Growing old – a neglected discussion in healthcare ethics? Outlining a healthcare ethic for geriatric patients

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Abstract

This study argues that a healthcare ethic for geriatric patients should include more clearly defined and better guidelines than those currently reflected in conventional medical and bio-ethical protocols. The argument is based on the central view that a geriatric patient should be treated as a subject in healthcare and not merely as an object that needs to be cared for. The view is informed by the vulnerability of the person of age: in dealing with this vulnerability, attention should be given to more aspects than the physical health of the patient only. Attention should be paid to the context of a patient (culture, background, language, value system, religion), habitat, access to food and water, safety and security. All of these aspects contribute towards the level of vulnerability of the geriatric patient.

This study is performed by means of a review of relevant literature and reports. The result of this qualitative method is the confirmation that a number of factors contribute to the vulnerability of the geriatric patient and that following from this, these factors should be included in a healthcare ethic. These factors relate to the dignity of the patient, respect

for the patient, a sustained and respected existence, the creation of an enabling livelihood and the education of people in relevant institutions and communities to contribute to an acceptable healthcare ethic for geriatric patients.

The study concludes with nine ethical dictums confirming the value and respect for life, attention to vulnerability, and supportive mechanisms to secure an enabling ethical environment for geriatric patients.

Opsomming

Oudword – 'n verwaarloosde bespreking in gesondheidsorgetiek? Die identifisering van 'n gesondheidsorgetiek vir geriatriese pasiënte

Hierdie studie argumenteer dat 'n gesondheidsorgetiek vir geriatriese pasiënte riglyne moet insluit wat duideliker en beter omskryf is as wat tans in die bestaande mediese en bio-etiese protokolle opgeneem is. Die argument is gebaseer op die sentrale perspektief dat die geriatriese pasiënt as 'n onderwerp in gesondheidsorg hanteer moet word en nie as net 'n voorwerp waarvoor gesorg moet word nie. Hierdie siening is ingelig deur die broosheid van die bejaarde persoon. Die hantering van broosheid verg meer as net die fisieke gesondheid van die geriatriese pasiënt. Aandag moet gegee word aan die konteks van die pasiënt (kultuur, agtergrond, taal, waardesisteem en godsdiens), woning, toegang tot kos en water, veiligheid en sekuriteit. Al hierdie aspekte dra by tot die broosheid van die geriatriese pasiënt.

Die studie is gebaseer op die ontleding van relevante literatuur en verslae. Die resultaat van hierdie kwalitatiewe metode is die bevestiging van die faktore wat bydra tot die broosheid van die geriatriese pasiënt: etiese riglyne vir hierdie faktore moet ook in 'n gesondheidsorgetiek vir geriatriese pasiënte ingesluit word. Hierdie faktore verwys na die waardigheid van die pasiënt, respek vir die pasiënt, die volhou van 'n menswaardige bestaan, volhoubare woning en die onderrig van die personeel van relevante instellings en gemeenskappe om by te dra tot 'n gesondheidsorg vir geriatriese pasiënte.

Die nege riglyne geïdentifiseer vir 'n gesondheidsorgetiek vir geriatriese pasiënte bevestig die waardes van respek vir die lewe, aandag aan die broosheid van die geriatriese pasiënt en ondersteuningsmeganismes om 'n volhoubare omgewing vir geriatriese pasiënte te skep.

1. Aging – a rapidly growing medical challenge

The World Health Organisation (WHO) continuously reports on a *growing aging population*. For example, the World Report on Ageing and Health (2015) deals with health issues, policy development, outdated stereotypes, new expectations and the economic imperative of aging. Aging is a demographic, economic, developmental and policy reality. The downside, however, is that relevant policies and development models are not living up to the longevity of an aging population.

The *Global health and aging* report (2011), from the National Institute on Aging and the World Health Organisation, has a similar view. This report shows the ongoing growth in life expectation (National Institute on Aging and the World Health Organisation, 2011:2). A daunting reality is that the numbers of people with dementia, especially Alzheimer's disease, will continue to grow alongside the aging population (National Institute on Aging and the World Health Organisation, 2011:3). This, together with the expected shift in the mortality rate because of chronic non-communicable diseases, will become very costly for healthcare (National Institute on Aging and the World Health Organisation, 2011:15). Another impact of the aging population is on family life, work and place in community (National Institute on Aging and the World Health Organisation, 2011:20-22). Needless to say, a growing aging population will have a big impact on the nature of healthcare and its delivery (National Institute on Aging and the World Health Organisation, 2011:22).

At the same time, a growing aging population will have a bearing not only on medical services, but also on financial systems because of additional pension and social security needs. As far back as 1996, Disney pointed to the impact that an aging population would have on American social security in his book aptly titled *Can we afford to grow older?* The subtitle of the book, namely "*A perspective on the economics of aging*", is particularly meaningful. Mitchell (2013:497) refers to metaphors used such as "time bomb", "age quake" and "glacier" to describe the rapid growth in the aging population.

