

Ethical Issues and Care of the Elderly

SCOPE OF STUDY

For the purposes of this paper care of the elderly is defined as “*the full continuum of older people’s experiences from that of growing old to that of being in need of significant health and social care in the late stages of life*”. The UK National Service Framework provides a useful definition of three stages of ageing. These are described as follows:

(i) Entering Old Age

This is a socially constructed definition and extends from the age of 50 right up to the end of life. People in this category are active and independent and remain so into late old age. In this category the goals are to promote and extend a healthy active life.

(ii) Transitional Phase

This phase refers to those who are between a healthy active life and frailty. The goal for this category is to identify emerging problems thereby ensuring effective responses which will prevent crises and reduce long-term dependency.

(iii) Frail Older People

This category refers to those who often have multiple long-term conditions and are vulnerable as a result of, for example, stroke or dementia. They often have complex social care needs. The goal with this group is to anticipate and respond to problems recognising the complex interaction of physical, mental and social care factors which can compromise independence and quality of life.

Drivers of Increase in Numbers of People Surviving into Old Age

Before analysing each of these stages in turn, a brief summary of the main factors accounting for a greater number of people surviving into old age. This includes:

1. Demographics

The changes in the age structure of the population are well known. Survival into old age is resulting in an increase in the number of older people and, in particular, very old people - those over the age of 85. At the same time the birth rate is declining so the proportion in the older age groups is also increasing.

Older people in Northern Ireland account for 15.9% of the population and in the Republic of Ireland 13% of the population is over 65. In the UK as a whole over 65 year olds make up 18.4% of the total population.

The actual number in Northern Ireland over 65 is predicted to increase from 274,000 in 2004 to 458,000 in 2042 representing an increase of 67%. The number over 85 is predicted to increase by 139% in the same period.

2. Age Discrimination

In the past age was a criterion for some medical procedures such as renal dialysis. It is now unacceptable to use age as a criterion for the delivery of health care. The key determinants

today are the condition of the patient, expected outcomes in relation to the burden of treatment and the wishes of the patient.

3. Technology

Older people are the beneficiaries of new technology. New techniques including scanning and non-invasive or minimally invasive treatments, e.g. endovascular, coronary angioplasty, stenting and minimally invasive surgery together with new anaesthetic techniques are all particularly suitable for older people.

REVIEWS OF UK GOVERNMENT PLANS

The Healthcare Commission, the Audit Commission and the Commission for Social Care Inspection have all delivered reports suggesting that government policy is betraying the elderly in particular in the area of respect for their dignity. The reports have concluded that, despite occupying two thirds of hospital beds, only 40% of funding is allocated to the elderly and that their views are neither sought nor valued with needs of the elderly too often ignored. Some specific findings include:-

- There remain mixed sex wards nine years after Labour pledged to abolish them.
- Patients are shunted from ward to ward to free up beds.
- Patients are malnourished because food is removed before they have a chance to eat.
- On the one hand patients are often discharged too soon whilst others who would wish to die at home are unable to do so.
- Staff are described as patronising, thoughtless and in some cases not properly trained, for example, Alzheimers sufferers are routinely sedated.

The UK Government has also introduced a 'respect for dignity' policy with a specific member of staff in each care establishment to be held responsible for its implementation.

RESEARCH & CLINICAL TRIALS

➤ The Ageing Process

Research into the ageing process highlights the intellectual poverty of single discipline approaches to defining questions and answering them.

Moving to trans-disciplinary research is not easy and requires a more integrated training of scientists, larger research groups, willingness to collaborate and a vision broad enough to accept that no one discipline has all the answers. In order to provide answers to such questions as 'What are the causes of increased life expectancy?' and 'What are the effects of increased life expectancy?' the disciplines of, for example, biology, sociology, epidemiology, demographics, economics and environmental science are needed.

The World Health Organisation has for example, published some studies on worldwide changes in life expectancy and on the differential life expectancy of different populations.

For the Church interest should be shown in Healthy Active Life Expectancy. This requires new national cohort studies to be established and maintained - such data will allow the monitoring of the success or failure of health and social policies on ageing.

➤ **Economic and Social Consequences of Ageing**

The economic and social consequences of ageing deserve further research and the Church should be supportive of social research directed at the aims, aspirations and needs of the population in caring for the elderly.

