Book Essay

An Ethic for Long-Term Care: The Role of Autonomy


These books reflect a growing interest in the ethics of health care, including long-term care (LTC). An interest in the ethical dimension of LTC is in fact long overdue. Medical ethics has been concerned almost entirely with acute care until quite recently, leaving LTC as a public policy issue almost completely in the hands of policy researchers with a relatively narrow focus on cost-effectiveness criteria (i.e., Is community-based care a fiscally feasible alternative to nursing homes?). These three books are a welcome sign that we are about to get a full-scale debate of the ethical issues surrounding LTC.

The focus of each of the three books reviewed here is the role of patient (i.e., client or resident) autonomy in LTC. Harry R. Moody suggests in Ethics in an Aging Society that the concept of personal autonomy (individual choice and decision-making) provides an inadequate framework for the development of a realistic and humane LTC policy that recognizes the dependence of frail elderly persons on others. George J. Agich offers a phenomenologically grounded argument (the felt facts of everyday experience) in support of making the protection of personal autonomy the major goal of LTC policy. Agich, however, interprets autonomy broadly, with at least as great an emphasis on positive as on negative notions of what it means for dependent persons to experience autonomy. Charles Lidz, Lynn Fischer, and Robert Arnold in The Erosion of Autonomy in Long Term Care use the results of their research to describe the wide gap between what we profess to do in LTC and what is actually achieved: the gap between the professed goal of supporting autonomy and everyday practices that generate barriers to autonomy.

Taken together, these three books offer a comprehensive view of the emerging debate over the role of autonomy in the development of LTC policy and the conduct of day-to-day care. Moody frankly advocates the relative devaluation of autonomy. Agich calls for an expanded concept of autonomy and a more rigorous commitment to policies and practices designed to protect and maintain his expanded version of the concept. Lidz and colleagues claim that it would take a revolution in current LTC policy and practice just to achieve an adequate fit between current ideology, which emphasizes a limited theory of autonomy (privacy), and actual caregiving practices.

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I do not think that Moody makes a convincing case for the devaluation of autonomy. As indicated by the work of Agich and Lidz and colleagues, any retreat from the use of the concept of autonomy as the major guiding principle in the development of LTC policy and practice would undermine the limited progress we have achieved in efforts to preserve the freedom and identity of persons requiring LTC. I will argue that now is not the time to back off a commitment to autonomy in LTC, but rather we should be prepared to push ahead with strategies shaped by Agich’s vision of autonomy and LTC.

In Ethics in an Aging Society, Moody makes an important and impressive effort to use the strategies and findings of the social sciences to inform our thinking about the ethical dimensions of LTC. In this respect he has adopted the perspective of a leading social theorist, Jurgen Habermas, who has long practiced the art of justifying ethical standards, at least partially and however satisfactorily, on the basis of knowledge generated by the social and behavioral sciences.

The antifoundationalism of contemporary philosophy, including ethics, had led to a pervasive aestheticism most commonly associated with the poststructuralist thought of Neo-Nietzscheans like Foucault, Lyotard, and Derrida. Habermas rejects antifoundationalism and aestheticism, and the nihilism that he thinks is inevitable in their wake. Much of the justification for his rejection is drawn from his reading of the social and behavioral sciences and linguistics literature. I do not have the space here to discuss the intricacies of Habermas’s effort to apply the procedures and results of the social sciences in his work in ethics and politics, except to say that he deserves a great deal of credit for trying to help us think our way out of the postmodern night in which all cows are black; in which all facts and values are essentially the same, the products of an arbitrary, endlessly creative linguistic universe where the correspondence theory of truth (or any other theory of “truth”) no longer holds.

Moody makes good use of Habermas’s updated enlightenment project and its major product, the concept of “communicative ethics,” in critiquing the autonomy principle and the individual rights model as they are conventionally used by ethicists interested in developing an ethics for medical care, including LTC. Most would agree with Moody that the autonomy principle alone does not provide a sufficient scaffolding for a comprehensive approach to an ethics of LTC. Moody rightly argues that informed negotiation between caregivers and recipients of care and professional judgment are clearly essential to the development of rational and fair LTC practices. They are not substitutes, however, for rigorous adherence to the autonomy principle and the individual rights model. They are supplemental values and are not inconsistent with an approach that assigns first place to the autonomy principle and the rights model. As I will try to describe later, Habermas’s concept of communicative ethics is compatible with an approach that gives supremacy to the rights model, particularly when it is used to defend the autonomy of disabled or dependent persons.

