

**The Ethics of Aging in the 21st Century:  
Applying a Utilitarian Framework to  
Long-Term Care & Physician-Assisted Suicide**

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Major research paper submitted to  
the Faculty of Human Sciences and Philosophy,  
School of Public Ethics, Saint Paul University,  
In partial fulfillment of the requirements  
for the degree in Master of Arts in Public Ethics

Ottawa, Canada  
August 15th, 2016

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## INTRODUCTION

One day, young Buddha stepped outside his palace grounds to tour the surrounding vistas. His venture was met with an awakening like no other, for he came across an old man bent with rheumatism, hair whitened and thinning, skin wrinkled and sagging, and gums devoid of teeth. Buddha did not see the man as an object, or as a dismissive subject past its prime, but rather, within this aged human being, he witnessed himself. “What is the use of pleasures and delights,” he asked, “since I myself am the future dwelling-place of old age?” (de Beauvoir 1).

Aging: an inevitable visceral experience deterred only by death. Not everyone has the privilege of growing old; similarly, not everyone has the privilege of not experiencing the biological factors of aging, much like the elderly man Buddha came across. As youth blooms into middle age, only to be replaced by the elder years, the realization is that “nothing should be more expected than old age:”...[and yet]... “nothing is more unforeseen” (de Beauvoir 4).

While the baby boomer generation prepares to dominate the economic and health care narrative, they can find comfort in the fact that the 21<sup>st</sup> Century is, perhaps, the best era to grow old in. Health care is at its zenith, care options abound, welfare provides a minimum quality of living, and suffering has become optional. The aging human finds themselves with an array of options in which to prolong and increase the quality of their life. Where “growing...old often means becoming physically and socially fragile and dependent on others,” the baby boomer possesses an incredible amount of autonomy in regards to their own being (de Lange 204). As Plato once said, “nobody, male or female, should ever be left without control...” (Plato 477). While the message can apply both ways, as in the need for societal boundaries, the value placed on personal agency can be appreciated as a necessary and desirable form of human existence. Growing older poses a very real challenge to the personal agency that is developed during

childhood, and nurtured into adulthood. One need not look any further than the nearest pharmacy to find a plethora of items to help counteract the effects of aging, suggesting this later phase of life has the ability to inhibit everyday autonomous activities.

Moreover, while growing older, as in increasing in years, is not optional, the 21st Century elder is inundated with options. Canadian baby boomers may or may not rely on a free health care system for their physical needs; medical tourism provides alternative options for those who can afford it. The difficulties of remaining at home versus moving into a long term care model are mitigated by the retirement industry; incurable diseases no longer require the necessary suffering, or prolongation until death.

Despite these conditions and provisions, ethical issues arise as a result of such, creating an atmosphere for problematic decision-making in caring for the elder. Thus, the main question is: how can we ethically care for 21<sup>st</sup> Century elder? Moreover, as de Lange argues in his article “The Dignity of the Old: Towards a Global Ethic of Ageing,” a more poignant question asks “what care for the elderly means...” in a very global sense, where there exists “no common moral ground for treating the weak and marginalized in a humane and just manner” (de Lange 204). As the aging population intimidates any existing moral structure for elder care, it becomes clear that there remains an imminent need for “a global ethic of ageing” (de Lange 204). The globalization of the family profoundly affects the elder, and the state; the burden of care that once fell to family members, has now become the responsibility of neighbors, friends, and inevitably, the state. This paper will argue for a global ethic of care model, by way of applying a practical utilitarian framework for the purposes of informing policy-making, funding initiatives, and global information sharing. The hope is to add to the stretching ethical rhetoric on the various ethical aging challenges in the 21st Century, and show that these issues can only be operationalized into mutually beneficial solutions from a utilitarian framework.

The structure of this paper will examine two core issues in relation to ethical care giving for the growing elderly population; although the primary focus will be on the baby boomers within Canada, a global ethic need also apply. To begin with, long term care will be examined in a threefold manner: restraint, consent, and Ontario's long-term care policies. The issue of restraint, as in chemical versus physical, and restraint versus non-restraint, will be evaluated via a utilitarian lens, reaching the conclusion that physical restraint, or non-restraint, of the elder, provides the most ethical response within a care dynamic.

Secondly, the issue of consent will be looked at via dementia and research. A few questions to consider will be: can the individual with dementia give consent? Furthermore, why are advance directives for treatment more valid than advance directives for research?

Thirdly, Ontario's long-term care policies will be examined in regards to the prevalence of antimicrobial resistant organisms within long-term care facilities, and the lacking policies for prevention and treatment. The most important question here is: is it ethical to promote treatment without addressing prevention? In other words, should obligation outweigh responsibility even when negative outcomes eventualize? Furthermore, is the Ontario government simply creating another form of elder abuse by not amending ambiguous policies regarding patient privacy, information sharing, and reporting? This section will address the current situation via a utilitarian lens, albeit a deontological framework will be acknowledged as a possible solution to examining the problem.

The second chapter of this essay will focus on the more recent debate of physician assisted suicide (PAS), and how this affects the elder and the state. The primary question asks: do aging humans possess the right to decide when they should die? While this is still a very much developing topic, this essay will argue from a consequentialist framework, suggesting that PAS is not good public policy. Moral considerations will include an examination of the varied

nuances of passive euthanasia, the ethics of end-of-life care, and the desire for dignity over prolongation of life. As dignity and public policy will be explored as a dual enterprise, leaving room for deontological discourse from the patient's perspective, the works of philosopher H.M. Hare will be examined as a response to such. The conclusion will show that PAS is a public policy issue with moral ideas. Furthermore, Professor Fritz de Lange's globalization of the elder argument will be used to show how PAS is a perpetuation of its negative effects, and does not embrace a consequentialist agenda that would otherwise benefit both the elder and the state long-term.

## **THE ETHICS OF LONG-TERM CARE**

### **Restraint, Ethics and the Elder**

This section of the essay will examine a hypothetical, qualitative case study of Ivy, an elderly woman living in a long-term care facility. Her narrative will be explored via issues of restraint, consent, and Ontario's long-term care policies. While Ivy is a fictitious character for the purposes of this paper, the motivation for her character comes from a real case study conducted in the U.K., and discussed by the *Virtual Ethics Committee*, lead by Professor Heather Draper. The purpose of this committee was to answer the ethical question: "Can we restrain Ivy for the benefit of others?" (Draper et al. 68). While the sole intention of the case study was to address the ethical dilemmas of restraining Ivy, this paper will take her narrative a bit further, in a fictitious sense. The purpose is to demonstrate how everyday ethical decisions and challenges are navigated for, and experienced by, an elderly person who requires care, yet wishes to maintain a level of autonomy in spite of cognitive and physical limitations.

Meet Ivy: a 92-year old widow living in an Ontario long-term care facility. She was married for over 60 years, has 6 children, and numerous grandchildren and great-grandchildren. One of her daughter's, named Claire, lives in the area, but she is in her seventies, and suffers from acute rheumatoid arthritis. She comes to visit her mother periodically, but is not well enough to participate in ongoing care decisions. Ivy's other children live all over the world, and are often unavailable to assist in care decisions.

In the three years that Ivy has lived in long-term care, not one family member has attended a care conference. Ivy's mother lived well into her eighties, logistically surrounded by her seven children. However, Ivy's situation is quite different, given the effects of globalization. For example, one hundred years ago, family members were more likely to stay within the same location, providing a greater network of care for their elderly. Today, this network comprises "blended families, friends, and neighbours..." along with state agencies, to provide support for the elder (de Lange 208). Inevitably, Ivy's care has fallen predominantly to the state.

Ivy's diagnosis is dementia of an unknown kind, yet she remains fully ambulatory, with declining cognitive function. Upon entrance to long-term care three years ago, she was able to navigate her way to the dining room and her bedroom without assistance. However, as her cognitive function has begun to deteriorate, she has been exhibiting difficult behaviors. For example, while en route to the dining room the other day, she entered several bedrooms of other residents, and rummaged through their things, even flushing items down the toilet (Draper et al. 68). Another time, she "tried to push away a mobile drip stand whilst another patient was still attached to it" (Draper et al. 68).

