.

CASE 2. Autonomy, Competency, Traditional Medical Values

Mary B. is a 79-year-old female recently diagnosed with mild vascular dementia, who was living at home with her daughter, Audrey, and attending an adult day care program until she suffered a fall at home and was admitted to the hospital. Mary’s past history also included hypertension, elevated cholesterol, and Type II diabetes mellitus – all of which were well-controlled by oral medications prescribed by her primary physician and that were administered by her daughter. Prior to her diagnosis of dementia two years prior to
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admission, Mary had lived by herself and functioned independently since being widowed at age 65. Most recently Mary was able to ambulate well at baseline, as well as bathe, dress, and feed herself. She had occasional episodes of mild confusion, particularly at night, but was for the most part oriented to person, place, and time. She [had] limitations with short-term memory, documented in prior mental status examinations. Mary had previously acknowledged in a Living Will that she did not wish to be resuscitated or intubated if she suffered a cardiopulmonary arrest, nor did she want a feeding tube placed if she became unable to support herself with oral nutrition. Mary had also designated Audrey as her health care agent in a prior Power of Attorney for Health Care document.

At the time of the current hospitalization, Mary had an unwitnessed fall at home while her daughter was in another room. When Audrey heard a commotion, she rushed to find her mother on the floor, with a small table turned over. Mary was, by Audrey’s report, conscious at the time but slightly confused. Paramedics were called and Mary was brought to the emergency room. Upon arrival, Mary was no longer confused, but also had no recollection of the event. A medical evaluation done by the emergency room physicians determined that Mary had an intertrochanteric fracture of her right femur and a urinary tract infection. Additionally, a 12-lead electrocardiogram showed that Mary had developed third-degree heart block. She was admitted to the inpatient medical service for further evaluation and treatment, and the cardiology and orthopedic surgery teams were consulted.

Case 2 perfectly illustrates how competency and autonomy collide as moral problem in aging ethics. First let’s take a look into the medical information. According to Snyder and the U.S. Congress, Office of Technology Assessment, Hip Fracture Outcomes in People Age 50 and Over-Background Paper (1994) information in the US among 300,000 patients admitted in hospitals 94% are elderly patients over the age of 50 years. 55% of them are over the age 80. The all-cause mortality rate shows that 24% of elderly patients with hip fracture die within one year after the fracture (even higher rate in male patients). There are options in the interventions. Some patients want operation others don’t. Snyder’s research shows that this is related to their income. It is likely that a patient who cannot afford the operation would not want it [6, 7]. The pacemaker would cost around $60,000 and it would have life expectancy of 6.49 years [6]. Despite that this is old information the problem has not changed.

According to WMA Declaration of Lisbon if the patient is unconscious or otherwise unable to express his/her will, informed consent must be obtained whenever possible, from a legally entitled representative [8]. In our case Audrey is the legal representative and she must make a decision which is in patient’s best interest: to allow the hip operation and placement of the pacemaker. We must address the living will situation as well. Mary’s living will is not a problem here due to the fact that it is concerned with only life-sustaining procedures when the patient is terminally ill or permanently unconscious [6]. If we want to respect the patient’s autonomy, the physicians must inform the legal representative and the patient herself as it is stated in the Declaration of Lisbon right 5. The legally incompetent patient b. If the legally incompetent patient can make rational decisions, his/her decisions must be respected, and he/she has the right to forbid the disclosure of information to his/her legally entitled representative. It is becoming more and more common to involve incompetent patients in the decision-making process. As unrealistic as it seems, this action contradicts traditional medical values, e.g. to help the patient. By involving incompetent patients into decision-making we respect not only their autonomy but show respect to their dignity as human beings.

Let’s address the contradiction stated above? In our case it would be really hard to evaluate whether our patient could actually make rational decisions. Do we have criteria for
rational decisions? Do incompetent patients make different kind of rational decisions? Those are just a few questions that ethicists, psychologists and physicians should answer in near future. As we can see in our case, even though Mary is 79, with vascular dementia, she could still make rational, to certain degree, decisions. Due to the fact that WMA recognized the ideas placed in point 5 in Declaration of Lisbon and if we follow Kant’s imperatives, Mary must be fully involved in the decision-making process along with her legal representative. The physician is morally obliged to provide the legal representative and the patient with all the relevant information to make an informed decision (including reasonable alternatives with their pros and cons). If we accept the idea that there is some autonomy involved in this case, i.e. autonomy to certain extend, we should accept the fact that along with patient’s autonomy her dignity is involved as well. The actions taken would aim at protecting her dignity. By explaining to the patient that her quality of life would improve and she won’t be so dependent, the physician would show that he sees her as a person and he is aiming at protecting her dignity.

Concerning Callahan’s ideas about natural life-span, it is justified in this case to spend those resources on Mary due to the fact that they will reduce her pain and suffering. The medical data shows that those resources are not aiming at extending her life but to sustain it on a worthy level. With this in mind the physicians will also have the moral duty to explain how the outcomes of this treatment would affect Audrey’s life because she is her legal representative and her social life is linked to Mary’s life.

**CONCLUSION**

Aging ethics is yet to be developed. Medical professionals would continue to face traditional bioethical problems and they must not forget that they are having rational principle that can guide their behavior. Elderly patients, though having specific need as any other patient, are part of society and their decisions must be respected in accordance with the circumstances. People change through time so their values change as well. Despite being older than other patients, elderly patients need more complex moral care. Their values may not change through time and medical professionals should be prepared to understand them and explain the values in life.

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