It is therefore not at all surprising that an awareness of the need for an ethic for the elderly has arisen simultaneously. This ethic includes more than the affordability of care, palliative care and euthanasia (not only the debate on active euthanasia, but also passive and slow euthanasia, the latter referring to too little money to care properly for the elderly and the sick); palliative sedation and requests for assisted death (see Gastmans & Dierickx, 2004; Remans, 2005; Schotsmans, 2008, 2012; Van den Broek, 2012). Ethical challenges will include aspects such as protection of human dignity, the protection of declining life, access to care and treatment, food, livelihoods and being part of a community. These needs exist alongside the known medical challenges. The undermentioned example informs this comment. Nanyonjo (2017) makes the following observation regarding the drought-stricken parts of Kenya. The ethical (health-)care of the elderly relates to their challenge to access distant relief and service points. This challenge makes the elderly people extremely vulnerable. Because of the drought, the Kenyan government is now recognising the vulnerability of elderly people in famine and similar situations. The vulnerability relates to access to food security, nutritious food and food production. Associated challenges are lack of sufficient family care and severe poverty. Consequently, a comprehensive public health policy must be implemented to address these problems. The primary move behind an approach to address challenges experienced by older people can be labelled as “successful aging” (Mitchell, 2013:491).

This background discussion informs the questions emerging from this study, namely (a) what are the healthcare ethical challenges and needs of elderly persons, and (b) how should these ethical challenges be addressed?

These questions are relevant since, while the diagnostics of geriatric challenges and accompanying demographic realities are well accounted for, the ethical challenges experienced by elderly people have not been sufficiently outlined.

The above challenges will be unpacked in this study.

2. Understanding old age: Perspectives from wisdom literature on old age and its challenges

Old age is not a new phenomenon. In all cultures, literature and through-out the history of humanity is old age a topic for discussion.

Although this is not a theology-based study, the Biblical narrative can be useful to illustrate a timeless reflection on old age. Consider the Old Testament books of Job, Psalms, Proverbs, Ecclesiastics and Song of Songs. These books form part of the collection of books commonly known as "wisdom literature". From a selection of the book of Psalms and Ecclesiastics the comments below on old age and its challenges may be noted.

Ecclesiastes is well-known for its poetic description of the breaking down of the human body and eventually life through its metaphor-rich description of aging. Venter (2003:407) refers to Ecclesiastes 12:1-8 as "a parable of old age". The description communicates the degeneration of life which is characterised by weak eyesight, deafness, slow movement, loss of sexual desire and general abilities. This stark reality must be understood against the décor of this book. The perspectives gained from this narration are the reality of physical degeneration and the unavoidable ending of life: the silver cord is severed and the golden bowl is broken (Ecclesiastes 12:6). These metaphors symbolise that life's "household" will eventually collapse (Loader, 1984:148-151; Vos, 2006:106-113).

The book of the Psalms is also helpful in understanding aging. In the broader context of the corpus of the book of Psalms, this collection of hymns is an expression of the coram Deo lifestyle (Burger, 1988:11). In addition, it is also a reflection of the daily experiences and challenges that a person may have (Burger, 1988:14). The book of Psalms is thus a collective reflection on life – present, past and future.

With regard to old age, Psalm 71 is reflective of the physical and religious vulnerability of the psalmist. The faith of the psalmist is challenged by circumstances as well as by old age (loss of strength) and doubt (confession of God before birth). His prayer is directed towards having a meaningful life and adding value to the life of other people (De Liagre Böhl & Gemser, 1968:119-121).

Psalm 90 reminds one of the temporality of life, and also that life is characterised by suffering and the wish to leave a legacy for the next generation. Here too, the vulnerability of people and the temporality of life are evident. Hence the prayer to have wisdom to live life, even if it has its challenges and temporality (De Liagre Böhl & Gemser, 1968:84-88).

From these references, the following perspectives may be formulated.

- *Life is vulnerable and temporary*. Part of the vulnerability of life is old age, declining life and the reality that life will come to an end. In view of the scope of this paper (ethical challenges of old age) an understanding is required of how to live a *meaningful* life regardless of old age and the approaching end of life. The desire for a meaningful life calls for ethical guidelines.
- *Declining life is characterised by physical weakness, fear, doubt and a loss of meaning*. In view of this study, one is alerted to deal with the protection of elderly people and to add continuous meaning to their life. From an ethical view it is not only how the geriatric person should behave but also how a community should behave towards elderly people.

Van Ommen (2016:149, 151) adds to our understanding of vulnerability by presenting an interesting view on vulnerable people. He says that "broken health" is the opposite of *shalom*. (Shalom refers to the encompassing well-being of a person.) Man/woman is created in shalom. When health is declining or people are suffering, they are clearly experiencing the opposite of what their existence was intended to be. This calls for closeness and comfort. Obviously, (elderly) people need to experience care and support as expression of shalom. From the wisdom literature the perspective is developed that physical, mental, social and religious support should be provided to uphold shalom. All of these form part of the well-being of elderly people.

Grűn's views on old age are also useful. He presents a holistic view on old age care. He refers to *acceptance* of what one's situation is, *letting go* of the past or those events in regard to which one feels unhappy or unfulfilled, and *reconciling oneself* with one's situation. In the context of acceptance, letting go and reconciling, there are many ethical challenges. Ethical guidelines can support the elderly person to deal with the past, present and future. The contents of such guidelines should be capacitated by addressing the needs of vulnerability, temporality and meaning (Grűn, 2016).