The nursing staff have suggested she poses a risk to the other residents in the facility, and something must be done to restrain Ivy. Both chemical and physical restraint have been used, both being equally effective in protecting the other residents. However, the staff are not only

concerned for the welfare of the other residents, but for Ivy as well. They have proposed the use of a tilted chair versus a chemical restraint. The idea of the tilted chair is that Ivy will be sat in the chair when she's feeling agitated, and is bothering other residents. While she is not tied to the chair, nor any obstruction placed in front of her, she won't be able to get out of it herself, due to her short stature, and physical impairments (Draper et al. 69). The impetus behind the use of a physical restraint stems from the concern over Ivy's rights and welfare during and after the use of a chemical restraint. For example, after being sedated, Ivy "is not herself for several hours once the sedation has worn off," compared to the restraint of the chair, where she can still participate in leisure activities, such as listening to music (Draper et al. 69).

There are a few ethical questions to consider before going any further. Foremost, "whose best interests come first?" (Draper et al. 70). This must be the primary question in health care ethics; deciding who the patient actually is can change the course of decision-making, and how the problem is examined. In other words: is Ivy the patient here, or are the other residents? During Draper's study, this question was one of the main concerns (Draper et al. 68). The suggestion was to re-examine the situation, placing "another elderly patient, injured or killed because of Ivy's uncontrolled actions," as the predominant focus (Draper et al.70). This pivotal viewpoint changes the problem altogether, putting Ivy on the sidelines. Nevertheless, the ethical conclusion is inconclusive, meaning both Ivy and the other residents are central figures. In the question of whether or not to restrain Ivy, "in the absence of one-to-one care...her right to roam must be restricted in order to preserve the other patients' right to safety" (Draper et al. 70). This dual approach to ethical care for the elder embraces both the safety and rights of each resident in equal consideration.

This leads to the second question: how should Ivy be restrained? If it is determined that she must experience some kind of restraint, then it must be decided what is the most ethical

approach to restraining her: chemical, physical, and non-restraint all included within this discourse. Henceforth, a utilitarian framework may be of some assistance in reaching an ethical conclusion.

To begin by asking how one must be restrained in a long-term care setting unfortunately places staff as the central focus of the study, not the resident. The welfare of Ivy and the other residents may well be the main concern; however, staffing issues take precedence. In the case study, the committee suggested that one-to-one care for her would be an ethical resolution; namely, non-restraint seemed like the best response in this situation. Nevertheless, although the staff agree that Ivy “should be getting one-to-one care...[they also realize] that we do not live in an ideal world” (Draper et al. 69). That “restraint of any kind should be governed by protocols that ensure that it is properly and appropriately applied,” should be inherent, especially within a global ethic of care model (Draper et al. 69). While the practices of risk management and evaluatory measures help reduce “abuses,” leading to a morally appealing solution to dealing with behaviors exacerbated by dementia, the morality of restraint itself comes into question (Draper et al. 69).

During Draper’s study, the committee offered a comparison of chemical versus physical restraint, disallowing for non-restraint as a viable option, given the “concerns that Ivy will at some point do something that does inadvertently have harmful consequences for one of the other patients on the ward,” coupled with the unrealistic staffing challenges (Draper et al. 69). The arguments given for physical restraint assume that it is a “less invasive” approach to dealing with Ivy, due to the notion that it still allows for her to be herself to a certain extent, which is the key factor here (Draper et al. 70). If Ivy is still allowed to enjoy the things that contribute to her quality of life during physical restraint, then it appears that this type of restraint is less invasive;

she is likely to experience far less disruptions to her participation in the activities that contribute to her quality of life.

Chemical restraint also makes a convincing argument. Clearly Ivy is experiencing a decline in her cognitive function, meaning she is becoming less and less of herself; what Ivy was in her previous, cognitive years is not the present Ivy. Within this mindset, perhaps the conclusion is that Ivy will never be “her old self again,” and she has “irreparably lost her powers of reason and caution” (Draper et al. 70). Thus, sedation is not an escape from the real Ivy, but merely an effort to “keep others safe,” and within this way of thinking, as the committee asked, “is it really so wrong...?” (Draper et al. 70). However, as the committee surmised, is there any point for even caring for Ivy, “if the only conditions that render care possible deprive her of conscious appreciation of her life?” (Draper et al. 70). The point is, chemical restraint is more problematic for Ivy’s quality of life. As the elderly person with cognitive and physical impairments struggles with the ability to communicate their needs, their “vulnerability...increases,” meaning it becomes crucial for caregivers to be able to “observe and interpret patients’ signals in order to provide ethical care” (de Casterle et al. 604). If chemically restraining Ivy means she is no longer herself during, and for several hours following, sedation, then it is reasonable to assume she is not able to express her wishes to her caregivers. Her quality of life is therefore compromised, and the care she receives is ethically questionable. Furthermore, perhaps the act of putting her under sedation is an unethical practice in itself.

Thus, to reach the most ethical answer to this dilemma, a consequentialist framework must be applied. As seen previously, Ivy must undergo some kind of restraint for the benefit of everyone. Moreover, the pain or angst that Ivy experiences during or after restraint produces the most amount of happiness all around. In this case, the end does justify the means; the harm inflicted upon Ivy during restraint does not outweigh the harm she would cause if not restrained.

If the same notion is applied to chemical versus physical restraint, it appears that the harms of chemical restraint do outweigh the harms of physical restraint. Going forward, it is therefore advisable that where non-restraint is not an option, physical restraint may be the most ethical solution to dealing with long-term care patients like Ivy. Nevertheless, a decision of how to restrain must be determined on a case-by-case basis.

Non-restraint must be considered at this point, asking two questions: What are the challenges to adopting a non-restraint approach? Is restraint a violation of human rights? Firstly, the challenge to “establish a restraint-free approach” is a complex notion often rejected by traditional thinking that physical safety trumps emotional security (Goldman 287). Thus, the argument for non-restraint is met with two obstacles. To begin with, despite growing awareness about restraint issues during the past quarter of a century, nurses are routinely “inadequately prepared in gerontology” (Goldman 288). A qualitative Belgium study of “physical restraint in acute elderly care” revealed that less than “1% of employed registered nurses were certified in geriatrics” (Goldman 288). The study also showed that while nursing students were educated in areas of “patient assessments,” the elderly population was largely neglected in regards to developing “individualized care” initiatives to address alternatives to using restraints (Goldman 288). Quite likely, this educational inadequacy has a negative effect on a “restraint-elimination program” (Goldman 289).

The second obstacle focuses on nursing hierarchies and poor care initiatives. As care institutions introduce anti-restraint programs, in line with state and provincial care mandates, the existing, and very traditional policies, are difficult to adapt (Goldman 288). The staff are already lacking gerontology training, and are now asked to change their approach. Combined with poor communication, and “lack of time or human resources to provide care and services” results in unhappy employees, which in turn affects the quality of care they provide (Goldman 287). The

reality is, they don't trust the administrative hierarchy, and nurses "fear liability or loss of their licenses if a resident" experiences injury or death due to lack of using a restraint (Goldman 288). Thus, when new anti-restraint initiatives are introduced, nursing staff approach it with negativity and fear (Goldman 287). The reality is, alternative options rely rather heavily on the availability of "resources, attitudes, and policies of health professionals, institutions and governments" (Dodds 162).

Moreover, despite the ongoing international discourse that has raised numerous queries in relation to restraint, such as human rights violations, physical restraint is still used between 33% and 68% of the time within "acute care settings" (de Casterle 604).

Perhaps a human rights approach can enlighten, asking if physical restraint is an infringement on Ivy's human rights. The notion of physical restraint is still viewed as an "imprisonment" of sorts, despite the side-effects of chemical restraint. The opinion that imposing such a restraint on Ivy is in violation of "Articles 3, 5 and 8...[such as]...the right not to be tortured, the right to liberty and security, and the right to family life and privacy" is questionable (Draper et al. 69). Draper suggested that Article 2 of the *Declaration* serves to endorse Article 3 in that the right to life denotes actions that save the life in question (Draper et al. 69).

