

George J. Agich, "Reassessing Autonomy in Long-term Care"

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The realities of long-term care call for a refurbished, concrete concept of autonomy that systematically attends to the history and development of persons and takes account of the experiences of daily living.

Long-term care is an increasingly important subject for bioethical reflection and analysis, yet when viewed through the spectacles of autonomy, the pivotal concept of much bioethical theory, the realities of long-term care seem paradoxical to say the least (1). The most striking feature of long-term care is that adult individuals suffering from diseases and illnesses of being old experience a compromised vigor and ability to function that requires regular care ranging from help in activities of daily living such as housework, food preparation, and hygiene to highly skilled nursing and medical care. Elders requiring long-term care generally exhibit functional disabilities that frequently bring with them vulnerabilities as well. They exhibit various kinds of dependencies and not the independence so prized by the traditional view of autonomy that stresses values of independence and rational free choice.

Traditional treatments of autonomy simply abstract from actual examples of finite human autonomy and contexts of choice and focus instead on idealizations of autonomous action and choice. As Onora O'Neill has pointed out:

The limitations of actual human autonomy aren't taken as constraints on working out the determinate implications with respect to autonomy in actual contexts, but often as aberrations from ideally autonomous choosing. The rhetoric of the liberal tradition shows this clearly. Although it is accepted that we are discussing the autonomy of "finite rational beings," finitude of all sorts is constantly forgotten in favor of loftier and more abstract perspectives. (2)

In short, a concrete concept of autonomy is needed if it is to play a significant analytical and practical role in long-term care.

The abstract liberal concept of autonomy has its proper place in the legal/political sphere, where protection of individuals from tyranny and oppression by powerful others is rightly defended, but not in the moral life, where a fuller conception is required, one that acknowledges the essential social nature of human development and recognizes dependence as a non-accidental feature of the human condition. Such a concept would systematically attend to the history and development of persons and take the experiences of daily living into account; it would view individuals concretely and see choice as a problem of positively providing options that are meaningful for concrete individuals rather than as an issue of removing obstacles to choice or impediments to action. Such a refurbished concept would offer important advantages for capturing the ethical complexities of long-term care.

Autonomy as Independence

As conceived in the western liberal tradition, autonomy focuses on independence of action, speech, and thought. The ideals implicit in this concept include independence and self-determination, the ability to make rational and free decisions, and the ability to identify accurately one's desires and to assess what constitutes one's own best interest. So construed, autonomy supports a broad set of rights that provide the normative basis from which tyranny, oppression, and even the benevolent use of power over vulnerable

individuals have been opposed. These features are certainly defensible and need to be preserved, but we must critically acknowledge that the underlying idea of independence that has come to dominate our understanding of autonomy is an idealization entangled in the historical roots of this tradition in seventeenth-century political and legal debates. Thus, we should not expect a fully adequate picture of what autonomy means in those heterogeneous circumstances that comprise the moral life from this important, but limited context. Unfortunately, this limited orientation has enjoyed a central place not only in academic ethical discourse, but public discourse as well.

According to this view, to be a person is by definition to be capable of free and rational choice; such abilities provide the ethical foundation for the expression of uniquely individual beliefs, desires, preferences, and values. So long as these individual beliefs and desires do not directly cause harm to others, anything goes. Furthermore, decision-making is regarded as a rational process that can ultimately be understood or explained in terms of decision theory. Communicative interactions between individuals are thought to involve primarily the exchange of information. An outgrowth and obvious example of this point is the stress placed on information disclosure in the legal doctrine of informed consent, a stress that tends to make informed consent an event rather than a process (3).

The attitudes and beliefs associated with this view engender a variety of secondary defenses against dependency: a denial of need, hostility toward helpers even in the face of disabilities that require assistance from others, contempt for the real or imagined weakness of others, and, in some cases, an inflated self-image. This culturally determined aversion to dependence has been termed “counterdependency,” an aversion to dependency of all sorts (4). As a result, Americans frequently look with dread on the thought of dependence and go to great costs to maintain independent lifestyles (5).