With regard to the focus of this study, the wisdom literature confirms the views presented in paragraph 1, namely that vulnerability of elderly people goes beyond their health challenges and that the need exists to deal with matters such as meaning of life, temporality of life and acceptance of life's ending. Van Ommen and Grűn add meaningful comments to the understanding of life in its completeness (Van Ommen) and the ongoing acceptance of life and its events (Grűn). These comments fit with the questions posed in paragraph 1. The next few paragraphs will assist further engagement with these questions and the perspectives formulated so far.

3. Conceptualisation

Old age, aging people and elderly people are well known concepts. These concepts presuppose a specific section of the population.

Another well-known concept is "geriatric". The word "geriatric" is derived from the Greek words "*geron*" (meaning old man) and "*iatros*" (meaning healer). Geriatric care means *caring for the elderly*. This too presupposes special care for a specific group of people.

The scientific study of aging is known as *gerontology*. While gerontology concerns itself with old age, geriatrics, a branch of gerontology, looks at the medical care aspect of aging (Mitchell, 2013:482).

Although the age of 65 is used as index of chronological age, Mitchell (2013:481) refers to the "older adult" to accommodate a variety of life spans. The World Health Organisation uses 60 years as criterion for older persons. Normally three groups of old age people are defined: the young-old (60-74 years); the old-old (75-84 years) and the very-old (85 years and older) (see Kalula, 2013:1).

From these concepts and WHO guidelines one can conclude that elderly people are a specific group of people with special needs and therefore in need of special care. Holtzer (2015:20, 49, 62) correctly scopes elderly care as more than merely the washing and hygiene care of elderly people. Old people are often challenged by chronic illness which demands special care, medicine and food. Ethical, family and psycho-social challenges are also concerns regarding aging people. Elderly people often have multiple pathologies and are surrounded by a complex social environment. Holtzer concludes that caring for elderly people is a highly skilled, professional and responsible job. This demands a more comprehensive view of elderly care which should be accommodated by the medical curriculum (medical used here in the broadest possible context). She continues to comment that ethically based care is different and challenging (Holtzer, 2015:24). This is, therefore, the focus of this study.

In dealing with geriatric care, the (ethical) question is often asked as to how much of the focus should be on curing the aged person. Is this doable, keeping budget constraints in mind, and realistic, in view of life expectancy? The ensuing question is whether the focus should not be more on what old people value, namely mobility, self-care, being able to pursue usual activities (whatever they may be) and being free from pain, discomfort, anxiety and depression (Williams & Evans, 2012:439). They comment: "It is important to get away from the notion of 'cure' as the criterion of benefit and adopt instead

measures of effectiveness that turn on the impact of treatments on people's health related quality of life." Weru's (2017) comment, in which he refers to the positive role of palliative care, can be aligned with their perspective. Palliative care should not be reserved for dying patients only but should also deal with the effects of incurable diseases. The respective points are that cure should be understood in the context of care and that care should be a major focus of health provision to elderly people.

Nuyens, De Ridder and Annemans (2013) discuss the context of healthcare. They refer to understanding the importance of the broader context of policy, budget management, efficiency, access and benefit, inequality, health and illness, age, investment in healthcare, mental health, cultural difference, religious experience, growing technology, role of medical insurance, assisted death, training (skills mix), information and innovation. All of these matters relate to geriatrics. Although they write from a European perspective, the comments of Nuyens, De Ridder and Annemans are very useful in understanding the difference between what healthcare used to imply and what it is now; particularly in relation to the ethical challenges associated with developments and the need to understand the complex context of healthcare provision. Their comments are particularly useful in extending the scope of ethical challenges beyond the already documented perspectives. Their remarks are also aligned with the argument in so far as a broad based understanding of ethical challenges is required when one studies the healthcare ethics associated with geriatric care.

4. Focus of the research

This study is based on a literature and report review of elderly people and geriatrics.

The research methodology study is aligned with Trafford and Leshem's (2012:68-74) idea of literature namely that it is "a specific body of knowledge … that is recognised by its respective users", it is identified by the researcher, yet it has a "recognisable identity when someone explains its corpus" and is explained through the researcher's lexicon and paradigms. The literature review can therefore not be isolated from the broader knowledge base, it has to engage with what is available on a topic and the analysis and reflection have to contribute to deepening the knowledge base. The literature review is influenced by personal orientations and perspectives (formed by scientific traditions, evidence-based research and world and life view).

The need for the study originates from an analysis of geriatric studies in South Africa. For the period 2011-2015 no topic-relevant studies could be identified from ethics, healthcare ethics or medical ethics in data bases such as Sabinet.

Evidence suggests that not enough attention is placed on ethically-based care for geriatric patients. In fact, Kalula (2013) expresses concern that "There is scant evidence of South Africa's preparedness to meet the challenges of providing adequate and appropriate healthcare to the older population in the future." This reference does not even include the ethical care of geriatric patients.