Furthermore, Article 5 can also be defended on the premise that the "future liberties" of the resident in question, such as Ivy, along with other residents, "are being protected" (Draper et al. 69). From a purely human rights position, there is a valid argument for the rights of Ivy, and her desire to not be restrained. Nevertheless, this is not necessarily supported by sections 3, 5 and 8 of the *Declaration*, in that the act of restraining Ivy is not a suspension of her human rights, but rather, upholds her right to life. In other words, in her current cognitive state, decisions are being made in support of her human rights, and the rights of those around her. This is by no means an exercise in changing Ivy's access to human rights due to her circumstances. In addition, what

Ivy's caregivers cannot know is what Ivy would have wished for prior to her deteriorating cognitive abilities. Perhaps, had she been able to foresee her diminished abilities, she might have requested that she be physically restrained, or even chemically restrained. If this was the case, the human rights argument need not apply; Ivy would have been restrained at her own cognitive request. As already established, whether cognitively incapacitated or not, restraining Ivy is, perhaps, not a violation of her human rights. Unfortunately, her care providers don't know what her wishes were, nor does her family, and restraining Ivy appears to be an exercise in respecting the human rights of all concerned.

This is a classic example of how globalization affects the elder, and the burden of care that needs to be borne by someone, in some fashion, and by some kind of code of ethics. That Ivy requires care is obvious; however, now that the state bears the responsibility, in a very global sense, there remains a need for some kind of global ethic of care framework to serve as a guide. The next section of this paper will hopefully shed some light on the above questions, further adding to the argument for an ethical care model that reflects globalization.

### **Consent, Dementia, and Ethical Considerations**

Who can give consent? The assumption here is that any sentient adult being can give consent for themselves, or others who require a carer to assist them. What happens when dementia enters the picture, and consent becomes a fuzzy and unclear picture? Ivy, as already established, has dementia. However, despite her declining cognitive function, there is something that she would like to consent to: research. Prior to exhibiting any signs of dementia, Ivy signed a consent form, indicating her wish to participate in dementia research should she ever be diagnosed with such. Her family is not available to assist her in making these decisions,

therefore, the nursing staff, the long-term care facility, and the province of Ontario must assist Ivy in coming to an ethical conclusion.

There are great difficulties in procuring informed consent with people who have been diagnosed with dementia (Cubit 232). Despite this ongoing debate, however, only Canada has developed stringent policies that “make explicit mention of advance directives for research” (Buller 701), which is a rather comforting thought given the projections regarding “substantial increases in life expectancy” (de Lange 205), and that by 2031, 1.4 Million people in Canada alone will have a dementia diagnosis (Alzheimer Society Ontario). Nevertheless, an urgency to do dementia research is greatly emphasized by the projected astronomical costs. It is estimated that by 2040, 293 billion Canadian dollars will be spent on dementia-related research and care; this number includes lost earnings, and health care costs (Alzheimer Society Ontario). Moreover, “if dementia were a country it would be the world’s largest economy...” (Buller 701). There is great emphasis placed on the relationship between aging successfully and “cognitive function” (Vallejo 1). The reality is, people are living longer not by “passive survival,” but by “the adaptive capacity of physiologic systems” (Vallejo 2). In other words, there is documented correlation between an individual’s “immune cells, humoral factors, physical function, and cognitive ability” (Vallejo 2). The bottom line: “future innovation” to help improve the “health outcomes in old age” requires research, and obtaining consent is critical to this research (Vallejo 2). It is important to remember that the chief intent of research is not just to “benefit the research participants, but to generate knowledge” (Jongsma and van de Vathorst 708). Thus, the goal of conducting research with patients suffering from cognitive decline is to find an ethical course to proliferate “research opportunities in this group” with future considerations (Jongsma and van de Vathorst 708).

The word “consent” also denotes capacity. When an individual gives consent for something, legally speaking, they must be deemed as capable for making that decision. The capacity of someone to make informed choices means they comprehend the information, can make decisions based on that information, and then communicate those decisions to others (Cubit 231). When someone is in a state of cognitive decline, it can be challenging to complete all three of these steps, and determine if they truly understand the “nature of the research...[and]...appreciate the consequences...” (Cubit 231). Furthermore, when doing research with dementia participants, it is important to consider their human rights to avoid harm (Cubit 231). In Ivy’s case, because her advance directives indicated she wished to participate in dementia research, there’s a likely chance that her consent to participate will be acknowledged, given she resides in Canada. However, if she lived in the United States, her advance directives would not carry much weight (Buller 701).

If it is determined that dementia patients are not capable of giving informed consent, then what next? The following steps involve family members, or caregivers that can legally give consent on their behalf. However, there are problems with this process as well. Most often, a “guardian, spouse, unpaid carer or close friend or relative” can give the consent, but in some cases, the patient with dementia may not (Cubit 232). Or, the patient may give consent at the beginning of the research, but as their cognitive function declines, they may express their wish to discontinue. During the earlier stages of dementia, the patient is often able to competently express their wishes, and have meaningful discussions about it (Cubit 231). Eventually, cognitive abilities diminish, giving way for state regulations and policies on research (Amella et al. 14). The very “nature of the illness” predicts that the “capacity to consent will diminish over a period of time” (Agarwal et al. 804). Although the past thirty years have yielded an increase in dementia

research, it is not enough, given the alarming projections, and the lack of a cure to be found (Amella et al. 14).

According to the 2009 *Partnership of Consent Protocol* there needs to be a specific process in place which protects the dementia patient, given that surrogate consent is often required to proceed (Amella et al. 14). The protocol team developed a framework to indicate the suggested steps to follow in obtaining consent, proceeding and/or discontinuing research. The multi-step process identifies dementia patients who could possibly be good candidates, then consent is sought by approaching powers of attorney, or a representative. The patient themselves are not asked for their consent directly, nor is there any caveat for advance directives. However, the patient can be excluded from the research based on their response to the proceedings. At no time at the outset of the study are they asked for consent, despite the importance of trying to obtain consent from the patient first (Cubit 231).

A recommended variation would be to first assess any advance directives, and proceed as if the dementia patient has already given their consent. Secondly, if no advance directives are in place, the patient should be contacted and asked for their consent to the study. While there are impediments to this process, the patient with dementia is still capable of some decisional capacity during the varying stages of dementia. However, while it is important to first obtain consent from the patient themselves, dementia can leave them profoundly “decisionally incapacitated” about big life and death decisions (Amella et al. 14). If it is determined that they are not able to give consent, they are often excluded from research. The result: less research is being done, and the chance of a cure is still out of reach. Perhaps, for the sake of future costs of dementia, the mental and physical strain on family members, and the individual suffering this diagnosis brings, consent for research given by an individual with limited cognitive function

should be fully acknowledged, and the research process should be initiated, so long as it does not result in undue harm to the participant.

A subsequent concern to consider in this discourse is the role of advance directives for research vis-a-vis advance directives for treatment. Professor Tom Buller from Illinois State University argues that there should not be a dividing line between consent for treatment, and consent for research (Buller 701). If the dementia patient can decide they wish to accept or reject treatment once they experience cognitive decline, then they can also choose if they wish to consent to research (Buller 701). For example, if Ivy was diagnosed with skin cancer and in her cognitively-impaired state she said she did not wish to undergo any treatment, her wishes would more than likely be acted upon. However, she has indicated she wishes to partake in the latest drug trial for dementia, as well as a study regarding the correlation between left-handed women and longevity. While her consent to the dementia research is recognized legally, due to her advance directive to participate in dementia research, her consent for the latter is not, because her advance directive makes no mention of any other research outside of dementia. Both decisions, as in consenting to no treatment for skin cancer, and consenting to dementia research, are major life decisions; therefore, why is her autonomy over her own body only recognized in the former scenario? Ivy's decisional capacity should not diminish within the research context. If the dementia patient can specify the kind of care or treatment they wish to have once they are no longer cognitively able to make such decisions, then their wishes regarding research should also be respected in the same manner. As Buller points out, there is a "principle of precedent autonomy," in which a fully cognitive individual can "refuse life-sustaining treatment when later incompetent," and likewise consent to future research during decisional incompetence (Buller 701).