Given the prominence of this cultural attitude in American society, it is not surprising that one common approach to the ethics of long-term care involves focusing on various mechanisms designed to provide elders with specific rights to enable them to resist unwanted interference from others. This approach takes many forms, including attention to the rights of the elderly to certain information (such as provided in preadmission agreements utilized by growing numbers of nursing homes and required by some state regulatory agencies), the access of elders to ombudsmen or advocacy reviews, or the use of formal surrogate decision-making procedures, especially in cases involving withholding or withdrawing life-sustaining treatments. These developments have been widely defended and supported by reference to the ideals of autonomy, yet focusing on procedural protections attests to the fact that even the staunchest proponents of this view recognize that the theory must accommodate in some way the realities of impaired decision-making capacity that are an ineliminable feature of long-term care. Beyond procedural protections, however, this view provides little practical guidance in clarifying the degree and kind of autonomy actually present.

Criticizing the scope and central thrust of the liberal concept of autonomy does not commit one to an outright rejection of the liberal theory. A version of the liberal view—itself admittedly more complex than this brief discussion acknowledges—can be defended along the lines marked out by Charles Larmore in his *Patterns of Moral Complexity*. In Larmore’s view, the liberal theory is defensible, but properly restricted to the political/legal sphere; it does not need to be uncritically extended into the realm of

ethics (6). A fuller account of the nature of autonomous moral agency would include a framework for interpreting what autonomy concretely means and for articulating the essential historical and social nature of persons by taking seriously the concrete developmental aspects of becoming and being a person (7), as well as the phenomenological reality of being an agent in the world of everyday life without embracing the notion that the ultimate source of value or authority is tradition or community.

Actual Autonomy and Ideal Autonomy

One difficulty with focusing on actual autonomy is the rather messy incompleteness and uncertainty that this phenomenon presents when compared with ideal autonomy. We are forced to say something definite about when specific expressions of autonomy are genuine and when they are spurious or misleading. We cannot simply rely on hypothetical examples of ideally autonomous action or choice, that is, action or choice taken as ideally rational and free, but rather must identify specific concrete conditions or features that contribute to or mark out an action or choice as autonomous. The problem is that autonomy is developmentally and socially conditioned, so that determinate expressions of autonomy will be unique and contextually situated, thus precluding adequate formulation in abstract terms. Instead, a phenomenologically accurate, concrete assessment is required. In point of fact, the task is less difficult than it may first appear if we seriously attend to the core meaning of autonomy itself.

“Autonomy” literally means “self-rule,” that is, behavior that is spontaneous and self-initiated; such behavior is regarded as action in the sense that it manifests intentionality. Human action, in turn, can be regarded as free if the individual agent can identify with the elements from which it flows; an action (or choice) is unfree or coerced if the agent cannot identify with or dissociates herself from the elements that generate or prompt the action (8). This means that the ability reflexively to identify with the constituents of an action is logically prior to freedom and that autonomy is best understood on the basis of the possession of an identity or of a self having a particular determinate nature and character. Expressions of autonomy are thus the playing out of who the individual is as well as who the individual is becoming; the field or stage for such “playing out” is the social world of everyday life.

Because autonomous individuals are situated in concrete social situations, choice is always contextual. To do *x* means that *y* is forgone. There are always costs associated with any choice. Making explicit choices or decisions, however, is not the central feature of our lives, most of which are spent acting in habitual, taken-for-granted ways that are not experienced as the result of express decision-making. Such actions might be seen as unfree on the traditional view of autonomy, but they are truly free or unfree to the extent that they are consistent with one’s self-identity or not. In other words, an individual is autonomous insofar as she is who she is, insofar as one’s actions exhibit a developed pattern. But since individuals are never fully formed, but are always dynamically in the process of development, “who an individual is” is always an open question. In the daily course of living that question is suspended or set aside as a conscious issue, but that does not mean that the matter is ever really closed.

