

Healthy Aging Reports: A Conceptual and Ethical Analysis of Vulnerability and Independency

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Abstract

Two separate reports from the Dutch Health Council of Netherlands and Social and Cultural Planning Bureau draw our attention to the tension between certain factors specifically related to healthy aging, namely, vulnerability and independency/functioning independently. Though appearing contradictory, both concepts are very relevant in the elderly health care. Hence, the objective was to develop a conceptual and ethical analysis of vulnerability and independency. To achieve that, we conducted a conceptual analysis of more than 80 scientific and philosophical data collected from Pubmed, Google Scholar, and Web of Science. Both concepts are mostly defined as separate compartments, thereby missing their intrinsic relationship. For an ethically well-argued analysis of care for the elderly, we present two new definitions in which the concept of dignity provides a fundamental basis of understanding both concepts, which are indeed two human conditions. Furthermore, we underline the implications of the new conceptualization for autonomy, and give some examples of humanly respectful empowerment strategies in the elderly care.

Keywords

functioning independently, vulnerability, healthy aging, care ethics, dignity

Background

In line with their efforts aimed at offering advices for Dutch government health care policy improvement, the Social Cultural Planning Office (SCP) and Health Council of the Netherlands (HCN; 2009) have published reports of their studies related to healthy aging. The separate reports contain pathways of certain overlapping and seemingly conflicting concepts, vulnerability and functioning independently, both of which play a vital role in elderly health care. In the SCP's publication (van Campen, 2011), contrary to the narrow definition that puts the accent on the physical aspect of frailty, a broad definition that pays attention to psychological and social aspects was used. For the SCP, frailty¹ is a process in the elderly life, involving the accumulation of physical, psychological, and/or social deficits in functioning, which increase the risk of adverse health outcomes, such as functional impairment, admission to an institution, and death. The above-65-year-olds participating in the study have cited health, life partner, children and grandchildren, and other close relatives as being important in their lives. For them, loss of health, relations, and anxiety about the loss would severely undermine their quality of life. They also expressed a desire to continue living independently for as long as possible.

The HCN report focuses on how prevention and proactivity might play a major role in the effective and efficient care

for the elderly. This view reflects the current thinking about aging through supporting the ability of older people to function as independently as possible (Drewes et al., 2011; Hansen-Kyle, 2005; Leezwijn et al., 2011; Ouwehand, de Ridder, & Bensing, 2007; Westendorp, 2006). HCN's emphasis is that self-management and empowerment are compatible with healthy aging. It says that the same vulnerable factor for one might not actually be the case for the other and that people are not always permanently vulnerable; they can repair it. The effort to prevent, reduce, or postpone disease or vulnerability therefore increases not only one's life quality but also life expectancy. Blagosklonny (2007) conceptualizes this process in the term "slow aging," and its synonyms are successful aging, independence, and autonomy (Hansen-Kyle, 2005).

Both concepts, and their relationship with autonomy, often create tensions in the practical provision of health care for the elderly. Even though the concepts feature prominently in practical health care interventions, few studies have tried to discuss their interaction. Hence, due to their ethical

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relevance, we contribute to the study by offering a fundamental conceptual and ethical analysis.

Independency and Vulnerability in the Elderly Care

Using theories about healthy aging and philosophical insights, our purpose here is to conduct an analysis of the concepts of vulnerability and independency in the elderly's life and then develop two new fundamental definitions.

Various ethical questions, which tug at the root of policies and principles behind the elderly health care, begin to emerge when delivering care in the context of values or preferences, such as those emphasized in the SCP's report by the Dutch aged 65 and above. For instance, what does it mean for them to function independently? How can we understand these two overlapping conditions in the life of these older citizens?