The bottom line comes back to the alarming future predictions regarding the rise in dementia, and the reality that something must be done. Research is imperative to finding a cure, and a cure would greatly benefit the whole of society. Therefore, it is strongly recommended that a consequentialist attitude apply, in a twofold manner. First, Buller is right in suggesting that advance directives for care are given much greater priority than research directives. This may temporarily benefit the family unit, for their loved one with dementia is allowed the dignity of suffering and dying in the way they wish to. However, this does not always benefit the state, nor its citizens. Care directives are important to follow, but given the globally alarming predictions, research should perhaps be given priority, but in a way that preserves the dignity of the elder, and of the research process. Perhaps one answer is more education to the general public, emphasizing the importance of advance directives for research in Canada. Thus, if the elder wishes to consent to research, even when declared cognitively incompetent, the good of the overall population should strongly influence the researcher's decision to proceed.

### **The Ethics of Antimicrobial Resistant Organisms in Ontario**

Imagine that Ivy has been recently diagnosed with Staphylococcus Aureus (MRSA), a highly contagious superbug, also referred to as “antimicrobial resistant organisms (AROs)” (Arbuckle et al. 1). The information sharing policies surrounding this diagnosis are contained within section 11 iv of the Ontario Long Term Care Act 2007, which reads as follows,

“...have his or her personal health information within the meaning of the *Personal Health Information Protection Act, 2004* kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act” (Long Term Care Homes Act).

The *Personal Health Information Protection Act 2004*, section 37 d & e stipulate that the resident's information can be shared "for the purpose of risk management, error management or for the purpose of activities to improve or maintain the quality of care..." (Long Term Care Homes Act). The College of Physicians and Surgeons of Ontario also present with an ambiguous description of privacy and information sharing, re-routing back to the Long-Term Care Act.

In other words, there remains highly ambiguous language within these Acts, allowing for misinterpretation. If an independent long-term care facility wished to interject their own notions or policies about sharing their residents' information, they are at liberty to do so. There are two areas of information sharing to consider here. First, the sharing of health information amongst the staff performing Ivy's care, and secondly, the sharing of Ivy's recent diagnosis within the province of Ontario.

Ivy, like many other residents within long-term care, receive multidisciplinary care during their course of stay. Care is comprised of nursing staff, physicians, recreation therapists, spiritual caregivers, administration, social workers, food services, sanitation services, etc. That resident care should fall to one department is a rather ludicrous idea. Similarly, it is equally ridiculous to suggest that information sharing should be contained within one department. However, existing long-term care policies in Ontario make provision for this scenario. For example, Ivy's long-term care facility could implement its own policy, stipulating that Ivy's recent diagnosis of MRSA is highly confidential and must be contained within her individual chart; no verbal communication is allowed. For those who have ever spent any amount of time within a long-term care facility can appreciate the number of departments and staff it takes to care for one individual. It is not inconceivable to imagine that staff from seven different departments come in contact with Ivy's bodily fluids in the course of a day. For instance, the nursing staff assist her in her activities of daily living, including brushing her teeth, and toileting.

The kitchen staff may assist her in feeding if she requires such, perhaps touching her cutlery. The cleaning staff enter her room each day to empty her garbage cans. The social worker may visit her to reassess the appropriateness of remaining on her unit, given her more recent cognitive decline. The recreation staff assist Ivy on and off the unit, taking her to various events, which may include baking with other residents. The spiritual care staff may have an afternoon visit, spending time praying with her, and scooping her dirty tissues into the garbage can. Ivy may even take a stroll to the administrative office for a little money so she can purchase items at the in-house pharmacy. It is not unreasonable to imagine that this might be a typical day in the life of a long-term care resident diagnosed with an ARO.

If the nursing staff was the only department privy to Ivy's health information, all other departments could unknowingly come in contact with the ARO, becoming infected themselves, or becoming carriers. This leads to the obvious question: is the act of not sharing information truly an exercise in ethics? It is approximated that "as high as 74.8% of residents [within long term care facilities are] found to be carrying at least one..." ARO (Arbuckle et al. 2). On average, MRSA is carried by between 11% and 48% of all residents (Arbuckle et al. 2). In Ontario, hospitals are mandated to collect data in relation to ARO's, follow specific protocols, and publicly report the findings "as patient safety indicators" (Arbuckle et al. 2). Nonetheless, long-term care facilities in Ontario are not required to collect, nor report such data, creating difficulties in making "informed decisions...and identify[ing] needs" (Arbuckle et al. 2).

Information is not being shared on two levels: at the provincial level, and at the caregiver level. First, by not collecting and reporting crucial health information, one cannot accurately inform a treatment regimen or develop prevention strategies. The province cannot provide the care necessary for dealing with ARO's, leaving the frailest population at even greater risk of illness and disease. Secondly, by allowing individual long-term care facilities to initiate their

own policies, which may result in not verbally, or efficiently, communicating between staff members about any present ARO's, the direct caregivers cannot provide adequate care, and they themselves can become carriers between residents. From a policy and caregiver perspective, the ethical question becomes a focus on what is more important: the overall good of the population, or individual privacy.

From the patient's perspective, "health information privacy...and security have been reported to be prominent concerns..." (Foster et al. 95). Simply put, people don't want the entire health community knowing everything about them. They would rather pick and choose what they wish to share with various health care providers. While electronic information sharing is a useful tool for physicians for the purposes of data collection, diagnostics, and treatment and prevention, patients want control over what and how their information is being shared. Long-term care, in this regard, is problematic on a few levels. To begin with, who is controlling consent? Much effort has been put into determining "containment, efficiency, and cost effectiveness" in elder care, leaving the "ethical and moral assumptions" on the back-burner (Polivka 1). The effects of globalization, as already determined, are rather profound; as "individualism" dominates the 21st Century narrative, "social counter-practices" become the daily routine (de Lange 208). Thus, the state moves into a growing position of control over the elderly patient's health information. The question becomes not one of who is giving consent, but how it is being controlled, and by whom. If the state shares in the control of the elderly patient's information sharing, perhaps a hybrid approach to addressing the ethical concerns is to be considered.

In 1997, physician and bioethicist John Dossetor wrote an interesting article entitled "Human values in health care: trying to get it right." The focus of the article is on the needed balance between a deontological and utilitarian approach to ethical decision-making. He gives the example of the terminally ill cancer patient who desires dialysis; Dossetor suggests that both

ethical perspectives be given equal roles in the decision-making. This hybrid approach acknowledges the elderly patient's wishes and privacy concerns, while making way for beneficence. The goal of deontology in this instance, takes a dual approach. First, it asks what Ontarians and Canadians should be doing in caring for the elder within long-term care. It also asks what should be done preventatively, in a future sense. (Dossetor 1689-1690)

Kant's description of the notion of free will, or autonomy, suggests "mental competence" (Secker 43) is performed by "rational agents" (Secker 46) in relation to decision-making. He argues for autonomy for the patient, and the duty of the health care practitioner to respect thus. The role of the patient is twofold: his or her "need for care," and enacting their own free will (Secker 43). The role of the caregiver is also twofold, according to Kant: care for the patient, while respecting their autonomy, and beneficence. However, as already determined, caring for the elderly population comes with a few complications. Consent becomes questionable when dementia is present, and the absence of family members thrusts the burden of care onto the state, who may not be aware of any previous wishes of the elder with dementia. Duty becomes an ambiguous exercise, asking for a balance between beneficence, patient autonomy, and what's best for the state. Moreover, approaching health care should, perhaps, not be a morally exclusive endeavor.

Utilitarianism takes a more straightforward approach. As Dossetor maintained, his hybrid methodology addresses the two exigent concerns. Respecting the "equal moral value" of each person, combined with "outcome-based" utilitarianism appeals to the fully-cognitive patient, and the dementia patient who can no longer make autonomous decisions (Dossetor 1690). Furthermore, it allows the state to make necessary provisions within existing health care policies.

Under this recommendation, the duty of the nursing staff is to provide optimal care for Ivy, while sharing their knowledge of the MRSA diagnosis will fellow staff members. However,

due to the ambiguity of Ontario's provincial long-term care policies, they fail Ivy in this instance: allowing for exposure to, and the spread of, MRSA. Furthermore, the complete lack of any policy regarding the reporting of ARO's in long-term care facilities within Ontario fails the entire population. While Dossetor's argument is not perfect, as it does not really address globalization, it does offer a solution to addressing decision-making within a growing dementia population. By applying a utilitarian context to the current inadequate long-term care policies, a policy that benefits the patient and the state would now be possible. For instance, by sharing Ivy's health information, data collection, prevention, and treatment of ARO's could be addressed on a much more accurate scale. The enhanced provision of health care would benefit the patient; allowing the state to make more precise predictions, resulting in more accurate resource allocation.