Based on this information, this study will contribute towards the establishment of a healthcare ethic for geriatric patients. A contribution to this topic can assist in extending the knowledge base of geriatric care, the practice of geriatric care and the formulation of relevant policy for geriatric care.

The research can also fit into the broader domain of public health. Public health may be very broadly defined, while this research has as narrow focus the "health of a population, the longevity of individual members and their freedom from disease". In a broad sense it refers to the "wider determinants of health", it deals with healthy and sick people, and is not limited to a "sick population" only. It is not so much the delineation of public health that is important but the scope that is associated with public health. For the topic of this research, lifestyle is especially important. Lifestyle includes food, the environment and housing (Berridge, 2016:2-5). In summary, public health deals with the promotion, creation and sustainability of healthy (physical, mental and social) communities. In view of a growing geriatric society, more attention should be given to this section of the population.

The specific contribution will be from the point of view of healthcare ethics. Healthcare ethics can be defined as the identification of principles and the application of values and norms informing the practice of healthcare. In essence, healthcare deals with vulnerable people, situations and institutions in the healthcare domain (Lategan & Van Zyl, 2017:6).

The contribution will be delivered in the format of guidelines set for ethical healthcare of geriatric patients, and the identification of these guidelines will be informed by the identified geriatric challenges

5. Geriatric challenges

The geriatrics patient experiences several challenges that may be summarised by five general challenges (see Holtzer, 2015; Lategan, 2011; Mitchell, 2013; Ten Have, Ter Meulen & Van Leeuwen, 2013; Vanlaere & Gastmans, 2010; Vanlaere & Burggraeve 2013; Vens, 2013):

Firstly, the geriatric patient is *vulnerable* because of declining health, absence of sense of self-worth, loss of independence, challenges to personal safety and security, declining finances due to inflation, uncertainty in the economy, passive income and cost of elderly care and the reality of death and dying. On top of these challenges are issues such as elderly abuse, elderly neglect and loss of autonomy and individualism.

Secondly, a *reflection of the past* is not always encouraging. One can very often be depressed because of missed opportunities, the knowledge that the past life cannot be undone, lack of recognition, and a sense of lost and broken relationships.

Thirdly, there is the *reality* of death and dying. Although it is expected of healthcare practitioners to care, they cannot record the reality of what happens after death or take away the anxiety caused by the imminent end of life. In different stages of old age, different needs exist. The early geriatric patient may want to do more, while the person in his/her last phase of life may have limited or no expectations.

Fourthly, there could be *a culture shock* experience. A replacement culture exists due to *consumerism*. If something is not good enough, has no further use or is broken, it is replaced by something new. The same attitude is experienced by the elderly. If they are no longer fit for society they should be replaced by a new generation. This creates a feeling that they are no longer wanted. At the same time the health economy can be a challenge to their income. Will they have enough money to pay for rising living and medical costs? Elderly people may also feel insecure because of a postmodern/post-religious/post-truth culture. They were used to certain fixed ideas and rules (modernism), and now everyone's opinion is valid (post-modernism). Where society has been based on religious orientation, such orientation no longer exists. Truth has taken on a new interpretation which very often clashes with former belief systems. These conditions are very often difficult to accept.

Fifthly, there is an emotional struggle with the *purpose of life*, loss of respect and status, how to add meaning to life and how to accept this phase/stage of

one's life. The harsh reality is that this is not just another phase of one's life: this is the last phase of life. The emotional distress caused by this knowledge can easily upset the well-being of the elderly person. Linked to this, elderly people are very often lonely people. Elderly people are lonely because of isolation either through lack of mobility, limited contact with other people, bad health or simply due to limitation of environment.

From these comments, it is evident that elderly people are challenged by physical, emotional, personal, religious and environmental issues. The next section will translate these challenges into ethical challenges experienced by elderly people.

6. Ethical challenges

Following from the literature and policy review as accounted in the aforementioned paragraphs, the following seven ethical challenges may be formulated:

A *first ethical challenge* is the classification of people above a certain age (see WHO's sixty years as guideline) as elderly and hence all "elderly people" are then treated in the same way.

Vens (2013) correctly argues that there cannot be generalisation, that elderly people are at different stages of their lives as part of their life cycles, and by default will have different health challenges. A proper solution would be to contextualise aging in an anthropological context. The value of this approach is that aging will be understood in the context of life cycle and the required care aligned with a life cycle need. Another advantage of this approach is that elderly people should also review and understand their changing life conditions against the broader context of a life cycle. By doing this, their personhood and autonomy will be respected. What should further emanate from a life cycle approach is that as people are aging, they are moving into new life cycles where human, social and health vulnerability are increasing. A major challenge, however, is the resistance of elderly people to accept that they no longer have the abilities that they used to have. This does not mean that the elderly person's life is valued on the basis of their abilities, but merely that there are special challenges associated with aging that may not be the case in other life cycles. To deny one's state of health and ability is just as unethical. To treat all elderly people as if they have no rights over their own life anymore is also unethical.

A *second ethical challenge* is that aging suggests both medical and social intervention.