Toward answering these questions, there exist some guidelines and theories attempting to address the meanings of both concepts. While Articles 25, 34, and 35 of the Charter of Fundamental Rights of the European Union (2000) recognize the right of the elderly to live in an independent, respectable manner, and be active participants in social and cultural life of member states, Beauchamp and Childress (2009) offer a limited discussion on vulnerability, focusing mainly on protecting the rights of persons, drawing the readers to Hume's observation that contiguity determines interest and empathy for others. For Joris Slaets (2006), the general concept of vulnerability possesses a specific meaning in the context of the elderly. In their aging process, the general level of vulnerability increases, with age becoming an indicator of health risks within the health care system. The risk varies: Older adults with physical disabilities can be differentiated from those lacking capacity for self-care and protection, because the former can identify and seek appropriate assistance to ensure their safety and independence (Naik, Teal, Pavlik, Dyer, & McCullough, 2008). Because resultant biological changes influence the physical and social aspects of the persons in aging, these developments impact their quality of life, which is largely determined by their ability to maintain autonomy and independence (World Health Organization [WHO]; 2002). Mainly for the fact that some retain communication and social skills, and claim abilities that are sometimes² inconsistent with their actual performance, vulnerable people are difficult to identify and diagnose (Naik et al., 2008). While humans are generally vulnerable to aging, (Universal Declaration on Bioethics and Human Rights, 2005) Dyer, Pickens, and Burnett (2007) delineate that vulnerability, as the object of a moral principle requiring care for the vulnerable, refers to the inability to engage in acts of self-care that adequately regulate safe and independent living.³ However, it is asserted that though the value placed on independence in older age has roots in the ideology that individuals should

have responsibility for their own well-being, this does not exclude appropriate social or medical intervention to enhance well-being (Ouwehand et al., 2007).

In discussing why healthy aging is slow aging, Blagosklonny (2007) says that the inhibition of age-related diseases speeding up the aging process, prolong life span by delaying disease in a process termed as *slow aging*. However, even in extended life span, vulnerability to age-related morbidity exists, and so also does the problem of how to optimize an increasingly aging population's health to complete the remaining life not in misery or poor health (Westendorp, 2006). Moreover, functioning optimally can also mean that, when necessary and in accordance with the older person, family caregivers are also involved in their decisions (Hansen-Kyle, 2005). Callahan (2000) takes a more holistic approach by accentuating that human beings are intrinsically vulnerable and, for this reason, the concept of vulnerability offers an interesting and potentially illuminating way to understand not only the many struggles of modern life in general but also the bioethics. For him, bioethics would do better to recognize it both as part of human condition as well as a necessary foundation of sustainable medicine. Joining the call for more attention to the concept, Solbakk (2010) suggests that vulnerability can be better understood as a basic human condition and hence being grasped as a universal principle.

Also, functioning independently is not the act of living life alone. While Drewes et al. (2011), Slaets (2006), Dyer et al. (2007), Hansen-Kyle (2005), Westendorp (2006), and Blagosklonny (2007) have helped in explaining the relationship between both concepts, we emphasize that in healthy aging, the interpretation of not only the concept of independency but also that of vulnerability tends to miss one fundamental. This is the ethical aspect of intrinsic nature of human beings, which is reflected in the Respect for human dignity (RHD). The growing appeal to the intrinsic nature of humans (Clapham, 2006; Haugen, 2010) in bioethical argumentation often arises from the abstract nature of the moral basis of clinical cases. Some of the strengths of principlism, for instance, its comprehensiveness and the ability to grasp values relevant to clinical practices, are outweighed by its lack of anthropological debt or a prenatal understanding of moral experience, as well as the high risk of missing the important dimensions of human experience, among which are vulnerability and independence.

For example, Waldow (2008) recounts how Fransesc Torralba's philosophical ideas on vulnerability expound on the fact that every human is vulnerable in all his dimensions. He is physically vulnerable because he is subject to falling ill, suffering from pain and disability, and for all that he needs care. He is psychologically vulnerable because his mind is fragile, needing attention; he is socially vulnerable because as a social agent, he is susceptible to stress and social justice. The pluridimensionality of being, the relational world, life, work, actions, thoughts, feelings, and

fantasies are all vulnerable. For Waldow, Torralba relates philosophy and vulnerability by saying that when experiencing vulnerability or suffering from illness, the human being philosophizes due to the need to find meaning in the suffering. Although humans may be more vulnerable than other living beings; Waldow argues that Torralba thinks that humans have a better capacity of protecting themselves. An example of this capacity is the concept behind healthy aging. Just as in the interacting processes described by authors earlier in this section, the dimensions are too interconnected, rendering it difficult to make a big distinction between both concepts. Hence, in elderly care interventions, this dynamism must be taken into consideration and respected.