That there remains an urgency for policy reform given the alarming statistics of the prevalence of ARO's within Ontario's long-term care facilities is quite obvious. Perhaps a deontological and utilitarian framework should apply in order to address prevention. It is not ethical to treat the patient, and not enact preventative measures. However, by no means does this suggest that the patient should not have control over the sharing of their personal health information. The suggestion is that patient autonomy over the sharing of their health information must play a role in mutually beneficial purposes within the state. The recommendation is to place a stronger emphasis on a utilitarian framework, always asking what will benefit the whole of society, and not just the patient. If the state suffers by keeping health information private, then the patient does not have the right to, nor should they own, private health records. Similarly, if the patient suffers because they have kept their own health information private, thus exposing themselves to other ARO's, they are also harming themselves, which in turn, burdens the state. Perhaps the following chapter can enlighten the necessary, but precarious, relationship between a

deontological and consequentialist approach to creating a global ethic of care framework for the elder.

## **THE ETHICS OF PHYSICIAN-ASSISTED SUICIDE AND THE ELDER**

In 1938, the *Euthanasia Society of America* asked the question: “Does the elder own the right to die?” (Clark 273). In 2016, the question has changed to: “Does the aging human possess the right to decide when they die?” While the obvious answer to the former is “yes”, the latter is a more specific query into determining the timing of one’s own death, and the public policy reflections of such. As with many moral issues, the question and the answer remains incomplete, calling for more research, more dialogue, and more policy adaptation to reflect the ever changing needs of society. It is without doubt that this issue has become “an increasingly important and controversial public policy issue in aging societies,” given the burgeoning baby boomer demographic (Clark 273). This seems to be the nexus of the matter; what about physician-assisted suicide (PAS) and the elder? The question itself suggests society is not prepared for this demographic, and must enter the debate while placing the elder at the center of it, asking “the debate...[to]...shift to an examination of the needs and values of patients that recognizes the limits of modern medicine and inevitability of death” (Cassel and Meier 751).

Nevertheless, despite the “multiple needs” of the elder as they near their final years, the interest of the elder must also share the stage with the state, calling for a consequentialist agenda (Hamlin 54). The second chapter of this paper is an attempt to reveal PAS as a burden, not a resolution, to the state’s economic agenda, and the interests of the elder. The conclusion will reveal an earnest need for a global ethic of care public policy framework that reflects the interests of the elder and the state, not particularly in that order.

Physician-assisted suicide (PAS) is described as the process by which a medical doctor “prescribes a lethal drug for a patient, gives the patient the drug, and/or is present when the patient takes the drug” (Gather and Vollmann 444-445). The Canadian *Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying*, dated November 30, 2015, recommended that the process of PAS be determined by the patient, thus defining PAS as assisted death that may be self-administered, which does not require the presence of a medical practitioner (41). Over the years, there have been numerous terms to describe PAS, such as assisted suicide, right to die, end-of-life decision making, do not resuscitate codes (DNR), patient self-determination, and aid-in-dying (Clark 273). As the Advisory Group suggested, this topic is quite new to Canada, leaving the Canadian narrative relatively unwritten.

Why do humans so strongly desire to control the conditions and timing of their death? In 1990, Dr. Kevorkian, a pathologist, helped a woman commit suicide. The conditions included a remote parking lot, a van, and the cover of darkness. Over dinner one evening, Janet Adkins told Dr. Kevorkian about her recent diagnosis with Alzheimer’s Disease. She expressed her desire to end her life, but wished for assistance in doing so. The doctor agreed that her demise was indeed worthy of suicide, and aided her in carrying through on her intentions. (Cassel and Meier 750)

Despite the 1978 Gallup poll which revealed that as high as forty percent of Americans condoned PAS “when faced with an incurable disease” (Clark 276), public outrage ensued, as lawyers, medical doctors, and ethicists “expressed their abhorrence of Dr. Kevorkian’s act...” (Cassel and Meier 750). Perhaps it was not so much the actual act of having a physician assist in the ending of life, but rather, the undignified conditions and lack of public policy, all of which driven by the “fear and anxiety...that...suffering will be prolonged by medical technology...” (Cassel and Meier 751). The past one hundred years have witnessed a tremendous leap in medical technology, and the ability to prolong life. One may not look any further than their own

family to recall stories of how life support sustained a loved one long after their brain ceased to function, or how someone suffering from cancer lived six months longer than anticipated due to a newly available treatment. The result has been a “substantial public desire for more control over the circumstances of death” (Cassel and Meier 751). In other words, facing death in a dignified manner is of more importance than “prolonging life” (Cassel Meier 751). Suffice to say, the medical community, which has strived to offer humans a longer life span, has hence burdened public policy-makers with how to end it in a similarly dignified manner. As some maintain, perhaps “it is never acceptable for a medical professional to take life...” despite the disparaging conditions (Cassel and Meier 750). There is nothing morally wrong this statement, as “actively cause[ing] death” was not legally condoned until quite recently (Battin 70).

Nevertheless, the rhetoric of morality, and the varied definitions of PAS, reveal a rather grey area for not only ethicists, but society as well. The practice of passive euthanasia has been, and is, a mechanism for “dealing with...hopeless...situations” (Battin 70). Moreover, the advancement of medical technology has driven health care practitioners and ethicists to find ways to approach end-of-life care that do not necessarily include PAS, but do “involve withholding or withdrawing various forms of treatment” (Battin 70). For example, the patient themselves may have explicitly demonstrated in an advance directive that they no longer wish to be treated for terminal cancer once the prognosis is grave. Furthermore, the use of DNR’s, Powers of Attorney for care, and outright refusal for further treatment, are all a means for ending life within a controlled context (Battin 70).

Allowing the patient to die, where it is determined there is “no medical or moral point in going on,” such as withholding “life-sustaining treatment,” has been, and is, a response to a lack public policy concerning PAS (Battin 70). The problem is in the definition, however. Can a distinction be drawn between this notion of passive euthanasia and actively causing an

individual's death? In legal terms, the answer is yes, the Kevorkian story a poignant case and point. Moreover, the question itself must begin and end within a moral context, only to be answered within a practical public policy framework.

Therefore, here is the burdensome question, and the first task at hand: is it moral to allow a patient to die by withholding medical treatment vis-a-vis hastening an inevitable death via medical interference? The distinction between the two actions is blurry at best; if a terminally ill patient chooses the drug that will prevent pain, but will hasten their death by a few days, as opposed to choosing another drug that will also prevent pain, but will put off their death by a week, is this an exercise in PAS? Perhaps, the patient wishes to stay alive long enough to see their family members, and the physician is able to assist them in doing so by offering one last life-sustaining treatment. However, once the family has rallied around for one last goodbye, the patient now declines further treatment, and asks the physician to administer the drug that will treat pain, but allow for an earlier death. Can this controlled scenario be described as PAS or passive euthanasia? The answers are not definitive, nor do they provide much moral guidance to finding a solution.

From a purely moral agenda, the issue is not one of polarity, nor arguably one of right versus wrong. Alas, there are many valid arguments made for the legitimacy of PAS; likewise, there are equally substantial arguments made for passive euthanasia as the moral answer. Nonetheless, as the Kevorkian case revealed, the public outcry is for public policy, and here remains the crucial matter at hand. Perhaps, the only clear response to this moral dilemma is to suggest that it is morally wrong not to respond within a public policy framework. Hence, an overarching utilitarian response is imminent. As Sir Giles of Rome once said, "There is never militia in the will unless there is error in the intellect" (Eardley 164). The task, therefore, is to inform a global ethic of care by way of developing public policy for PAS and the elder.

## **End-of-Life Care and the Elder**

The task is twofold; First, end-of-life care issues must be the greater part of the narrative, while engaging a deontological framework from the patient's perspective. Dignity and policy can, and must, be a dual enterprise in order to breach the gap between inequalities in care practices amongst the elderly and policy-makers. That there remains a gap in the first place demands an inquiry, as indicated earlier within long-term care institutions in Ontario, but also from an end-of-life care perspective.