Medical intervention is necessary since elderly people are no longer in a position to take care of their health on their own. Social intervention is required to manage their broader interaction with society and communities. These interventions create the impression that the elderly constitute a "problem" group (Vens, 2013). The ethical challenge that emerges is the behaviour and/or perception that the elderly need to be treated differently from other people. It is this relativism of capability and dignity that leads to confrontation between the elderly and the community (collective for other people). The elderly very often experience that their life has been taken over by other people or that other people are now deciding what is good for them and what is not. This leads to a feeling of disempowerment and loss of autonomy. As if this is not enough, elderly people often encounter this disempowerment and loss of autonomy in the way that people treat them, communicate with them and involve them in decisions pertaining their own lives. The common layman's explanation is that elderly people are now comparable to infants – they are no longer able to make any decisions on their own. Although this reality may be applicable to senile patients or those with dementia, one cannot generalise and apply this to all elderly people. A complex problem that may arise is, for example, the question of the dignity of the elderly patient who has limited, if any, quality of life. The question is, how should this patient be treated? This dilemma is further deepened by the contemporary challenge of ending of life on request.

A *third ethical challenge* is that within the context of disempowerment and loss of autonomy, culture and communication challenges arise.

Communication is supposed to involve one person (read the elderly) in a broader context (read the community). But communication often excludes the elderly from the discourse, leading to a degrading of personhood. A well-known example is where elderly people are very often addressed by doctors, nurses, therapists and caregivers in an overly familiar manner, as if all people are to be treated the same. Their "past" is ignored. This example is further problematised in different cultures where elderly people may interpret such communication as disrespectful and ignorant, in view of who they used to be (see Phalime, 2014).

A *fourth ethical challenge* is the question of whether life should be prolonged at all cost, whether there is meaning to a declining life, and how the value of life should be determined.

Because of suffering, death and dying, Onfray (2004), for example, pleads for absolute pleasure. The body is not meant to suffer, but to enjoy the fullness of life. A meaningful life is expressed as a life without suffering. *Euthanasia is therefore not a choice, but a reality*. From an ethical point of view, euthanasia is problematic because of issues such as the self-determination of man, technical abilities and the declining dignity of life (Remans, 2005; Van Bergen, 2010). Euthanasia is often discussed and justification offered as a possible means of relieving meaningless suffering or a life without quality. These arguments are, however, very subjective. Vanlaere and Gastmans (2010:121-122) formulate four norms as to why euthanasia is not the solution.

- It is far too subjective to link the loss of self-worth to the quality of life. This is no reason why life should come to an end.
- The respect for individual autonomy is not a convincing enough argument to bring life to a closure.
- More attention should be given to palliative care to optimally support patients with dementia.
- It remains a moral duty to care for all people.

Euthanasia is never the answer to unbearable suffering. Suffering as criterion for the quality of life should be regarded as an enormous devaluation of the value of life (Holtzer, 2015:127, 129).

A *fifth ethical challenge* is that elderly treatment at all costs cannot be sustainable.

In healthcare the approach is always to do everything that is possible to do. Due to budget limitations this may not be possible and cost and age should be weighed against the cost of treatment. This calls not only for the correct modelling of cost but also for dealing with the abovementioned moral dilemma. Williams and Evans (2017) attend respectively to the cases for and against in this moral dilemma in order to highlight the complexity of this matter.

Where a treatment offers only modest benefits, a person may have to live a long time to make treatment worthwhile – that is, to make the benefit to the person larger than the sacrifices of rival candidates who failed to get treated. Theoretically, depending on the circumstances, the cost of a national health programme for the entire population may be so important or expensive that it may require cut-backs on treatment of elderly people because of, for example, life expectation. This may be regarded as discrimination against the elderly. Addressing this potential dilemma, the following has to be considered: age matters in two ways: people's capacity to benefit from treatment, and a benefit already received. In prioritising benefit, younger people are often favoured above elderly people (Williams in Williams & Evans, 2017: 440).

Evans (in Williams & Evans, 2012:442-443) argues that one needs to understand the individual risk and situation before a decision can be taken. Age, however, is no reason to deprive people of healthcare. The potential value younger people may have above elderly people is no reason to make a decision in favour of one group (Evans in Williams & Evans, 2012:443). The fact that older people are widely seen as being of lesser social worth than younger people is the result of prejudice and should also be disregarded. Age should not become the reason not to support a specific group:

> We should not create, on the basis of age or any other characteristic over which individuals have no control, classes of Untermenschen whose lives and wellbeing are deemed not worth spending money on (Evans in Williams & Evans, 2012:446).

Ten Have, *et al.* (2013:144-149, 155) refer to the challenge of age as a criterion to determine the roll-out of healthcare (selection criterion). Very often the challenge is the choice between long term care and affordability. For them evidence must be offered to justify a decision. Before the final decision can be taken, the ethical values of these evidences should be evaluated.

A *sixth ethical challenge* is the conflict between what needs to be done and what can be done.

Holtzer (2015:71) refers to Lieven Annemans who identified three values in healthcare, namely *quality*, *solidarity* and *sustainability*. These values can also be in conflict with each other. If the objective is to strive towards the highest quality, it may not always be affordable. This challenges the sustainability of care. If patients themselves have to pay, it may be interpreted as a loss of solidarity with the community. If cost efficiency is the solution, how must it be implemented? As ethical guideline, three actions count: *prevention* (keep people healthy), *cure* (make sick people healthy again) and *care* (assist

those in need). This guideline should address the expectation of the elderly in regard to good care. The conflict is created through managing the healthcare; it is not caused by the patient. To put the health of a person at risk because of management and policy implementation is ethically unacceptable.