The concept of human dignity (HD) is argued to define both what is common for all human beings and what makes them unique and to stand out from others (Clapham, 2006). One approach goes further to buttress that dignity should have priority over autonomy (Barbarosa da Silvia, 2009). Barbarosa argues that dignity is both the basic normative principle and fully applicable medical ethics and bioethics, and should be preferred to autonomy if both concepts collide. Again, the term *human dignity* (HD) appears in the Charter of the United Nations, second paragraph, reaffirming faith in among other things the fundamental human rights in the dignity and worth of the human person. One of the points of the Preamble, Article 1 of the Universal Declaration of Human Rights is that all human beings are born free and equal in dignity and rights: “Whereas the recognition of inherent dignity and of equal and inalienable of all members of the human life is the foundation, justice and peace of the world.” Examining the occurrence of HD in international documents, Haugen (2010) says that among eight legal, including one EU directive and two conventions, only one refers to autonomy, while many refer to HD because they seek to bring constraints on the exercise of biomedical science (Haugen, 2010).

Based on the convergence of most of these theories and the cross-cultural grounding of RHD in the international documents, we refer to RH as an approach that prioritizes the respect for humans in moral deliberation in health care. Applying the RH in our analysis, we define respect for vulnerability as,

Paying heed to the human contingent health condition, which can be worsened through overlapping interactions, such as inability to routinely perform activities of daily living, dwindling social support, social and demographic factors, as well as neuropsychiatric conditions.

However, independency can be defined as,

The focus by individuals to use the resources made available to them in order to postpone care dependency and the complication of their aging condition, as intrinsically vulnerable human beings.

We argue that the international grounding of the RHD forms the basis for understanding the overlapping process of both concepts. Generally, this means that in healthy aging theories as well as elderly health care, the respect for human vulnerability should in principle and practice be acknowledged.

Next, we use our definition to examine the implication for autonomy in its new relationship with vulnerability and functioning independently in elderly life.

Autonomy in the Elderly Care

The issue of patients’ self-determination and values is increasingly becoming important in elderly care. While the SCP’s reports say that independence is highly valued by elders, their vulnerability, however, might be increasing.

Therefore, having derived new definitions of vulnerability and independency, the next task is to understand how autonomy can be understood with these concepts. Can the concepts of autonomy and vulnerability go together in the care of these vulnerable elderly?

The equation of autonomy with independence occurs from falsely considering them synonymous and at the possible negligence of a disability in the form of different human vulnerability. Scanlan and Kerridge (2009) argue that any useful conception of autonomy must acknowledge the impact of illness on choice and behavior and the influences, constraints, and obligations arising from the network of social relationships, which envelope us. Successful aging is not limited to independent living persons. It can, in terms of autonomy and well-being, occur in people dependent on others for their daily living. Successful aging has social interdependence as its desirable element (Breheny & Stephens, 2009). It should not be limited to autonomy.

For the fact that vulnerability is often believed to be particularly useful when demonstrating the insufficiency of autonomy, while analyzing the concept of vulnerability in addition to the concepts of autonomy and dignity, Haugen (2010) argues that dignity is an intrinsic element of human beings rather than being preconditioned by the actual exercise of autonomy. His assumption is that dignity is applicable and relevant in health care ethics, while autonomy is applied to medical ethics and bioethics as a guiding principle. Autonomy is then the respect for the individual’s own decision or self-determination, applying both to giving consent to any decision impacting on one’s situation as well as the ability to withdraw such a consent. Haugen argues that taking away autonomy or the right to self-determination is tantamount to setting aside one’s dignity. On this last point we beg to differ. Autonomy and HD are not the same—the intrinsic nature of human being, which has vulnerability as a human condition, implies that one cannot take it away; it can only be violated.

Rather than work out a practical guideline, Agich (2003) on his part tries to sketch a framework for respecting

autonomy in the long-term care. Agich (1993) argues that being autonomous means focusing on an integrative process of accommodating self to new circumstances and adapting the circumstances to one's unique structures of meaning, and that autonomy has to be seen as ongoing process of deliberation. Individualism and rationalism should not be the driving factor or prevailing tendency, but real-life developments, where autonomy is very much active in the way people live their lives (Agich, 2003). Hence for older people and us, autonomy is understood as essential interrelationship with others and the world.