Moody is also right to point out that,

...what we find in advanced industrialized societies is a condition of “systematically distorted communications,” which serve to frustrate free and open deliberations. In mass media, in the educational system, in the workplace, in political communication, everywhere we find an evasion or falsification of discourse. Instead of open deliberation, we see domination by power or manipulation. Instead of freedom, we have the “colonization of the life-world” in old age, where the last stage of life is emptied of any meaning beyond sheer biological survival. This whole development is part of a social and historical process, not at all a matter of individual choice. Therefore it is not surprising that the traditional ethic of individual autonomy has been helpless to halt this erosion of freedom. The ethics of patient autonomy may insist on informed consent or encourage advanced directives. But those very
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struments are compromised by the institutional structures and the systematically distorted
communications in which the elderly receive care.

This is a wonderfully accurate and eloquent description of how we treat many of our frail
elderly. I do not think, however, that giving up on the ethics of patient autonomy will lead
to less distorted communication or halt the erosion of freedom. What would be the goal of
undistorted communication and Moody's concept of negotiated consent if not enhanced
individual autonomy?

The autonomy principle, which is based on the fundamental liberal values of freedom and
the integrity and dignity of the self (the bases of identity in Western cultures), provides the
framework for the legal concepts of competency, consent, and confidentiality. After years of
legislation and litigation, these concepts have emerged as hard-won tools for ensuring that
an individual has the rights to be presumed competent (rigorous criteria must be met to prove
incompetence) and to control what is done to and for her (consent and confidentiality). These
rights, if effectively enforced, protect autonomy (freedom) and help preserve integrity. In the
last 20 years, the autonomy principle has been expanded to include the right to appropriate
care, the absence of which may threaten a person's competency and her ability to exercise
consent.

The autonomy principle and the rights designed to achieve it create philosophical and legal
strategies that can be used to curb paternalism, penalize abuse and neglect by others, and
foster a patient/client-oriented environment that supports the virtues model, which Moody
seems to offer, along with communicative ethics, as an alternative to the individual rights
model. This model, which places a premium on the virtues, such as fairness, wisdom,
honesty, compassion, and courage, is largely dependent on the autonomy principle for
effective utilization. In the absence of rules establishing the rights to be presumed competent,
to consent, and to privacy, virtues have a way of being imposed through the paternalistic
exercise of power by professionals. Professionalism, understood as dedication to serving the
needs of clients with practical wisdom, with technical competence, and in the spirit of client
advocacy, is essential to the provision of effective care. It is no substitute, however, for a
bottom-line commitment to the autonomy of the individual and the rights required to protect
her autonomy.

Why is autonomy important? What is the rationale for the claim that autonomy has
primacy among the values we use to shape LTC policy and practice or any other policy
involving vulnerable persons? What is autonomy for?

I would argue that autonomy is an essential condition for the sense of self(ness) in modern
society. Charles Taylor (1991) has described the modern era in terms of the concept of
authenticity. We derive our sense of self from an original way of being. The creative sense of
self appeared only in the modern era with the decline of hierarchical society and a shared
sense of a divine order that characterized the premodern era. The romantic movement of the
19th century, with its emphasis on individual consciousness and sensibility, generated the
framework for what Taylor calls the ethics of authenticity: the notion that one is obligated to
develop the unique qualities of his/her own self. In its most popular form, this ethic has
evolved into the concept of individual self-fulfillment achieved through the modalities of
instrumental reason, i.e., the most efficient means to some ultimate source of self-fulfillment.

In Taylor’s view, this is a very diminished (flattened and narrowed) concept of authenticity.
It fails to recognize what Taylor calls the “horizons of significance” that make freedom
(autonomy, choice) meaningful, and a sense of the “valuable” possible. An authentic sense
of self and meaningful autonomy are dependent on a background of intelligibility.
provided by horizons of significance that emerge from the historical context and all of the interpersonal relations that constitute our immediate world. In short, an authentic sense of self is dependent on our horizons of significance, which shape choices and channel the exercise of autonomy. Horizons of significance provide part of the equation that generates authenticity (meaning). The other part is autonomy, which is grounded in horizons of significance.

Autonomy is not experienced in a void. The significance of issues I make choices about is not self-chosen—a product of the free play of consciousness, of whimsy. The modern sense of self is generated through autonomous interaction with the given (horizon of significance).