At the same time the potential conflict includes not only the patient but also the healthcare worker. This confirms the ethical vulnerability of the healthcare worker who has to cure and care in spite of the potential conflict that may exist (see Vanlaere & Burggraeve, 2013, and Phalime, 2014). The emerging question is, who is attending to the overall impact of this conflict?

A *seventh ethical challenge* is the role of the elderly in view of the destruction of the family unit.

Next to the growing aging population is an associated problem, namely the growing number of orphans in Third World countries due to HIV/Aids, (civil) war, poverty and hunger. The problem that develops here is how to care for children in a society where there are no parents, but only grandparents. This puts an additional strain on the elderly people and their well-being. Elderly people have to take on the role of parents again – this time for a second generation. At the same time is it evident that caring for children can be compromised if the elderly person is sick and is not in a position to take care of someone else. Such a situation cannot contribute towards the well-being of people and their societies.

Following from these identified ethical challenges, the follow-up question concerns how to deal with these ethical challenges.

7. A healthcare approach in support of healthcare ethics for geriatric patients

The primary purpose of healthcare is to secure a humane existence for the patient. This purpose is evident in Creplet's (2013:119-126) identification of a number of role players in healthcare. He identifies the following:

- Patients: They are the "clients" and owners of their own bodies. Patients are informed and want to make informed decisions. They should feel responsible for their own bodies.
- Doctors: The doctor is an "architect" and "coach" in healthcare. Creplet compares healthcare to the renovation of health (architect). As "coach" the doctor assists the patient and attends to individual needs.
- Specialists: They can be compared to "engineers" working with

sophisticated technology. Specialists attend to individual needs and should not follow a blockbuster approach to pharmaceuticals, in other words the massification of treatment.

- Hospitals: Facilities where care is rolled out.
- Medical insurance: The insurance determines what treatment will be paid for.
- Politicians. They are compared with “magicians” or “wizards”. Through policies they create expectations which can be either good or unrealistic.

From these role players a quadruple approach to healthcare can be identified. In this approach the following perspectives are important:

- Healthcare calls for a multi-disciplinary approach to attend to the patient in a holistic manner (cure and care).
- Healthcare depends on supportive resources and a well-managed professional environment (hospitals, clinics and hospices).
- Healthcare must be supported through enabling policies.
- Healthcare must avoid power relations between curer, carer, controller (management) and community (support systems).

This approach should secure good care for (geriatric) patients. Good care refers not so much to following protocols only, but also to a relationship and better/more dialogue with the elderly (Vanlaere & Gastmans, 2010:132-133). In such a relationship dignity will be realised and supported (Vanlaere & Gastmans, 2010:169). The authors add that the mere existence of care ethics is not always sufficient to care in a concrete situation. It is for this reason that they advocate fewer rules and more dialogue (Vanlaere & Gastmans, 2010:131-132). Holtzer (2015: 21) shares a similar view. Good care is much more than technical activities and precise procedures and protocols. It depends on strong personalities. It also depends very much on the attitude and approach of the caregiver.

Healthcare for the geriatric patient should be aligned with the unique set of circumstances. Matters such as personality (who he/she is), context, habitat, view on meaning of life and a value and belief system are important. It is evident that good care ethics are defined by the relationships between people. This does not imply that action and the implementation of good protocols are not important. It simply emphasises that good care includes much more than merely physical care. Holtzer (2015:125) rightly comments that the caring way of dealing with vulnerability presupposes the acceptance of the imperfection of life and of people.

This leads to the question as to what motivates healthcare practitioners to provide quality care. Evidently is it based on how one feels about people (sympathy) (Vanlaere & Gastmans, 2010:136). This is closely linked to views of people and the dynamics between caregiver and care receiver (Vanlaere & Gastmans, 2010:136-137). It also requires more interaction between the management of care facilities and ethical committees to promote ethically-informed healthcare (Vanlaere & Gastmans, 2010:166, 168).

Medicine can never be about repositories only, and care cannot be reduced to merely providing food and drink and keeping the patient clean. Healthcare is defined to reach out to the needs of the vulnerable on the basis of what resources are available to the caregivers, together with their professional (knowledge, behaviour) and personal (commitment) engagement with the patient.

Based on this approach, ethical guidelines for healthcare ethics for geriatric patients can be formulated.