This reorients back to the original question of whether or not the elder possesses the right to decide when they die. If past actions are any indication, the answer has already been answered. That the patient can choose one particular drug over another, which may hasten their death, or refuse further treatment for terminal illness, suggests that humans already are exercising the right to choose the timing of their death. Perhaps, the debate is now focused on precise timing, rather than approximate timing, and what society is calling for is policy that reflects such. Dignity is important to society, and the inequalities in which the elder years are often defined by have led to the current debate.

The end-of-life care situation for the elder is less than rosy. In general terms, the elderly patient is "viewed as being more vulnerable" (Bilsen et al. 2). Aging in itself is a risky endeavor, given the effects of globalization (de Lange 207); the elder's "capacity for physical work...increases their risk of debt, hunger, illness, and isolation..." (de Lange 206-207). While the effects are much more dire in developing countries, the North American elder also feels the profound effects of globalization; the 2008 economic crisis revealed the fragility of pensions, and the economic future (de Lange 207). However, the greater concern for the elder is increased life expectancy, which can be examined in two ways. To begin with, the "prolonged dying process"

makes the precise timing of death of great interest (Bilsen et al 2). In the past, the elder was more likely to die of an “acute infectious disease,” as opposed to “chronic and degenerative disease” (Bilsen et al. 2). The latter denotes a prolonged process made possible by medical advancements. Despite the positive side to medical advancements, such as “better health in late life,” the elder still fears a prolonged death (Vallejo 1). That 85% of deaths occur within some kind of health-care facility, 70% of which are the result of passive euthanasia, the fear of not controlling the timing of one’s own death is not entirely unfounded (Battin 70). A strong argument for the elder having a “unique claim to an ethical, unobstructed suicide...” emerges, given the effects of globalization (Clark 274).

As explained earlier, the responsibility of care for the elder has greatly changed within the past century, leaving the state to reconcile end-of-life decisions with adequate public policy. The reality is, public policy regarding end of life care issues is inadequate. The fact that over 74% of long-term care residents carry at least one ARO exemplifies this. As the state grapples with providing end-of-life care options for the elder, the growing baby boomer demographic demands a dignified response which reflects the patient’s perspective. Although Kant pointed to the “source of moral value” as something that certainly did not include any form of suicide, he failed to acknowledge that “rational beings” not only “owe themselves,” but are owed a certain modicum of dignity that fully embraces the duty of the state (Cholbi 607). Furthermore, this duty must give equal consideration to death as it does life. Thus, the suggestion is that “equal moral value” entail end-of-life care initiatives (Dossetor 1690). The deontological approach outlines a patient-centered scenario in which autonomous decisions are given precedence. In this instance, the patient would actively take a role in making their own end-of-life decisions in a much more precise context. The problem, as outlined earlier, is inadequate policies to reflect this.

Secondly, health care rationing in end-of-life care decisions is equally concerning to the elder that supports PAS, and the elder who does not support PAS. Firstly, the elder in favor of PAS fears the “inequitable distribution of scarce medical resources (Bilsen et al. 2). That the elderly patient reports having “less access to specialist or palliative care...[and less]...adequate pain and symptom treatment,” is grounds for the state providing greater autonomy for the elder (Bilsen et al. 2). Furthermore, family members and physicians do not always have the elder’s best interests at the forefront, given their propensity to not “continue or intensify end-of-life treatment in older than in younger patients” (Bilsen et al. 2). This can be a frightening scenario for the elder who allows for health care practitioners, powers of attorney, and family members to make their end-of-life care decisions should they become incapable of making autonomous decisions (Hamlin, Hawkins and Kane 50). The “multiple needs” of the elder suggests the more pressing need for advance directives to be put in place prior to any cognitive decline (Hamlin, Hawkins and Kane 54). The use of advance directives can be a fairly efficient and comforting response to the rationing of health care.

Moreover, the elder that opposes PAS also makes a compelling case. The vulnerability of the elder is emphasized, warning “of a slippery slope” toward less than ethical practices in the future (Bilsen et al. 2). Legalization of PAS creates a climate of anxiety, given the dementia predictions, and the fear that explicit consent from the elder will not be sought, nor respected, in making end-of-life decisions (Bilsen et al. 2). However, as already determined, the consent process becomes complicated as the elder loses “their capacity to make self-determined decisions” (Gather and Vollmann 450). Despite efforts to comprehend the patient’s case history and “core values,” an accurate assessment of whether or not they qualify for PAS may not reach an ethical resolution (Gather and Vollmann 446-447).

In 2007, five patients in the Netherlands requested, and were granted, PAS. All the patients were “relatively young...with atypical disease courses and/or rather rare types of dementia” (Gather and Vollmann 445). It was determined that these patients all had decisional capacity, and were therefore competent to make such a huge decision (Gather and Vollmann 445). There is great emphasis placed on offering PAS during the very early stages of a dementia diagnosis due to the small window in which autonomous decisions can be made. Thus, there remains a legitimate fear that hurried decisions to initiate PAS amongst early dementia sufferers may dominate the end-of-life care narrative.

Furthermore, a dementia diagnosis is often defined by depression, “changes in personality, memory loss, and a decline in cognitive impairment...” (Bauer et al. 610). Therefore, determining the “critical interests” of the patient during the early stages of the disease can become misaligned. The suggestion that early dementia sufferers can, and should, make critical decisions concerning something as important as PAS is, perhaps, not respecting the dignity of the individual. Moreover, duty and dignity cannot be reconciled within such a context.

### **Morality and Public Policy**

The second task reorients the question yet again: does the aging human have the right to decide the precise timing of their death? The goal is to develop public policy within a utilitarian framework that does not engage in arguments of morality. This does not mean moral conclusions do not matter; acting morally is highly desirable behavior in health care. Nevertheless, answers based on moral conclusions do not always presuppose a moral outcome for society. If the answer is yes, people do have the right to decide when they die, then good; the moral conclusion reflects the autonomous actions people wish to take. Furthermore, exercising control over one’s own body is a positive reflection of the public freedom society enjoys. Moral judgements do not make

good public policy, however. The ethical response to morality, within a public policy context, is utilitarianism. Thus, PAS is not a moral agenda in itself, but rather, a part of the moral public freedom that needs to be fit within a public policy framework. Hence, the task is to find a place within the already burdened public policy structure. In other words, PAS must make sense within public policy, and the only way to accomplish this is within a consequentialist agenda.

There are a few ways to go about this. First, globalization of the elder must become part of the discourse. The effects are far-reaching, and the earlier example of Ivy helps to explain. Her family no longer participated in care decisions, despite her declining cognitive function. The burden of her care became the economic responsibility of the province of Ontario, thus leaving them also to make the majority of her care decisions. Ivy's case in particular engaged the state in her end-of-life care. While not yet palliative, Ivy's end-of-life decisions were already being made for her. For example, upon arriving at the long-term care facility, she was asked, as all new residents are asked, if she wished to sign a DNR order. Ivy did indeed sign it, thus ensuring her own control over her mortality; nonetheless, the state now also had control as well.

As the burden of care becomes the focal point in caring for the elder, the response to this must be a global ethic of care framework with desirable consequences. Philosopher R.M. Hare asked the crucial question of: "What consideration ought in general to be given to moral principles of any kind when framing legislation and policy?" (Hare 196). This question implies that public policy and human dignity are a dual endeavor, but with desirable outcomes. The suggestion here is that a global ethic of care framework should have far-reaching outcomes for society, which, as Hare alludes to, can only be accomplished within a utilitarian agenda.

However, a few counter arguments must be made. Hare points to two distinct positions regarding policy, the first of which he calls the "keep morality out of politics position" (Hare 196). This viewpoint maintains that the interests of the governed people are to be preserved,

despite the moral objections of others (Hare 196). The sole duty of the political leader is thus to the people they serve. Moreover, within a morally pluralistic society, this is a way to deal with conflicting ideas. As Hare points out, this position is void of mechanisms to support it. For example, suppose the majority of citizens wish for the law to allow for killings of thieves; the duty of the politician would be to enact legislation to reflect this, despite any moral considerations. This argument suggests the politician's only duty "appeals to the convictions of those who maintain the position..." (Hare 196).