Taylor claims that,

Even the sense that the significance of my life comes from its being chosen—the case where authenticity is actually grounded on self-determining freedom—depends on the understanding that independent of my will there is something noble, courageous, and hence significant in giving shape to my own life.

But more: this minimum of degree of givenness, which underpins the importance of choice, is not sufficient as a horizon. It may be important that my life be chosen, as John Stuart Mill asserts in On Liberty, but unless some options are more significant than others, the very idea of self-choice falls into triviality and hence incoherence.

Only if I exist in a world in which history, or the demands of nature, or the needs of my fellow human beings, or the duties of citizenship, or the call of God, or something else of this order matters crucially, can I define an identity for myself that is not trivial. Authenticity is not the enemy of demands that emanate from beyond the self, but it supposes such demands.

Autonomy then is important because it is a necessary (but not sufficient) condition for the creation of a valued sense of self and others (mutual recognition). For this reason it should hold first place among the principles that guide the development of LTC policy and all other policies that affect the status of vulnerable persons. From this perspective, negotiated consent (communicative ethics) and the virtues model constitute procedural safeguards designed to protect the maximum feasible exercise of individual autonomy. The preservation or expansion of autonomy should constitute the substantive content of negotiation and the goal of virtuous conduct. A rigorous adherence to the autonomy principle is necessary to avoid the slippery slope toward paternalism, and the emergence of policies and practices that mainly serve the interests of others—i.e., convenience of family members or service providers.

I would submit that an ethics of authenticity and autonomy, along the lines delineated by Taylor, is consistent with Habermas’s concept of communicative ethics. Habermas’s theory of communicative ethics is based on the values of free and open speech and democratic decision-making. As noted earlier, he uses social and behavioral science research to support the view that these values are derived from behavioral facts, including the fundamentally truth-seeking nature of the human speech act and the desire to negotiate honestly.

One would be hard-pressed to offer a better rationale for the autonomy principle or a better argument for the dependence of communicative ethics on the autonomy principle. Without the preservation of autonomy and the enforcement of individual rights, communicative ethics would not be practically possible. History shows that the stronger party will almost inevitably dominate in the absence of enforceable rules or legally defined procedures of decision-making. Though free speech and honest negotiation cannot be perfectly achieved without true material equality (which seems increasingly remote), they can be approached through the application of rules and procedures derived from the concept of autonomy and individual rights.
Moody has made a very valuable contribution to the growing debate about the future of LTC. He reminds us that this debate has an unavoidably ethical dimension. LTC policy must be guided by more than narrowly defined criteria of efficiency and cost-effectiveness. Our capacity to improve the quality and availability of LTC will depend on our ability to articulate values and to construct a compelling moral vision. If this is not accomplished, purely fiscal considerations and power politics will determine the future of LTC.

What would a compelling vision for LTC reform include? I submit that it would include features of all three models (autonomy and individual rights, communicative ethics, and the virtues model) discussed by Moody. A fourth, or integrated, model would emphasize individual rights within a communal context and recognize the need to protect the autonomy of disabled (dependent) individuals through negotiation and other means. In practice, an integrated model based on the primacy of autonomy would require qualitative changes in the current system of LTC. Most importantly, it would require the creation of a full array of LTC options (in-home care, assisted living, etc.) that would provide enough choices for individuals to have something to negotiate about.

This vision of LTC corresponds to an ethics of authenticity (autonomy within horizons of significance) that requires the creation of material conditions allowing the fullest possible exercise of freedom. Such conditions would allow an individual to exercise choice without limiting conditions, which are never accepted as final. They would always be perceived as situational and subject to change. It is at the edges of these limiting conditions that negotiated consent as defined by Moody should occur as we collectively redefine dependency and expand opportunities for autonomy.

In Autonomy and Long Term Care, George J. Agich makes a sophisticated argument for autonomy as the core value governing LTC policy and practice. His argument is based on a critique of the concept of autonomy that includes many of the same concerns raised by Moody. The concept of autonomy derived from liberal theory with its heavy emphasis on individual independence, nonintervention, and rational decision-making does not provide a practical framework for an ethics of LTC. It is too abstract and removed from the complex realities of LTC. Like Moody, Agich’s view of autonomy is grounded in a contextual, situated perspective that focuses on interpersonal relations, institutions, culture, and other contextual factors that shape the development of the self. In rejecting liberal theory’s absolutist emphasis on the rights of independence and nonintervention (negative autonomy), Agich does not embrace the alternative of communalism, which emphasizes tradition rather than innovation and the community rather than the individual. Unlike Moody, he adheres to the concept of autonomy as the principle guiding value in the development of LTC policy and in the conduct of day-to-day LTC services.