Self-identity is not something that one discovers as an uncharted island in the middle of a sea, but rather is something that is made by individuals in the very course of their living. Existential crises or life transitions are clearly paradigmatic ways in which

questions such as “who am I?” or “in what do I believe?” come to the fore. Sickness, too, frequently forces an examination of what is so commonly termed one’s “values.” In point of fact, however, in daily life we seem to proceed oblivious to our own spontaneity and freedom. Thus, to speak of individuals as autonomous requires that we pay attention to the kinds of things with which they properly identify in their lives. Saying this is to expand on the slogan “respect for persons” in a way that reflects the concrete reality of human existence. To respect persons properly requires that we attend to their concrete individuality, to their affective and personal experiences; we need to learn how to acknowledge their habits and identifications.

Frithjof Bergmann has nicely articulated the central elements of such a situated or contextual concept of autonomy:

For those without identity freedom is indeed “absolute independence.” They, it is true, must “go against everything” in order to be free. But this is not the case for all those who do not share in this extreme condition. The greater the extent to which they do identify with something, the less is the complete isolation prerequisite to their being free. To put the point paradoxically: “dependency” on something does not in any way diminish one’s degree of freedom as long as one truly identifies with the thing on which one is “dependent.” If I am in harmony with something--if in fact it is me--(and that is the point of talking about “identification”)--then I need not be isolated from it, and need not be protected from it, to be “free.” The demand for freedom takes the form of an insistence on total independence only for those who lack identity. For all others the claim is not compelled to this extreme--and yet, in terms of freedom, they have not been compromised and do not receive less. (9)

Thus, not only is tolerance of diversity of choice and taste a necessary adjunct of respecting liberty, but so is acknowledging the irreducible individuality of concrete expressions of autonomy in those individuals not always able to manifest ideally rational and reflective free choice.

Autonomy in Long-Term Care

Culturally defined perceptions that autonomy means independence lead to the attitude of counterdependency 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 home care services and support, including insurance, for instance, often makes illness or disability an all or none choice: either one accepts full dependency in hospital or nursing home or one struggles with the functional disabilities associated with the illnesses of being old without adequate help until disaster arrives. Long-term care, however, does not always involve institutional living arrangements and such arrangements need not mean passivity for elders.

Long-term care of all sorts, including home care services, is required precisely because individuals experience to some degree an actual loss of functions that we associate with a full sense of developed adult autonomy. They lose various abilities to act in the world and so require more than usual amounts and kinds of support and care from others. Our society displays profound ambivalence about this situation in that we seem to want these individuals to deny their need for care--in short, we want to support their individual right to noninterference even at great personal cost--and yet we recognize that

individuals who cannot care for themselves and who place undue burdens on family members require specialized professional care.

Consistent with our society's concern for the right of noninterference, however, is the development of efforts to secure institutionalized patients' rights to noninterference by even benevolently motivated health care professionals, family, or friends. Unfortunately, this adversarial orientation does not adequately capture the mundane ethical reality of either autonomy or long-term care. A contextual account is wanted that attends to the phenomenon of actual rather than ideal autonomy.

The implications for long-term care of this turn to actual autonomy are important. Respect for autonomy cannot mean that caregivers are primarily and absolutely precluded from influencing the decisions of elders. To be exposed to influence as such is not to be enslaved. In fact, we need to acknowledge that the relationship between the receiver of care and the caregiver is far more complicated, especially in long-term care, than the usual model implies (10). The operating paradigm, however, seems to assume that because the health professional is in a position of power and authority, the patient must be protected by an insulating fabric of rights or else the bogeyman of paternalism will appear. In long-term care, especially when care is provided by family or by professionals in the patient's home, the situation is likely to be reversed, that is, the elder retains significant power and independence, and so the application of the ideal view of autonomy as avoidance of paternalism seems too easy and too simplistic.

Some observers have properly pointed out that what are frequently alleged to be cases of paternalism in health care are actually cases of communication failure on the part of the health professional; health professionals are more frequently "guilty" of beneficence toward patients than paternalism, in the strict sense that patient decisions are overridden in favor of health professionals' view of patients' best interests (11). Also, it needs to be stressed that the personal relationships that develop between elders and caregivers in long-term care contexts may be more ethically relevant than the professional power or authority that the criticism of paternalism seeks to curb.