The second position to consider is one of natural law. This public policy angle engages the notion that morality is a very natural endeavor, or that a "moral law" exists (Hare 196). The purpose of such law is to inform policy, imposing "penalties and sanctions" (Hare 196). For example, one could suggest that stealing goes against moral law, meaning such actions should be penalized. The difficulty with this arrangement is how to determine what actually constitutes a natural law. Furthermore, the very nature of a pluralist society means there exist differing opinions on what translates as natural law. In other words, "like a harlot, the natural law is at the disposal of everyone" (Hare 196).

Furthermore, like the first counter argument, natural law does not consider consequences, presenting duty as a singular exercise. That society could function on such a polarized view of policy creates a public condition for chaos and governmental instability. The duty of legislators cannot be bound in moral law, nor solely in the interests of the citizens they serve. The response to Dr. Kevorkian's actions in 1990, as in "it is never acceptable for a medical professional to take life..." does not acknowledge a pluralist society, nor does it engage in a consequential discourse (Cassel Meier 750). It does somewhat appeal to natural law, but the argument does not carry any weight given its ignorance of desired public policy and future consequences. The issue of PAS in 1990 became obscured by interest groups touting natural law,

and a pluralist society that refused to see this as anything but an issue of morality, despite their desire for public policy. The inability of legislators to respond further frustrated the process, as a utilitarian agenda was not considered.

Therefore, creating good public policy relies on answering Hare's question: "What consequences would we be bringing about if we followed it?" (Hare 198). Furthermore, by asking why and how a global ethic of care framework should have far-reaching outcomes suggests PAS is less of a moral issue, and more of a public policy issue that needs to reflect a pluralist society. That "moral principles" exist is true; however, despite these principles that citizens hold, as in their ideas about what actions are moral and what are not, does not necessarily make an issue a moral one (Hare 198). Moral ideas about an issue within a pluralist society should not be ignored, nor is the duty of the state bound by such. Duty is therefore dually defined: careful consideration of the moral ideas, and the consequences of creating public policies to reflect them. Hare suggests that policy-making is a response to moral issues, and his argument is compelling. However, morality is, perhaps, better understood as a human response to a public policy issue. This does not mean that moral ideas matter less than policy, but rather, it allows for public policy to function in such a way that engages a consequentialist agenda which better serves a pluralist society.

By asking if a global ethic of care framework should have far-reaching outcomes is asking if a pluralist society wishes to exist in the future. That there remains very strong moral ideas about PAS is true, and rightly so. However, it should not be considered a moral issue to be fit within the confines of policy. This particular viewpoint asks for pressure groups, natural law zealots, and religious beliefs to be categorized within the margins of society, which is counterproductive to achieving public policy that reflects the varied moral ideas. That there is equality in all moral ideas should be the goal of all citizens that hold them. Moreover, the goal of

public policy should be to equally consider each moral idea and the different consequences of such. It is within this context that dignity and policy are on equal footing, concluding that PAS is not good public policy.

To begin with, the legalization of PAS does not ask what the future consequences are for the globalized elder and the state, which reflect the two interests at work here: a much-needed global ethic of care, and the interests of the state. Developing a framework that embraces the globalized elder need not, and should not, perpetuate the cycle of globalization. As already determined, care for the elder has primarily become the responsibility of the state. By legalizing PAS, and publicly funding it, the state is agreeing to take on more responsibility of the elder that should, perhaps, fall to private business endeavors, family members and loved ones. Seniors who were eighty years of age and older were less reluctant to choose a non-treatment regimen in 2007 than in 1998, suggesting public funds would be better allocated in palliative care initiatives. Moreover, part of the public concern is that PAS will take funds away from other end-of-life care options, putting pressure on the elder to choose PAS. Bill C-14 in Canada, which is slated to become public policy as of June 6th, 2016, requires the person who wishes to die by PAS to sign a document; if the individual is unable to sign, an independent third party who does not benefit from their death, nor provides any personal care to the individual, can sign (Parliament of Canada). In other words, family members are relatively excluded from the process, meaning the state has taken on further responsibility for the elder. This perpetuation of globalization does not benefit the elder, whose true wishes may or may not be acted upon.

Secondly, the utilitarian argument must ask if the perpetuation of state dependency is good public policy. Perhaps, some would argue that it is, given the presumed cost savings of PAS. End-of-life care is thought to be the most expensive time in an individual's life; the dependency on the state for health care costs totals approximately "30-40 percent" of the

patient's lifetime (Battin and Emanuel 167). Furthermore, mitigating "the high cost of death" with PAS is thought to be the economical answer to reducing public expenses (Battin and Emanuel 167). If this were so, and PAS was the answer to cost saving initiatives, there is a problem. The "decreasing availability" of health care services, which is in part the result of globalization of elder care, promotes increased intensity to choose PAS (Battin and Emanuel 167). The cyclical relationship between globalization of elder care and decreased availability of care is perpetuated by the introduction of PAS into the cycle. Thus, pressure of the state to reduce costs is thrust onto the elder directly or indirectly. That coercion exists in an underhanded way is implied here. Within this context, offering PAS as an end-of-life care option does not necessarily represent the moral ideas of citizens, but perhaps the misaligned agenda of the state.

The reality is, PAS does not really save the state much money. If good public policy is to evaluate the consequences, then PAS would not be considered as a very viable end-of-life care option. For example, patients who typically choose PAS "forego an average of four weeks of life" (Battin and Emanuel 168). According to the *Canadian Hospice Palliative Care Association*, it is approximated that the average cost of a death of someone who has a terminal diagnosis is between \$30,000 and \$40,000 (Canadian Hospice Palliative Care Association). The overall cost of total Canadian health care costs in 2015 was 219.1 billion dollars (Canadian Institute for Health Information). The savings per person if they chose PAS, calculated at \$40,000, would total 0.0000008% of the total health care dollars spent in one year. Supposing 62,000 Canadians chose PAS in the course of one year, the total cost savings would be 0.01% of total annual health care dollars spent. To even reach a cost savings of 1%, 1,400,000 Canadians would have to choose PAS in the course of one year. The entire populations of Newfoundland and Nova Scotia would have to die by PAS within a twelve month span to reach a cost savings of 1%. In other words, the health care cost savings of PAS in Canada is almost negligible.

Developing a global ethic of care framework that engages PAS merely serves to sustain the negative effects of the globalization on the elder. Furthermore, the utilitarian approach suggests examining the interests of the state more closely; the future consequences of allowing PAS will, in effect, end up costing the state more money in the future. The process of taking on more responsibility for elder care by adding PAS to end-of-life care options is not the ethical solution to better public policy.

The suggestion, which will require further work during the lifespan of the baby boomers, is to focus public policy initiatives on already existing end of life care options. Thus, the recommendation for future state interests and enhanced elder care is less, but improved, government programs, which may or may not result in privatization of health care enterprises. If the interest is dignity and public policy as a concerted effort, the consequentialist solution realizes future benefits for the state, such as economic advantages, along with improved health care services for the elder, such as shorter wait times for tests, increased home care and lifestyle options, and more autonomy over health services.

## **CONCLUSION**

In conclusion, aging, or growing older, arrives at the most inopportune moments, such as the individual who arrives at a long-term care facility and discovers that existing policies will not protect their health or their autonomy. As de Beauvoir wrote: “It is life that has happened; and I am old” (de Beauvoir 283). While the 21st Century may be the most ideal scenario in which to enter the elder years, there are some critical ethical issues left unresolved. The reality is that society is only partially prepared for the baby boomers, in that there is a plethora of options in how one wishes to age, such as whether or not they look older, where they wish to live, and their

choice of allocating resources to improve their health care options. Autonomy for the baby boomer dominates the face of advertising in almost every aspect. However, what will happen when this demographic becomes more frail and many experience cognitive decline? As long-term care will become a reality for some, so will the loss of their autonomy. This is one area in which society, government, health care institutions, and communities are grossly under-prepared for this burgeoning demographic. The globalization effect on the elder is quite profound, leaving their care to the state in many instances. Thus, the argument for a global ethic of care framework becomes an urgent task, calling for an ethical response to long-term care issues of restraint, consent, the current situation in Ontario, and a public policy response to physician-assisted suicide. As governments and institutions ask “what care for the elderly means...” (de Lange 204), in response to globalization, it is interesting to note that de Lange’s 2009 description of how society treats the elder varies little from de Beauvoir’s 1972 account. Both agree that the elder is subject to marginalization, and simply “allowed to wither away in physical neglect” (de Beauvoir 85). While treatment of the elder is subject to gender, race, culture, socioeconomic status, etc, of which this paper acknowledges these overarching frameworks, there remains an enduring theme of questionable ethical practices within long-term care, and the more recent end-of-life care options.