Agich (2003) adds that the prevalent view of autonomy (and consent) is deficient in its abstract view of persons as independent, self-sufficient centers of decision making. His idea of parentalism indicates the essential interconnectedness of humans rooted in the basic response to the needy other, which such relationships engender. By alluding to Merleau-Ponty and Heidegger, he sees the experiential comprehension of what might constitute autonomy in the real world in the long-term care as one that emphasizes agency in an interconnected world.

The agent in the everyday world is thus an essentially dependent entity, dependent on a socially derived stock of knowledge at hand and at a repertoire of abilities and skills that comprise the background against which individual difference is manifested. (Agich, 2003, p. 134)

Maintaining a sense of autonomous well-being is consistent with dependence insofar as those dependencies help maintain a more basic sense of functional integrity in areas of life valued by the individual.

Therefore autonomy and vulnerability can go together due to their interdependent nature. In most cases, the patients' autonomy is extremely disturbed due to the nature of their vulnerability. What then, if possible, could alternatively be done to improve such situation? These are the issues dealt in the next section, where we show that the RHD, in our conceptualization, has strong links with the empowerment of the elderly.

Elderly Values and Their Empowerment

How compatible is the idea of empowerment, as suggested in the HCN's report, with healthy aging? Even though the elderly who were interviewed by SCP have expressed a desire to continue living independently for as long as possible, the concern remains that the increasing number of many other elderly patients may be accompanied not only by increased expenditure, but also disturbed autonomy. In their own reports, HCN's emphasis is that self-management and empowerment are compatible with healthy aging. With our new conceptualization, we assert that due to the vulnerable nature of human beings, empowerment is vital as it can also

help bridge the gap of mutual trust between caregivers and patients.

Empowerment started receiving paramount attention since after Ottawa Charter (WHO, 1986). In health promotion, empowerment is seen as a process by which people gain control over decisions and actions affecting their care (Nutbeam, 1998). A distinction is made between community and individual levels of empowerment. Individual empowerment has also been referred to as psychological empowerment (Nutbeam, 1998; Zimmerman, 2000). Zimmerman (2000) adds that others use various terms such as *powerlessness* and *alienation* to depict empowerment. For the purpose of this thesis, empowerment is viewed in relation to the elderly care perspective. Elaborating on their study, which shows that care farms can contribute to empowerment-oriented and strengths-based practices, Hassink, Elings, Zweekhorst, van den Nieuwenhuizen, and Smit (2010) argue that a true empowerment of the elderly should have as its point of departure the acknowledgment of the older persons' vulnerability.

However, Koelen and Lindstrom (2005) emphasize that health professionals are expected to play a role in enabling individuals toward empowerment through health literacy, described as critical to empowerment, and by supporting and providing options that enable people to make sound options. Although the concept of empowerment stems from sociology and educational science, it is rapidly popularized in public and health care research and practice. The reasons for that include the shift to health promotion, where healthy aging is paramount, and relatively the focus on capacity of individuals to deal with their own problems. For them, the national organization of health care, availability of resources may play a role; for instance, the Netherlands has a good system that nurtures empowerment.

The idea of care farms or therapeutic landscapes development in the Netherlands serves as innovative examples in the empowerment process. In the majority of these Dutch farms, the farmers, most of who have no professional education in health care, take care of the clients (Hassink et al., 2010). The care farms for the frail elderly are private family farms providing day care for the elderly. It includes older persons living at home without serious signs of dementia, otherwise characterized as passive and dependent old people lacking resilience to absorb the loss of structure (through work, partners, children) and experience deterioration in their personal vitality. They visit the farm to minimize social isolation and/or provide respite to their partners a few half days in a week. With social isolation being one of the problems facing frail persons, providing such care for frail elderly dependent people is geared toward good life ideals.

Second, Vernooij-Dassen, Leatherman, and OldeRikkert (2011) draw our attention to one particular psychosocial approach. In it, by acknowledging the norm of reciprocity for all citizens, the loss of autonomy and dignity of the frail elderly, who are dependent on care, would be prevented.