Focusing on actual autonomy raises at least two questions regarding long-term care. First, are the choices actually afforded individuals in long-term care the kind that are meaningful or worth making? Even when individuals are afforded an array of choices, autonomy may not be significantly enhanced because the choices available may not be meaningful for the individuals involved. Put simply, choice that enhances autonomy is choice that is meaningful for individuals and allows them to express and develop their own individuality. If such is not the case, then the true sense of autonomy of persons is not enhanced.

Consider, for example, the kinds of choices typically afforded individuals in nursing homes. There are choices regarding limited outings, the use of special services such as hair dressing or participation in structured social and recreational activities such as bingo, or choosing when and what to eat, with whom to associate, or "permission" to ask or not ask staff for help. No matter how extensive this list is, one can and should ask whether it includes alternatives that are meaningful, that preserve and enhance patients' unique individuality and identity. If the actual choices afforded individuals in nursing homes are not experienced by those individuals as meaningful, and other "choices" that are meaningful are discouraged and not enhanced--and that is an empirical matter to be

determined on a case-by-case basis--then serious questions arise regarding how autonomy is being respected in these circumstances.

Being able to identify with one's choices is a prerequisite for true autonomy. There are choices individuals can be forced to make that diminish the integrity and self-worth of the person. The 75-year-old woman whose own health is deteriorating must make choices regarding the care of her 78-year-old husband who has suffered a stroke and is now bedridden. Similarly, the husband must choose institutionalization or watch as his own care literally consumes his wife. The family of such a couple, too, must struggle with equally difficult choices. Do they take the couple into their households for care? Do they break up the couple and arrange for different care for each of their parents? Sometimes, the cost to self for the elder in agreeing to move in with children is too great not because the elder fears dependency and prizes independence, but because the elder cannot identify with a choice that imposes burdens on children and means the loss of friends and familiar surroundings.

The psychological consequence of this point is evident everywhere in long-term care. Non-identification characteristically carries with it a sense of "passivity." As Bergmann notes,

Once the subject structures his experience in a certain way, he has to feel passive, but the sense of passivity in turn reinforces the non-identification: the self that is overwhelmed at every moment withdraws still further. (12)

Thus, the phenomena of withdrawal and generalized depression often seen among institutionalized elderly may partly be traceable to the existentially tragic choices that the elder is forced to make, or to an abject lack of meaningful choice currently available in our society for impaired elders. From the point of view of actual autonomy, we should see the psychological sequelae of choice, the problems of adapting to new circumstances, as factors that are ethically significant.

If the conscious exercise of choice typically comprises only a small part of our lives, then questions about the style of life and the structure and organization of long-term care become important. For example, is the life available in long-term care something with which the elder can identify, not only through explicit choice but passively and reflexively? Raising this question suggests that a different metaphor of autonomy is appropriate to the new focus on actual autonomy.

Autonomy is not best understood, as in the traditional view, in terms of a model of explicit decision-making nodes along a narrow path, such as the decision to institutionalize or to initiate skilled care. Instead, actual autonomy is more complex and clearly less neat. For the most part, there are no well-defined paths or hallways in which one is regularly confronted by a range of options amenable to rational decision-making; a more apt metaphor would be an open field with no clearly defined alternatives. Patterns exist, but they are subject to change; they evolve over time. Rather than emerging relatively rarely in conflicts involving rational choice, actual autonomy is always present, though sometimes submerged from view as individuals go about their daily lives. It is because autonomy is always present that it is so difficult to bring into view.

Actual autonomy is utterly ordinary and unremarkable most of the time. Thus, the proper understanding of autonomy involves appreciating how individuals are interconnected and how persons develop in terms of historical and social circumstance.