As the basis for an ethics of LTC, however, Agich’s treatment of autonomy is complex and subject to the influence of many real-world variables that are excluded from the more conventional treatment of autonomy in liberal theory. For Agich, autonomy is more than just the power of an individual to keep others from intervening in her life without fully informed and uncoerced consent. Autonomy is also the power of an individual to interact and communicate freely with others, to give and receive affection, and to initiate actions that are consistent with her sense of self. This positive version of autonomy is especially important in developing an ethics for LTC. Few persons requiring LTC services fit the liberal theory model of the fully competent, independent individual whose goal is achieving freedom from intervention by others.
For Agich, this negative interpretation of autonomy is of limited utility in formulating an ethics for the care of dependent persons. He does not, however, recommend replacing autonomy in the hierarchy of values guiding the provision of LTC. Instead, he proposes to enrich the concept of autonomy by bringing in the real world of the day-to-day life of LTC recipients and by demonstrating how a positive notion of autonomy can shape policies and service strategies that help preserve a disabled person’s sense of self and extend the boundaries of his or her own volitional capacities. Positive autonomy means looking at the world of LTC from the perspective of an impaired individual’s need and efforts to define and make a world that is consistent with his or her own identity.

Agich is not only critical of the limitations of the liberal theory ethics. He is also critical of the principles derived from the medical model of acute care, which he describes as inappropriate for LTC. The ethics of acute care emphasize the role of informed consent by a competent, uninjured patient confronting relatively precise decision-making events involving specific medical procedures and short-term treatment strategies. This approach to informed consent is not an effective means of preserving autonomy in LTC, where the lives of patients are shaped less by discrete decision-making events than by daily routines and styles of caregiving. The effective application of informed consent in LTC is dependent on continuous, undistorted communication between the impaired person and her care providers. Agich refers to this approach as a process model of informed consent, as contrasted with the event model of informed consent in acute care.

Agich’s emphasis on communication and negotiation reflects his intention to identify ways of protecting and expanding opportunities for autonomy in the complex “real world” of LTC. A person’s evolving sense of self and the need to choose activities and projects consistent with her sense of self does not end with frailty and LTC. Autonomy in LTC is preserved by listening to and taking seriously the unique life stories of the impaired person and providing the kind of support that helps her maintain her identity despite impairment and illness. This positive interpretation of autonomy is based on the recognition of human interdependence and the limitations inherent in the liberal theory model of complete independence, especially in the context of LTC.

For Agich, autonomy in LTC is achievable to the extent that the impaired person is able to identify with the choices she makes. She must not be forced to make decisions or adapt to conditions that negate her integrity and sense of self-worth. LTC therefore must include a broad range of options and alternatives in order to maximize the opportunities for choices and actions that are consistent with the impaired person’s sense of self and the need to maintain openings for her continued development. Even the most limited LTC environment (nursing homes) should be designed to maximize opportunities for autonomy. This means offering supportive substitutes for the activities that the impaired person values but may no longer be competent to perform without assistance.

In his effort to identify the concrete possibilities for autonomy in the everyday world of LTC, Agich conducts a phenomenological analysis of nursing home care, organized around the themes of space, time, communication, and affectivity. This analysis provides a framework for a critical assessment of the gap between “what is” and what “ought to be” as defined by an ethics of LTC based on Agich’s concept of complex autonomy.

The extent to which one can move freely within and across space and time is a critical parameter of autonomy and one of the most important criteria in determining the quality of life in any LTC setting. Drawing on literature from the ethnography of nursing home experiences, Agich claims that nursing home patients have little control over the
organization and use of time in the nursing home. Time is organized to support the bureaucratic routines of the institution. The patient's autonomy and sense of self are sharply diminished when the patient loses control over the scheduling of events and activities, which may have very little meaning to the patient anyway given their group-oriented nature.

The loss of control over the flow of activities and the strict limitation on the array of choices a patient may have in determining how he can spend his time are not the only time-based ways in which a patient's autonomy and sense of self may be damaged. Agich uses ethnographic findings to demonstrate that patients need to spend time with staff members talking about their lives and their perceptions of relationships between their past experiences and present circumstances. The need may frequently take the form of simply asking someone to witness, however indirectly, the patient's suffering. The bureaucratic structuring of nursing home routines and the compartmentalizing of staff tasks, however, provide few incentives or time for this kind of intimate interaction between staff and patients.