8. Guidelines for healthcare ethics for geriatric patients

Based on the arguments in this study, the following healthcare ethics guidelines can be presented for geriatric care:

- Age, health condition, economic activity and level of community participation can never be the standard to assess the value of a person or the criterion for the provision of healthcare. The protection of the person, respect for his/her vulnerability, provision of medical cure and care, provision of food and the creation of a habitable living environment are interwoven human rights of any person. Because of the situation of vulnerable people, these rights can easily be ignored. No person of age should be without constitutional protection for his/her vulnerability. The ethical dictum is to keep on respecting the person as an individual and a human being in own right.
- Geriatric care includes a human-centred approach. This approach includes the environment, food, housing, community (safety and security) and money (the challenge of disadvantaged people). No geriatric care programme can ignore a human-centred approach. The ethical dictum is to acknowledge the inclusive personhood of elderly people.
- Care for the elderly is based on a holistic care approach. This approach accommodates the physical, mental, social and religious needs of the elderly person. This accounts for not only palliative care (required when

there is no spontaneous reaction to therapies) but care right through the lifetime of the elderly person. The ethical dictum is the respect for a person's life through all stages of the life, especially when a person is vulnerable.

- Healthcare can easily create a power relationship where the caregiver in command has to deal with vulnerability. This calls for responsibility on the part of the caregiver to deal respectfully with vulnerability. In return, the geriatric patient has to respect the caregiver's position as a position based on expertise and knowledge to perform the care. The ethical dictum is a respectful relationship between caregiver and the patient. The conviction is that a good relationship is core to good health.
- In geriatric healthcare it is important to understand culture, diversity, religion, orientation, background and language to perform constructive care. This is not to say that these must *direct* care but rather that they must *inform* respectful care. Nothing can be a substitute for good *health*care. These attributes inform primarily the basis of good care which is then focused on the needs of the patient. The ethical dictum is to understand the patient and his/her context in order to perform good care. However, no attribute can be a replacement for healthcare. Neither can the attention to these attributes be regarded as the only values for healthcare.
- The geriatric patient is no longer the *focus* in care but should be regarded as a *partner* in care. Constructive care should be focused on the needs of elderly people and integrated into their healthcare plan. The ethical dictum is that healthcare should include the geriatric patient's views as part of the care. The implication is obvious that it may not be possible to have an individual's input throughout all stages of the elderly person's lifecycle, or to include the patient with dementia or Alzheimer in these discussions. The intention, and therefore the ethical dictum, is that where medically possible, the patient should be treated as a subject and not a mere object in healthcare.
- Geriatric care calls for ongoing education – not only in the training of the caregiver but also for those institutions and committees where decisions are taken about care provision to geriatric patients. Also, communities should be educated on how to deal with the vulnerability of geriatric patients. It is not only the caregiver or healthcare institutions that have a responsibility towards the geriatric patient. This is a shared responsibility where healthcare practitioners, healthcare institutions

and the community have to make an engaged contribution. The ethical dictum is the acceptance of a joint societal responsibility to care for the vulnerability of the geriatric patient.

- Good healthcare is based on knowledge, resources and an enabling environment. This means that next to appropriate therapies, medical interventions, medicine and implementation of medical protocols, sufficient support systems should also be available to secure good healthcare. A balance should be struck between rules and dialogue. The ethical dictum is that good healthcare acknowledges the *patient* as patient but also as a person.
- Healthcare ethics for geriatric patients should not be understood as a set of rules, i.e. what to do and what not to do. Healthcare ethics is rather a dynamic normative guideline that balances what ought to be done, what is possible and how a situation can be improved to optimise the health of the geriatric patient. The emphasis should be on the dynamic improvement of a situation and not merely on pointing out what is missing in a situation. This implies a shift in focus from what is missing in a situation, to what can be done to improve that situation. Ethics is not the teacher with the proverbial red pen, pointing out all the errors. Ethics is more like a signalman – he/she points to the warnings signs and shows the appropriate and safe way to travel.

9. Conclusion

This study had as objective the provision of a set of healthcare ethics for geriatric patients. The motivation for this study is that sufficient medical protocols exist for the care and treatment of elderly people but that integrated healthcare ethics could not be identified.

The study points out the global trend of a growing aging community that will increasingly access healthcare facilities which in return will have a big impact on the provision of healthcare and its affordability. A growing aging population will also demand more services to deal with their growing vulnerability.

The study has argued that characteristic of old age, there are different categories of elderly people, each with needs associated with the particular stage of old age. The pessimistic view of old age as a period of loss of abilities and self-worth, breakdown of communication, limitation of habitat and movement and the growing experience of being a mortal object dealing

with the ignorance of others regarding the personhood of the elderly person, is no longer acceptable. The study has unpacked the ethical challenges and on the basis of these, presents an ethic according to which medical care and personal care run parallel in healthcare. The central argument is that a healthcare ethic should respect all the medical and bio-ethical protocols of life, treatment, access to cure and care, protection of life and avoidance of harmful activities but at the same time enlarge its focus to accommodate personhood (subject and not object), value system, habitat, environment, food and water and safety and security. This drive for the argument is a holistic and integrated approach to healthcare.

This study's contribution is to enrich the literature on geriatric care through the provision of healthcare ethics guidelines that go beyond typical medical and bio-ethical protocols.

Bibliography

BERRIDGE, V. 2016. *Public health. A very short introduction*. Oxford: Oxford University Press.

BURGER, C.W. 1988. Die prediking van die Psalms. In Burger, C.W., Műller, B.A. & Smit, D.J. (Reds.). 1988. *Riglyne vir die prediking oor die Psalms. Woord teen die Lig 2/4*. Kaapstad: N.G. Kerk-Uitgewers. pp 9-17.