Autonomy is just as significantly present in the acquisition of habits of action and thought (which are as much socially derived as they are individually and uniquely determined) as in clear instances of reflective, deliberative decision-making. For this reason, conditions that foster or thwart the development and expression of individuality and self are more significant than the phenomenon of explicit, conscious choice.

One condition central to long-term care is the fact that elders are more likely than younger persons to experience functional disabilities as the result of chronic illnesses (13). These are often measured in empirical studies by the number of days lost from housework, school, or work, or days spent in bed, but functional disabilities also preclude performing actions that are meaningful or important for individuals. The concept of functional ability measures the impact of an illness or impairment on the individual and on the individual's ability to engage and interact meaningfully in the social world, rather than focusing on the presence or absence of disease. Indeed, some have noted that "the loss or impairment of the ability to perform such basic daily functions as shopping or bathing strikes at what the elderly value most--independent living"(14). "Independent living," however, should not be interpreted as reinstating the concepts of independence and noninterference, but rather as indicating the ability to perform those normal functions of daily living that define the individual's own sense of self-worth and identity.

That loss of function is an important concern is supported by the literature that notes a lack of association in the minds of the elderly between health and the presence of chronic illness or disability (15). In some studies, 68 percent of noninstitutionalized elderly report their health as excellent or good despite the fact that 85 percent have at least one chronic illness and 47 percent have some functional disability (16). These findings suggest that individuals experience themselves as healthy if they maintain functional ability even in the face of chronic disease. It would be a mistake, however, to assume that functional ability is important as an end; rather, functional abilities are important not because they are coincident with independence, but because they instrumentally define the sense of self and self-worth of the individuals in question. The account of autonomy just offered helps to explain this.

Maintaining a sense of autonomous well-being is consistent with dependencies on medication or professional care if those dependencies help to maintain a sense of functional integrity in the areas of life that individuals value. Dependencies do not conflict with autonomy if individuals can still maintain a sufficiently adequate range of identifications to sustain their own sense of integrity and worth. Functional ability, then, has to be understood in terms of concrete individuals, not abstractly as general abilities that define independence as a good in itself.

The paradigm case of an actually autonomous person and a liberal non-autonomous person would be a wheelchair-bound individual assisted by others in various activities of daily living. At the same time, this person is devoted to the cause of Food for Peace (FFP). What this woman can do for FFP is limited, yet she identifies strongly with it. She stuffs envelopes twice a week for the local chapter and rejoices when she sees a television feature on FFP's projects. She has visitors from FFP. Her choices are meaningful in the context of her identifications with FFP. She does not care whether she has her bath at 6:00 am on Thursday or at 2:00 on Friday. Not all choices matter to her, just those that are meaningful in terms of her participatory identification in a larger social context (17).

A similar and more familiar case would be the intense involvement of an elder with her grandchildren or hobby or commitment to a favorite sports team. The inability to shop or leave the home or institution may be far less significant for such an individual than the ability to entertain her family, pursue her hobby, or watch her team compete on television. The central point is that such matters cannot be determined generally, but only specifically. After all, the core sense of respecting autonomy involves treating individuals as unique individuals, rather than simply as members of a class.

It is possible for health professionals or other caregivers to interact with elders in long-term care such that the professional does not take over the care of the patient, but rather gives the patient's own care back to herself authentically (18). "Giving the patient's own care back to herself authentically" does not mean that the patient is expected to regain independent functioning or take over her own physical care, but that the caregiver support the patient's own unique identifications and sense of self or values as health care needs are met.

Care-giving relationships involve all kinds of social interactions during the course of which the patient's sense of satisfaction and self-worth can either be enhanced or thwarted. Truly to care for another, one must allow the other to experience the world meaningfully; that means affording "choices" with which the person can genuinely identify and acknowledging his or her sense of self in the course of the myriad interactions that comprise long-term care. This conclusion points us away from an ethics that focuses on what Laurence McCullough and Stephen Wear have termed "four-alarm cases"--on intractable problems or issues arising in dramatic and conflictual contexts--and toward the mundane attitudes and behaviors of caregivers and elders themselves (19). These concerns are sometimes denigrated as being merely psychological or psychosocial concerns best left for specialists in these areas; yet helping individuals to flourish, even in the context of long-term care, is an activity that deserves serious ethical reflection. Failure to appreciate this point encourages the view that concern for autonomy must restrictively focus on specific dramatic problems and issues rather than the mundane, interstitial features of long-term care. That view, I have argued, is basically mistaken.