Here we argue that due to the intrinsic nature of HD, it can only be violated, and cannot, like autonomy, be lost. In essence, the normative approach of reciprocity is suggested as an attempt at empowering the frail patients. The authors remind us of an often forgotten fact, which is that health care focuses more on frailty consequences than on the older persons' wishes to give. Cognizant of the growing population of the elderly, such focus can exert more pressure or burden on the health care system. Contrariwise, a giving back relationship, evident in reciprocity, can be motivational to the elderly. These findings are very important; however, the authors add that due to sparsity of findings, more studies should help to fully integrate the approach in health care policies. The skills needed to allow the patients to reciprocate include being able to encourage patients to support other patients, ability to support patients to use all remaining capacities, the ability to show attention and affection, and ability to coach caregivers in valuing these attempts to give. In the policy, the caregivers should aim at including medical interventions that allow patients to give back, such as behavioral therapy and community occupational therapy intervention for dementia patients (Vernooij-Dassen et al., 2011).

We see that apart from a focus on the empowerment of the patient to reproduce several benefits in the aging condition, reciprocity falls within the normative approach of respecting the dignity of persons. In our project, it is highly vital to grasp that RHD, rather than being losable by human beings, can only be violated by, for instance, caregivers. Some of the claims for preferring to "move on with their lives" arise from their effort to come out of that prejudice. The idea of empowerment can be a great way of restoring the elderly's violated autonomy, especially at a time when they are often seen as a burden and incapable of any contribution to the society. They require this sense of belonging. Therefore, Vernooij-Dassen et al.'s (2011) suggestion and the idea of care farms are worthy examples. As indicted above, skills are required to realize empowerment's full meaning, or the good type of care that Vernooij-Dassen et al. (2011) and Koelen and Lindstrom (2005) have pointed out.

Discussion

We have presented a conceptual and ethical analysis of vulnerability and independency as constituents of the elderly care policy aimed at healthy aging. This includes the seemingly inherent tension between both concepts, which contain pathways of dynamic, overlapping, and seemingly conflicting aspects, and have been mentioned in the SCP and HCN's reports. Often, the focus of healthy aging is on the individual responsibility in shaping one's life (Drewes et al., 2011; Hansen-Kyle, 2005; Leezwijs et al., 2011; Ouwehand et al., 2007; Westendorp, 2006), it comes at the expense of equating functioning independently with healthy aging, or drawing a chasm between the last two concepts and vulnerability. Several authors, including Drewes et al. (2011), Slaets

(2006), Dyer et al. (2007), and Hansen-Kyle (2005) have helped, with scientific theories, to explain this intricate relationship. Our investigation results in a more fundamental approach: a call to give priority to the concept of RHD, which is an intrinsic value of all humans (Clapham, 2006; Haugen, 2010), and entrenched in the UN Charter and Universal Declaration of Human Rights (UNDHR). Applying the RH, our findings have resulted in the development of a new theory of vulnerability and functioning independently.

The citation of respect for human dignity (RHD) in international documents builds a strong argument for the RH concept, which is as an approach that can prioritise the respect for persons in moral deliberation in health care. The RH offers a more fundamental approach in understanding vulnerability and functioning independently in several ways. First, the vulnerable nature of humans evident in the intrinsic value of humans (Callahan, 2000; Haugen, 2010; Waldow, 2008) entails that vulnerability is not automatically the presence of a disability but the likelihood of acquisition of a disability. This premise should be acknowledged and respected in areas such as care practices. Some people are vulnerable with less or more disease, while others are vulnerable without disease. In addition, the extent and nature of vulnerability can change with time, for instance, by being repaired, by proactive coping or by identifying potential stressors of poor functional decline in time. Within the appeal to HD, this means that while treating vulnerable patients, their self-evident HD cannot be taken away but can actually be violated.

Second, with our new conceptualization, the concepts of autonomy and vulnerability can go together in the care of the elderly because we understand them as two intrinsic interdependent conditions of human life being played out especially in the healthy aging context. There is no wide margin between them. Despite the dynamic process in healthy aging, which Blagosklonny (2007) conceptualizes as "slow aging," with synonyms such as successful aging, independence, and autonomy (Hansen-Kyle, 2005), Breheny and Stephens (2009) argue that successful aging is not limited to living independently. It can occur in people dependent on others for their daily living, and has social interdependence as its desirable element. For Agich (2003), in autonomy, individualism and independency should not be the driving factors, but autonomy must be seen as an interdependent and ongoing process of deliberation. Scanlan and Kerridge (2009) opine that any useful conception of autonomy must take into account men's interdependency and relations arising from the network of social relationship that envelops us. Understanding autonomy from an interdependent point of view shows that, rather than being discrepant, both concepts can work together. Categorizing the elderly as vulnerable and independent does not exclude them from the intersubjective relationship, which is an intrinsic nature of all humans. As in the SCP's reports, the elderly expressed a similar desire for interdependent relation. The fact that the elderly are functioning independently, but when their health deteriorates, rely on care and its peculiar attendant human affection,