CREPLET, J. 2013. *De derde revolutie in de geneeskunde*. Brussel: Pharma. be vzw.

DE LIAGRE BÖHL, F.M.T. & GEMSER, B. 1968. *De Psalmen*. Nijkerk: Uitgeverij G.F. Callenbach.

DISNEY, R. 1996. *Can we afford to grow older? A perspective on the economics of aging*. Cambridge, MA: MIT Press.

GASTMANS, C. & DIERICKX, K. 2004. *Ethiek in witte jas. Zorgsaam omgaan met de leven*. Leuven: Davidsfonds.

GRŰN, A. 2016 (6th print). *Gelukkig ouder worden. Aanvaarden, loslaten en je verzoenen*. Utrecht: Ten Have.

HOLTZER, L. 2015. *De 7 privileges van de zorg*. Leuven: Acco.

KALULA, S.Z. 2013. Guest editorial: Medicine in the elderly: Unique challenges and management. *Continuing Medical Education*. 31(10):1-3. Downloaded from the internet http:/cmej.org.za/index.php on 16 July.

LATEGAN, L.O.K. 2011. *Characteristics of Geriatrics*. Lecture to the annual meeting of the Geriatric Society. Bloemfontein

LATEGAN, L.O.K. & VAN ZYL, G.J. 2017. An introduction to healthcare ethics. In Lategan, L.O.K. & Van Zyl, G.J. (Eds.). 2017. *Healthcare ethics for healthcare practitioners*. Bloemfontein: SUN MeDIA. pp 5-10.

LOADER, J.A. 1984. *Prediker: Een praktische bijbelverklaring*. Kampen: J.H. Kok.

MITCHELL, D.B. 2013. Global health of the older adult. In Holz, C. Global health care. *Issues and policies* (second edition). Burlington: Jones & Bartlett Learning. 481-508.

NANYONJO, A. 2017. Kenya needs to protect elderly people during drought and famine emergencies. *The Conversation*. 28 June.

NUYENS, Y., DE RIDDER, H. & ANNEMANS, L. 2013. Brief aan beleidvoerders. In Nuyens, Y. & De Ridder, H. *Dokter ik heb ook iets te zeggen*. Tielt: Lannoo Campus. pp 222-235.

NATIONAL INSTITUTE ON AGING AND THE WORLD HEALTH ORGANIZATION. 2011. *Global health and aging*. World Health Organization. NIH Publication 11-7737.

ONFRAY, M. 2004. *Het lichaam, het leven en tijd*. Rotterdam: Lemniscaat.

PHALIME, M. 2014. *Postmortem: The doctor who walked away. A true story*. Cape Town: Tafelberg.

REMANS, J. 2005. D*e boom van goed en kwaad: Over bio-ethiek, biotechniek, biopolitiek*. Leuven: Acco.

SCHOTSMANS, P. 2008. *Handboek medische ethiek*. Tielt: Lannoo.

SCHOTSMANS, P. 2012. *In goede handen*. Tielt: Lannoo.

TEN HAVE, H., TER MEULEN, R. & VAN LEEUWEN, E. 2013. *Leerboek medische ethiek* (vierde, herziene druk). Houten: Bohn Stafleu van Loghum.

TRAFFORD, V. & LESHEM, S. 2012. *Stepping stones to achieving your doctorate*. Berkshire: Open University Press.

VANLAERE, L. & BURGGRAEVE, R. 2013. *Gekkenwerk: Kleine ondeugden voor zorgdragers*. Tielt: Uitgeverij LannooCampus.

VANLAERE, L. & GASTMANS, C. 2010. *Zorg aan zet. Ethisch omgaan met ouderen*. Leuven: Davidsfonds.

VAN BERGEN, 2010. *Mijn moeder wilde dood*. Amsterdam: Atlas.

VAN DEN BROEK, G. 2012. *Een bed voor de dood. Sterfstage op een palliatieve eenheid*. Leuven: Uitgeverij Van Halewyck.

VAN OMMEN, L. 2016. *Ruimte voor gebrokenheid. plaats voor lijden in de eredienst*. Utrecht: Uitgeverij Kok.

VENS, E. 2013. Ouderen en zorg. Een verkennend antropologisch perspectief. In Van Kerckhove, C., De Kock, C. and Vens, E. (Eds.). *Ethiek en zorg in de hulpverlening. Over taboes gesproken*. Gent: Academia Press. pp 31-41.

VENTER, P. 2003. Prediker. In Van der Watt, J. (Red.). *Die Bybel A-Z*. Vereeniging: CUM. pp 403-408.

VOS, C. 2006. *'n Hand vol wind. Die stem van die Prediker vir ons tyd*. Wellington: Lux Verbi BM.

WERU, J. 2017. Most people in Africa don't have access to palliative care. This needs to change. *The Conversation*. 7 July.

WILLIAMS, A. & EVANS, J.G. 2012. The rationing debate: rationing healthcare by age. In Holland, S. (Ed.). 2012. *Arguing about bioethics*. London: Routledge. pp 439-446.

WORLD HEALTH ORGANISATION. 2011. *World Report on Ageing and Health*. Geneva: WHO Press.