Robert Kastenbaum has observed that in long-term care,

we often see the clinical ambience minus the clinical benefits. The person who is a patient only temporarily can adjust to the unfamiliar and unlovely hospital routines knowing that this is only an interlude. Some comfort and individuality is sacrificed; however, in fair return the person receives state-of-the-art medical and nursing care. By contrast, the geriatric milieu is a long-term or permanent arrangement for many people, and the clinical ambience is not counter-balanced by superb care. Perhaps the most infuriating note from the standpoint of the patient is the attitude that "this is all for your own good." It is not--and everybody knows it. (20)

Kastenbaum argues that the necessary goal for a clinical milieu is "making the world right again."

Frail and impaired older persons experience many sorrows, losses, fears, and frustrations in addition to physical ailments and disabilities. Certainly, a therapeutic environment must provide treatments that can help prevent discomfort and help individuals maintain a level of integrated functioning. But there must be a broader environment that is conducive to health besides the episodic medical treatments that are now provided. In effect, geriatric practice must attend to what Hans Selye has termed "the syndrome of just being sick," (21) the pervasive sense that things are just "not right."

Besides specific disabilities and pains, there is a sense of the world gone awry, a pervasive sense of loss or what might be simply termed “existential despair.” Kastenbaum argues that the “just being sick” syndrome can be countered effectively by a milieu that accentuates the positive, namely one that develops a systematic and encompassing framework of positive expectations on the part of everyone involved. Clarifying the components of such a milieu would be one way to operationalize concern for autonomy. To do that, however, requires that the concept of autonomy be refurbished along the lines suggested above.

The Practical Pursuit of Autonomy

Respecting the autonomy of persons in long-term care entails a commitment to identifying and establishing conditions that encourage individuals to face the adversity and threats to self inevitable as a result of the disability and illness that bring elders to long-term care in the first place. Respecting autonomy requires attending to those things with which individuals can truly and significantly identify. Elders must be treated as individuals, as unique persons with identifiable personal histories so far as that is possible. Even when such identifications are difficult to assess, as in cases of severe memory deficits associated with Alzheimer’s disease, patients frequently respond, albeit minimally and in deficient ways, to direct contact with caregivers and others. Thus, long-term care can provide positive messages and hope even in the face of serious impairments. Hope does not have to portend recovery, as is frequently assumed in the medical context; rather, hope refers to the prospect of meaningful experience together with others at those times when one most needs comfort and companionship.

The practical pursuit of autonomy varies depending on the context and the different moral agents involved; nonetheless, ethical analysis can still suggest some general guidelines to inform the efforts of long-term care practice. These guidelines include not accepting loss of autonomy and dignity as a normal fate of aging, and challenging accepted beliefs that loss of autonomy is a universal and ineliminable feature in the frail elderly. We must recognize that dependencies may be induced by institutional settings that erode autonomy by robbing individuals of their most basic identifications, and that essential differences between acute care and long-term care should point to the need for the latter to develop a different commitment to enhance the values and identifications of patients, and, finally, that autonomy should not be dealt with as a “problem” reactively, but as an integral and essential aspect of caring for patients (22).

Focusing on actual autonomy brings ethical reflection to bear on the mundane, interstitial reality of long-term care rather than on idealized crises or problems. A natural consequence of this shift in focus is the awareness that “giving” a frail elder a range of choices or “letting” an elder choose may be ethically less compelling than helping the elder to live in the face of frailty, loss, and ultimately death. So many of the problems that ideal autonomy so aptly addresses seem to arise just because caregivers fail to care in a responsive and responsible fashion. Actual autonomy thus helps to reveal the concrete and complex ethical features of long-term care that are otherwise transparent to the traditional concept of autonomy.