➤ **The Prioritisation of Ageing Within Large Studies**

There is also a need to prioritise ageing within government-sponsored research. At present it is often assumed that policy initiatives have the capacity to tackle ageing and longevity with the consequence that it has no central priority.

Likewise the Medical Research charities have a disease focus without having a priority or focus on ageing.

The Church could influence the prioritisation of ageing within studies when it has the opportunity to comment on policy.

➤ **Clinical Trials**

There have been considerable improvements in the last decade in the inclusion of older people in clinical trials. Up until then there were perhaps misconceptions that the elderly were too frail and might not see the benefit of trials or would react unfavourably to the toxicity of interventions.

The new era of drug development more concerned with the biological nature of disease has perhaps contributed to this more inclusive trend in that there is more current emphasis on molecular targeted approaches and less on toxic compounds (if Northwick Park experience is regarded as an exception).

➤ **Cancer Trials**

In Cancer Trials for example there is no cut off based on age. Entry into trials is based on the clinical condition and history of the patient.

However, the proportion of people above age 70 in cancer trials is under 15% and the average age of participants is 58.

There is general agreement amongst cancer specialists that these numbers of older people need to be increased given the age profile of the population.

Clinicians would inform that a sizeable proportion of older people do equally as well as younger people where there is a good medical history. However there is a second category of older person with a complicated medical history and who experience toxicity quickly and cannot therefore continue the trial.

➤ **Church Role**

In the area of clinical trials the Church may have a role in articulating the importance of older people participating in trials. Otherwise drugs will be licensed only for younger members of the population with the result that certain treatments might have to be accepted on an individual risk

basis for the older person. The relative safety of trials for those with a good medical history could be emphasised, whilst at the same time recognising that the Northwick Park experience may have negative impact for some time.

ARE MORAL CLAIMS AGE RELATIVE?

Moral claims could be age relative in three obvious ways -

- (i) They could vary with elapsed time or increase in proportion to the amount of lifetime an individual has experienced or consumed.
- (ii) They could vary not with a lifetime lived but a lifetime in prospect.
- (iii) They could vary according to quality of life - poor quality of life could be considered a worthless expenditure on resources.

Quality adjusted life years and reasonable lifespan approach take into account these propositions. There are also of course lifestyle choices which may affect moral claims or entitlements. All make health related choices about, for example, drug, alcohol use, exercise, choice of domicile, occupation etc. and wealth related choices about for example how much of disposable resources are put aside to support healthcare, retirement, old age, insurance against health risks etc. There is an increasingly vocal lobby favouring an element of individual responsibility for adverse health related to the choices made about lifestyle and personal funding for health.

If the age relative view described above is taken once the old, however defined had been ruled out, the middle aged would become the old and the cycle of discrimination could have a tendency to extend indefinitely.

In addition if the ageist age relative view is extended to other aspects of life one corollary of that view might be that murder victims, for example, would be considered to be less serious when victims are old or terminally ill.

The anti-ageist view expounded by John Harris, Professor of Bioethics, Manchester University is to be preferred with his hypothesis resting on the concept of something we all value equally 'the rest of our lives'. So long as we do not know the date of death the 'rest of life' is of indefinite duration and whether 17 or 70 in perfect health or suffering from a terminal disease we have the 'rest of our lives' to lead. So long as we each fervently wish to live out the rest of our lives however long that turns out to be, then we suffer the same injustice if our wishes are deliberately frustrated and if we are cut off prematurely.

The limitations of the fair innings concept is illustrated by, for example, Nelson Mandela who arguably has had his most important achievements after reaching his fair innings when still in prison. The fair innings value of a life measures life in units of a lifetime - the more the better up to a certain point but thereafter extreme discounting. People value particular events within their life disproportionately to the time required to experience such events - again Mandela is a case in point. Life years are not a commodity.

The anti-ageist case has a very strong moral base. If this approach was accepted by the Church there could be some articulation of the equal value of 'the rest of our lives' whether 17 or 70 and the equal injustice if any are thwarted by a premature end. This argument can be reinforced by the fact that some people experience their best moments after reaching a fair innings and that life events are not valued in a way that is proportional to the time taken to experience them.

ROLE OF THE CHURCH IN THE THREE PHASES OF AGEING

The following paragraphs look at the three phases of aging as described earlier and the implications for the Church. There will inevitably be some overlap of needs and possible interventions in each category.