In the absence of personalized communication, there is not much in the nursing home environment to confirm the patient's sense of self. Undistorted, personalized communication is a necessary condition for the effective expression of compassion and affection by staff members for patients.

Agich points out that,

Good long term care requires an attunement to the elder so that one knows her so intimately that one immediately recognizes when she is incontinent or confused. This kind of recognition is not a matter of performing specific tasks or maintaining specialized technical skills, but involves cultivating intimate social relationships that can only be understood by reference to affectivity, which is all-too-often over-looked and undervalued as the stress on service and tasks impersonalizes care to the point where bureaucratic efficiency replaces any vestige of social or ethical significance for these basic acts of care.

The following passage from the concluding chapter of *Autonomy and Long Term Care* summarizes Agich's critique of the conventional concept of autonomy as expressed in liberal theory and conventional medical ethics. He concludes that efforts to apply liberal theory and acute-care-oriented ethics to LTC have left many disabled elderly (and younger adults) stranded in a moral vacuum without the resources to maintain a sense of their own humanity.

Throughout this study an expansive use of the liberal concept of autonomy and independence and noninterference was opposed on the grounds that it is really a limited political/legal concept that is woefully incomplete for the full purposes of ethical theory. Its most notable deficiency is its failure to accommodate a concrete understanding of persons and the nature of ethical responsibilities in the everyday world. In various guises the liberal view of autonomy influences thinking about long-term care. For example, social perceptions that autonomy means independence leads to the attitude of counterdependence in which elders feel obligated to avoid anything that appears to involve dependence; society for its part supports this behavior by institutional arrangements that assure that the full price of independence is paid. The lack of adequate long-term care insurance, including home care services and support in this country, often makes illness or disability for elders an all or nothing choice: either one accepts full dependence in a hospital or nursing home because medical problems are
not attended to in a timely fashion, or one struggles with the functional disabilities associated with the illnesses of being old without adequate care until disaster arrives. Positively, elders do enjoy important and significant benefits afforded by a panoply of rights that is supported by the liberal ideas of noninterference and dependence.

The Erosion of Autonomy in Long Term Care by Charles Lidz, Lynn Fischer, and Robert Arnold is an observational study of the effects of organizational patterns and routine practices on the autonomy of frail elderly persons in a nursing home and a residential care program. The authors' definition of autonomy includes the liberal theory emphasis on intentionality, freedom from coercion, and they insist that some criterion of understanding and deliberation is necessary for a discrete autonomous act. They also adopt Agich's concept of consistency as an essential feature of their definition of autonomy.

Thus one critical aspect of understanding how the nursing home environment affects the autonomy of the elderly concerns how the elderly individual's persona is affected by the environment. Are the past activities, current identifications, and commitments and envisioned enterprises respected and encouraged or ignored and demeaned?

The authors used participant observation techniques and, to a lesser extent, interviews and quantitative methods to examine the daily lives of patients and residents in a nursing home and in a less structured residential care program. Their major research questions focused on the degree of autonomy, as defined above, experienced by residents in the two programs. The study has several methodological limitations, which lead the authors to suggest that their findings be treated as hypotheses requiring further research. This caveat notwithstanding, their findings are largely consistent with previous research on nursing home care and the much more limited research that has been conducted on residential care, or what is increasingly called assisted living.

Among their more interesting findings are the following:

- The families of patients and residents and the upper-level staff of the facilities strongly support autonomy. In practice, however, nursing home routines and line staff attitudes encourage passivity, and efforts by patients to act autonomously are treated as unreasonable demands. Families also encourage passive behavior, and both groups place greater value on physical safety than autonomy.

- The ethos of the residential care unit was quite different. The caregivers here viewed promoting autonomy as central to their role. Autonomous behavior, rather than constituting a problem, was one of the primary goals of residential living. In the residence sustaining autonomous functioning, not health care, seemed the dominant value among line staff.

- The amount of structuring and rigid scheduling of routine activities was strongly related to the cognitive and physical abilities of patients and residents. Even here, however, there was a substantial difference between the nursing home and residential units. Residents of the latter, cognitively capable or not, were allowed to spend much of their time as they liked.

- Residents of the residential care unit had greater privacy than patients in the nursing home, where almost anyone could gain unrestricted access to the patient's space.