shows their interdependent nature. Prolonged life span, healthy aging, or Blagosklonny's (2007) term, *slow aging*, can still mean vulnerability to age-related morbidity exists, or misery or poor health (Westendorp, 2006).

Furthermore, through the review of both HCN and SCP's reports on the elderly preferences and values, we have argued that patient empowerment is a tool vitally needed to help the elderly spend the rest of their life on earth. However, the elderly empowerment assumes a more effective value base with the prioritization of HD as an intrinsic value of humans. While Hassink et al. (2010) view care farms as a great innovative example of empowerment, Koelen and Lindstrom (2005) emphasize the need for health care professional engagement. In another example of empowerment model, Vernooij-Dassen et al. (2011) focus on a psychosocial approach. The approach draws on the idea of reciprocity and has a motivational dimension. What is required in both cases is skill acquisition by caregivers to optimize their efficiency.

By prioritizing and applying RH, the strength of this study lies in the innate potential of RH in helping to explain the experiences of the elderly's life, such as vulnerability and independence. Considering the intrinsic vulnerability of humans, the relationship between vulnerability and independence is too dynamic that a big difference between them cannot be made. In addition, our allusion to the RHD imbedded in the international documents has an intrinsic normative justification as a fundamental point of departure in moral deliberation in health care.

These findings should be considered in the light of certain consideration; criticisms against the HD approach could arise from the different definitions that it offers (Beauchamp & Childress, 2009; Haugen, 2010), that is, the definition it provides can sway arguments in health care cases in either directions. However, these various definitions are a source of its richness, and its fundamental nature sets some kind of social limit to the interpretations that can be ascribed to it.

Research Limitations

We want to recognize some unavoidable limitations in this research. Even though the SCP's and HCN's reports have touched on various issues, in this research we have focused on very relevant or specific concepts, vulnerability and independence. It might also be good to emphasize that we only are analyzing independence and vulnerability as regard to the elderly (human) dimension.

Recommendations for Further Research

Due to both the growing rate of the elderly population and the dynamic nature of the notions of vulnerability, independence, and healthy aging, we recommend the creation of research opportunities on the tension between these connected concepts as well as their continuous ethical evaluation. The fruits

of such research will contribute positively to relevant approaches and policies in elderly care.

Conclusion

The overlapping relationship between the concepts of vulnerability and functioning independently, as mirrored by the separate HCN and SCP's reports reverberates the daily experiences of the elderly, which often create ethical problems in the elderly health care. Following the arguments of certain authors, this study has conceptualized both concepts by applying the RH. The argument is that in elderly care as well as issues related to aging, the respect for human vulnerability should be acknowledged as the appeal to the RH provides a substantial ethical fundament in understanding the interaction between both concepts. Even though the nature of vulnerability impacts functioning independently, they are not poles apart but have interdependent relation. In this study, we have analyzed the implication of the new conceptualization for autonomy by underscoring the interdependence of the concepts. Empowerment strategies, as a way of respecting the dignity of the elderly, are suggested.

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Notes

1. On frailty's connection with vulnerability, Slaets (2006), in a different study, elaborates that frailty can be understood as increased vulnerability associated with aging.
2. My emphasis, but also a view shared by many authors, including Callahan (2000) and Haugen (2010).
3. This is comparable with the Social Cultural Planning Office (SCP)'s report where the elderly have expressed a desire to continue living independently for as long as possible.

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Author Biography

Francis C. Agu Born in 1968 in Nigeria, I am based in The Netherlands where I live with Ellis and our lovely son Hugo. In recent years, my career has taken a gigantic shift from marketing and theology to bioethics, which is the main reason that I presently head a healthcare ethics center.