(i) Entering Old Age:

Prevention

This is the phase in which more time needs to be devoted to prevention. Many problems occur in the elderly as a result of, for example, high blood pressure in their 40s and 50s. These include heart failure, stroke and dementia. Public Health Initiatives here could have significant effects in elderly morbidity in 15 years time. The theme of prevention recurs in the other two categories and is an area in which the Church could encourage both individuals to take a more proactive approach, and those making government health policy to put prevention higher on the list of priorities. An important selling point for governments is that the costs of not treating and preventing the illnesses of old age are high. For example, the cost of not treating depression includes expenditure on falls, reduced immunity to other disease and longer-term cognitive decline.

A recent article in the BMJ concludes that a forward-looking policy for older age would be a programme to promote successful aging from middle age onwards rather than simply aiming to support elderly people with chronic conditions.

There are broadly three interleaved components of thought on successful aging - the biomedical definition, the psychosocial definition and the views of older people themselves.

The biomedical definition concentrates on absence or avoidance of disease and of risk factors for disease, the maintenance of physical and cognitive functioning and an active engagement with life including the maintenance of autonomy and social support. The psychosocial definition emphasises life satisfaction, social participation and social functioning as well as the presence of psychological resources including personal growth. Older people as well as accepting the above definitions also add additional specific characteristics and perceptions of successful ageing. These including accomplishments, enjoyment of diet, financial security, belonging to a good neighbourhood, physical appearance, productivity and contribution to life, sense of humour, sense of purpose and spirituality.

It is on the psychosocial and lay approaches that the Church can have most influence. Awareness and pursuit of appropriate prevention measures as previously discussed apply to the medical approach, eg encouragement of regular checks of blood pressure and appropriate action where results unsatisfactory.

Psychosocial and lay definitions of successful ageing include satisfaction with ones past and present life and continued social functioning. Psychological resources for successful aging include a positive outlook, a sense of self worth and control over life, autonomy and effective coping and adaptive strategies in the face of changing circumstances. If high social functioning is accepted as part of aging successfully the implication is that people need encouragement to build-up their social activities and networks from a very young age, and the provision of enabling community facilities is needed. The Church has a key role in both provision of such physical facilities, and in the development of social activities associated with life satisfaction. These in turn foster the development of relationships associated with better health and functioning.

The Church can also encourage the thought processes of its members and of governments to recognise the importance of the psychosocial aspects of ageing as well as the biomedical approach. This emphasis could in turn assist in reducing the media and other concentrations on the burden of old age and the decline and failure of the body

(ii) Transitional Phase

Prevention

In the transitional phase between a healthy active life and frailty the emphasis is on the prevention of illness or in ameliorating the impact of illness should it occur. Whilst the Church cannot make a direct intervention it can encourage the development of policies with a preventative focus. For example, in some areas of the United States and in pilot studies in England, there are concerted hospital/community care policies which reduce hospital admissions. In practical terms this works by identifying patients most likely to require emergency admission and by providing a case management approach from a highly skilled practitioner who both treats and stabilises the condition as well as coordinating inputs required to maintain the individual at home.

Early Diagnosis

Other policies which the Church could vocalise and support are those which seek to proactively assist individuals to identify illness thus reducing long-term disability and enhancing well being. For example, a recognition of the symptoms of stroke could reduce the time taken from confirmed diagnosis to treatment and thereby ameliorate the disability aspects of stroke. Another example would be the early detection of cognitive problems which could have important benefits for mental health.

Easy Access to Care

Additionally, the Church could lobby for easy access to health checks to improve basic functioning. These could include access to oral health, eye checks, hearing, falls prevention and healthy feet.

(iii) Frail Older People

The third category refers to those who develop complex chronic conditions and who are intensive users of health and social care. This group needs to be distinguished from fit older people with an acute medical problem requiring, for example, cardiovascular services and who return from hospital with an improved quality of life. This third category is often characterised by repeated hospitalisation, deterioration of function and self confidence and the emphasis is on developing strategies to manage their conditions and to take control of their own care where possible.