This essay has concluded that the most ethical response to restraint is of a physical nature; however, only when non-restraint is not an option. An application of utilitarianism suggests that Ivy must be restrained for the benefit of the other residents, which in turn results in the most favorable results for Ivy as well. That Ivy’s dignity is preserved during this process is very important; however, the safety of the larger number of her fellow residents does take precedence, suggesting, not concluding, that Ivy is not necessarily the patient. In this two-step process of determining whether or not to restrain Ivy, and then how to restrain her, the utilitarian calculus

can, and does, make the most sense in finding the best ethical resolution. Were Ivy's human rights violated during this process? The Virtual Ethics Committee concluded that they were not; nevertheless, this paper cannot completely agree. While the consequentialist argument maintains that Ivy's restraint is morally approved based on the notion that the "potential harm to others...[is] sufficient to outweigh the harms to her caused by restraint" (Draper et al. 70), there are some gray areas to consider. How can the harm to Ivy be measured and quantified vis-a-vis the harm endured by her fellow residents if she is not restrained? This discourse requires further study by engaging other disciplines.

Consent, and prolongation of autonomy for the elder, is perhaps an even more murky issue. Nevertheless, endeavors for preservation of dignity and personal agency can often coincide with a consequentialist approach to conducting research. The importance of research in dementia is crucial for the future; the ambiguous policies, institutional strategies, and bedside decisions predict a dire future for research amongst the baby boomers, despite alarming predictions concerning the rise of dementia within the next fifteen years. Not just a Canadian problem, the global rise of dementia demands a re-evaluation of what constitutes as consent within the twofold context of advance directives, and the elder with declining cognitive function. If dementia predictions were diminishing, and the baby boomer population did not exist, the urgency to apply a utilitarian framework would very possibly be a moot point. This then raises the question of whether or not this a tailored ethical response to current circumstances. Furthermore, is ethics, as a whole, a circumstantial exercise? Perhaps it is, and perhaps it is not. At the risk of sounding unaccountable, given the imminent prerequisite and dire predictions, this particular discourse is unconcerned. Finding the most ethical response is paramount, followed by informing current policies, and methods of care. Therefore, the conclusion that the most ethical response to conducting research amongst elderly patients with dementia demands a utilitarian

schema. Thus, the solution is to fully accept advance directives for research, and acknowledge consent from an individual who may otherwise be proclaimed as decisionally incompetent. This position is in no way a recommendation for all consent issues regarding decisionally incompetent individuals and research. It is a suggestion, however, of how to contribute toward developing a global ethic of care framework for the elderly that embraces the interests of the state given the burgeoning demographic.

An examination of Ontario's long-term care policies presents a relatively unambiguous argument. Buddha's acceptance of what he would inevitably experience during his elder years led him to the sad conclusion that, given the horrors of growing older, pleasure was a redundant exercise. Thankfully, the 21st Century has much more to offer the aging adult; moreover, some modicum of pleasure is expected. In fact, it is only fair and just for the elder to expect a good quality of life even once they enter long-term care. However, does this quality of life include control over health care information to the detriment of others?

The Province of Ontario fails the long-term care resident on two levels: ambivalent privacy and information policies, and the treatment and prevention of ARO's. The recommendation is a thorough examination of Ontario's long-term care policies, for the purpose of improving the quality of life for the long-term care resident, and the safety of others. The ongoing neglect to respond to the prevalence of ARO's allows for, perhaps, a new kind of elder abuse. A second suggestion looks at individual privacy, concluding that the patient does not necessarily own their own health care information if the population is negatively affected by doing so. Neither does the health care institution own the individual's information, as was Ivy's case. The facility she resided at acted as if they owned her information, and enacted their own privacy regulations for her own protection. However, this well-meaning enterprise resulted in creating a large amount of harm to the other residents and staff. The fault hardly lies in the

institution itself, however, but rather in the ambiguous policies endorsed by the Province. The utilitarian response, economically, and for the overall health of residents in long-term care is to revamp existing policies; the health care costs to the Province will more than likely decrease as ARO's are treated and prevented properly. Secondly, the residents' quality of life will increase as the prevalence of ARO's are reduced.

PAS has presented policy-makers with a dilemma of moral proportions. As the question has changed over the decades, the desire of patients facing intolerable suffering and unwanted health diagnosis' is for more autonomy over the circumstances and timing of their death. However, the task of finding a way to ensure the dignity of the end-of-life process for the elder by developing public policy as a reflection of such is a intersecting relationship between moral ideas and enforced ethical practices. Whether or not PAS is a moral issue, or merely moral ideas about a public policy issue, is a matter of perspective. The conclusion to such an assignment may better reflect the moral ideas of citizens if an overarching policy framework determines the discourse.

Nevertheless, the moral discussion must happen, as the notion of passive euthanasia challenges opinions about drawing a line between passively and actively causing death. The nuanced definitions of how one chooses to die, such as refusing treatment, or choosing one particular drug over another, speaks of the control humans already have over their end-of-life care. The ethical question is this: does the aging human have the right to decide the precise timing of their death? The moral answer already exists, and can be found within the pages of history. Given the great leaps in medical technology, humans are faced with more decisions regarding their own death, as in timing and circumstances. Therefore, the moral answer to whether or not the elder possesses the right to decide when to die is yes, of course they do. This is a direct reflection of the public freedoms that are, and should, be acted upon. Making an

autonomous decision based on personal moral ideas is an expression of a healthy pluralist society. Nevertheless, this does not aid in concluding what is moral and what is not. As Hare suggested, it is difficult to fit “moral principles” into public policy; neither leaving morality out of the process, nor acting from a natural law perspective, is a practical way of addressing issues (Hare 195). While he makes a good argument, suggesting utilitarianism is the only answer, he fails to address the inequalities within moral ideas. Looking to moral mechanisms to answer public policy issues is not the most efficient way, nor the most dignified manner in which good public policy is developed. The duty is a dual one, beginning with the citizen to give all moral ideas equal consideration, and the duty of policy-makers to equally consider all moral ideas.

Moreover, a deontological approach must also define the landscape of elder care. There remains a duty toward the elder to develop a global ethic of care, as in creating ethical conditions for autonomous decisions regarding end-of-life care, and far-reaching decisions within a consequentialist agenda that benefit both the state and the elder. As Gather and Vollmann argued, this hybrid approach to caring for the elder is necessary to create conditions that understand the “core values” of the patient (Gather and Vollmann 446). However, for there to exist a “common moral ground” in elder care, as in developing the global ethic of care that de Lange speaks of, duty-based activities must be defined by a consequentialist agenda (de Lange 204). Hare emphasized the importance of analyzing and predicting future consequences of public policy decisions, which when applied, lead one to conclude that PAS is simply not good public policy. Despite the moral ideas of citizens, which are equal and good in themselves, they do not predict a positive outcome for the aging baby boomer, nor the state that currently supports them.

If the task, therefore, is to inform a global ethic of care by way of developing public policy for the baby boomer demographic and beyond, end-of-life care options must not include PAS. The suggestion for improving current government programs for the elder, not creating

more, along with encouraging privatization of health care services, predicts a better ethic of care available for the elder, and is in the best long-term economic interests of the state. The savings to overall health care costs within Canada if a vast number of Canadians chose PAS are hardly worth mentioning. Moreover, by not perpetuating the current cycle of globalization, as in the state taking on another responsibility in elder care, and by the promotion of private health care practices, the benefits to the state will predictably far outweigh the almost negligible savings of PAS.

There is much further to work to be done in both areas addressed within this essay: the area of long-term care, primarily in Ontario, and the complex issue of PAS. It is the sincere hope of this author that these areas will be addressed sooner rather than later, so that Canada does not find itself in a health care and financial crisis when the baby boomers hit those very elderly years. Creating a global ethic of care for the elderly is not just the ethical thing to do, but a critical reflection on society's values. As de Beauvoir so poignantly said, "Old age exposes the failure of our entire civilization" (de Beauvoir 543).

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