The authors conclude from their findings that nursing homes have many of the features of a "total institution" as described by Erving Goffman in his studies of mental hospitals, military training camps, and other organizations. These features include
entry rituals designed to strip an individual of his private identity, anonymous group activities, uniform treatment of all patients, little individual variation in activity scheduling, frequent violations of privacy, and the acceptance of mutually hostile stereotypes by patient staff.

The authors are not optimistic that current federal and state regulations governing nursing home practices will ever do much to enhance patient autonomy. These regulations reflect the medical model bias that dominates nursing home care and leaves little room for a serious commitment to patient autonomy. They do not think that the most recent federal regulations (Omnibus Budget Reconciliation Act [OBRA] 1987) will significantly elevate the priority placed on autonomy. For instance, the OBRA 1987 requirement that patients be informed of changes in their environment or services does not provide the right to have any influence on the decisions to make changes.

In the authors' view, a serious commitment to protecting the autonomy of nursing home patients would entail a shift away from the medical model toward a model of care and support derived from what they learned in their research on the nature of care and provisions for autonomy in the residential care unit. They recommend that the following steps be taken in shifting from the medical model toward a model of care that characterizes the residential care unit analyzed in their study.

• Promote autonomy by balancing competing values.

Current policies, such as routine use of restraints, favor body care and institutional efficacy over promoting patients' autonomy. It may be that allowing patients increased autonomy will result in patients' safety being at higher risk or in a decrease in institutional efficacy.

• Shift regulatory schemes toward a greater emphasis on autonomy and quality of life. The authors point out that,

Administrators who must spend all of their time managing the completeness of nursing records cannot focus on making the lives of their charges fuller and more independent. Nursing home regulations grew out of the desire to upgrade care. However, this upgrading was based on the hospital model of care and is thus focused on maintaining sanitation and safety rather than personal independence.

• Separate the medical care function from the residential function of nursing homes.

Nursing care, like medical care and social services, can be a specialized, as-needed, function. Most important, we need to abolish the idea that elderly people who are in some way disabled are full-time patients and should "follow (caregivers) orders" full-time.

• Separate patients according to cognitive ability.

The needs of very demented patients are quite different from the needs of those whose physical impairments limit their ability to live without substantial help. Any staff, no matter how well trained and thoughtful, will need to rely on routines and will, to some extent, try to treat all cases similarly. Thus, it seems counterproductive to mix together elderly individuals whose care should require radically different orientations.

The authors conclude by stating that the successful implementation of these changes will require a minor revolution in LTC policy and practice rather than just procedural changes at the margin. It should also be pointed out, however, that these changes cannot be made by focusing on nursing homes alone—in isolation from the rest of the LTC continuum.
We should be prepared to construct an LTC system designed to accommodate a wide range of dependency and to maximize autonomy at every point. A flexible system of care that is responsive to individual needs and does not impose uniform practices within hard institutional structures. We have barely begun to tap the potential of programs designed to expand the outer limits of dependency by providing resources for the exercise of autonomy. We have learned enough from our limited initiatives, however, to know how such resources can be effectively employed. Adequately funded in-home and congregate care (assisted living) alternatives to institutional care can provide opportunities for autonomy far beyond those currently available. This is true for even those who are seriously disabled, including persons with Alzheimer’s disease, who should not be limited to locked units in congregate settings but should be provided the space they need to wander.

An ethics of authenticity and autonomy is necessary to prevent what Habermas calls the “colonization of the life-world” by administrative (instrumental) rationality. If LTC is to remain or become part of the life-world (of a civil society that remains largely “unadministered”), then it must be shaped by rigorous efforts to protect the autonomy of those receiving care. We must be prepared to improvise policies and practices in the interests of expanding opportunities for autonomy. Negotiated consent should be understood as a vehicle for improvisation in pursuit of autonomy and authenticity.

Nursing home care now absorbs over 80% of all public funding for LTC. Nursing homes are a necessary part of the LTC system. They do not, however, offer the most favorable environment for undistorted communication and fully negotiated consent. Moreover, they are not even the most cost-effective options for many of the elderly and disabled who now reside in them. An integrated moral vision that assigns first place to the autonomy principle could play a critical role in creating an LTC system better designed to meet their needs and ensure their rights.

NOTE

1. Moody also addresses issues related to the ethics of intergenerational obligations and equity, such as social security and health insurance, in the second half of his book. This review is limited to the first section on LTC.

REFERENCE


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