The Church could influence both the policies and the quality of care for these people in several ways:

a) Creating a Culture which Values Older People

By its pronouncements, the Church could help create a culture in which older people are valued and are treated in such a way that reflects values such as dignity, equality, respect and choice. This could be manifested, for example, in supporting policies to ensure that those in caring professions are trained to respond to the specific needs of older people, that screening services do not exclude older people, and that there is flexibility in care packages.

b) Equality and Inclusion

In relation to equality and inclusion it is important that the Church and their associated community groups continue to recognise and act on the important role they have in being inclusive. This could be done by vocalising the need to ensure that services are accessible and usable by older citizens and that sheltered housing schemes are included in development plans by government and their delivery agents. People in this group can suffer from social isolation and loneliness. The Church could ensure that its human resources are used to prevent such loneliness and could also assist in the provision of practical everyday services essential to maintaining independence. Where these services are provided by the government, or where they don't exist, it would be incumbent on the Church to ensure their development and adequacy.

In terms of equality and inclusion older people are concerned when the ability to pay for private treatment determines access to services from the same consultants who provide treatment for them. It would be difficult for the Church to intervene in this issue but some thought could be given as to what measures might be put in place to protect the timely intervention in care of the elderly and to ensure they are not disadvantaged by others' ability to pay.

c) Carers

The role played by carers is very important for this group. A recent report for Department of Health in Northern Ireland estimated that 1 in 6 carers are now older people themselves. The contribution carers make towards helping people remain in their own homes and to stay independent cannot be overstated. In Northern Ireland their importance is acknowledged in this report which expresses the aim of providing better practical and emotional support to carers. The Church could vocalise its support of these policies and encourage its members to assist this group of older carers whose numbers are likely to increase due to the demographics described earlier. Some may be caring intensively for others while suffering from health problems themselves. More overall support is needed to alleviate this impact of caring in old age and the Church through its organisation and membership may be able to offer practical help.

Finally, for this group and indeed for others a strong lobby is required to ensure that the provision of palliative care is increased and extended outside of cancer. Plans for the delivery of care at the last stages of life must be planned to allow for home and community care. The Church has a role in the encouragement of governments and other providers to extend community based palliative care.

FURTHER ISSUES OF INTEREST TO THE CHURCH

The following paragraphs describe issues which may be of interest to the Church in terms of these broader factors influencing the increase in survival into old age and in each of the stages of aging described earlier. In terms of these broader factors there are two issues in which the Church should have an interest:

Portrayal of Demographics in the Media

The first concerns the portrayal of the demographics in the media and elsewhere. The growing number of older people is often portrayed as an intolerable strain. This assertion needs to be examined not only in terms of its validity but also because of the ageist attitudes this description can generate. Whilst most people age successfully it is true that NHS use increases with age and expenditure peaks in the final five years of life. This unfortunately is regarded as a problem and the success of ageing is replaced with the stereotype of dependency. It is estimated for example that only 15% of elderly people have multiple complex health problems. The theme of successful ageing will be returned to in the discussion of the three categories of aging. In this regard, the Church may have a role in both shifting the perception of ageing from the negative to the positive aspects of successful aging and may indeed also find an active role in assisting its members to age successfully.

Age Discrimination

The second matter is to do with age discrimination. Whilst overt age discrimination is outlawed there is perhaps an undercurrent of older people having disadvantage in other ways. For example, the shortage of orthopaedic surgeons and facilities for hip and knee replacement affects a disproportionate number of older people. Another example is in the area of screening. For example, preliminary studies have illustrated the efficacy of screening for Abdominal Aortic Aneurysms (AAA) but there is no public or other demand for screening to be considered pending the outcome of further studies. Could this in part be because AAA is predominant in the older age categories of the population? Without labouring these points they are worthy of reflection.

There are also the topical media issues such as cardiopulmonary resuscitation for the elderly and the alleged refusal to resuscitate in some establishments such as continuing care homes. The Church may have a role in clarifying some of the issues and in particular the fact that UK guidelines presume that patients should be resuscitated unless they have clearly requested otherwise. Resuscitation is not always appropriate and can cause rather than avoid harm and consequently there may be a case for redefining the guidelines. Whatever the outcome the theological belief in the sanctity of life may take precedence for the Church and for some individuals. However, in all cases there needs to be transparency in order that patients and relatives may make informed choices. Lack of clarity gives rise to media frenzy which in turn raises concern for members of the public. The Church can be vocal in demanding transparency.

Sources

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