References

(1) See Gerald Dworkin’s discussion of the paradoxes of autonomy in *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988), 3-20.

- (2) Onora O'Neill, "Paternalism and Partial Autonomy," *Journal of Medical Ethics* 10 (1984), 175.
- (3) Charles W. Lidz et al., "Two Models of Implementing the Idea of Informed Consent," *Archives of Internal Medicine* 148 (June 1988), 1385-89.
- (4) For a full discussion of this concept see Andrew Joseph Christiansen, "Autonomy and Dependence in Old Age: An Ethical Analysis" (Yale University Doctoral Dissertation, 1982), 37-128.
- (5) Christiansen, "Autonomy," provides an excellent summary of these cultural attitudes and their negative implications for the ethics of long-term care. See also Phillip Clater, *The Pursuit of Loneliness* (Boston: Beacon Press, 1970), 1-28, and Margaret Clar, "Cultural Values and Dependency in Later Life," in *Aging and Modernization*, Donald O. Cowgill and Lowell D. Holmes, eds. (New York: Meredith Corporation, 1972), 263-74.
- (6) Charles E. Larmore, *Patterns of Moral Complexity* (Cambridge: Cambridge University Press: 1987)
- (7) Lawrence Haworth, *Autonomy: An Essay in Philosophical Psychology and Ethics* (New Haven: Yale University Press, 1986). See also Mary B. Mahowald, "Against Paternalism: A Developmental View," *Philosophy Research Archives* (1980), 6, No. 1386; and "Sex-Role Stereotypes in Medicine," *Hypatia* 2 (Summer 1987), 21-38.
- (8) Frithjof Bergmann, *On Being Free* (Notre Dame, IN: University of Notre Dame Press, 1977), 37.
- (9) Bergmann, *On Being Free*, 48. Mill, too, insisted that individuals require different conditions for their development: "The same things which are helps to one person toward the cultivation of his higher nature are hindrances to another. The same mode of life is a healthy excitement to one, keeping all his faculties of action and enjoyment in their best order, which to another it is a distracting burden which suspends or crashes all internal life" (*On Liberty* [Indianapolis, IN: Hackett Publishing Co., 1978], 65).
- (10) Two helpful critical treatments of the typical model are Andrew Jameton, "In the Borderlands of Autonomy: Responsibility in Long-Term Care Facilities," *The Gerontologist* 28, Supplement (June 1988), 18-23; and Harry R. Moody, "From Informed Consent to Negotiated Consent," *The Gerontologist* 28, Supplement (June 1988), 64-70.
- (11) David C. Thomasma, "Freedom, Dependency, and the Care of the Very Old," *Journal of the American Geriatrics Society* 31 (December 1984), 911-12; and Caroline Whitbeck, "Why the Attention to Paternalism in Medical Ethics?" *Journal of Health Politics, Policy and Law* 10 (1985), 181-87.
- (12) Bergmann, *On Being Free*, 47.
- (13) L. Fredman and S.G. Hynes, "An Epidemiologic Profile of the Elderly," in *Aging and Public Health*, H.T. Phillips and S.A. Gaylord, eds. (New York: Springer, 1985), 1-41.
- (14) C.C. Pegels, *Health Care and the Elderly* (Rockville, MD: Aspen Publishing Company, 1981), 5.
- (15) K.E. Ferraro, "Self-Ratings of Health Among the Old and the Old Old," *Journal of Health and Social Behavior* 20 (1980), 377-83, and G.G. Fillenbaum, "Social Context and Self-Assessments of Health Among the Elderly," *Journal of Health and Social Behavior* 20 (1979), 44-51.
- (16) B. Filner and T.F. Williams, "Health Promotion for the Elderly: Reducing Functional Dependency" in *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention: Background Papers* (Washington, D.C.: U.S. Government Printing Office, 1979), 367-86; and M.G. Kovar, "Health of the Elderly and the Use of Health Services," *Public Health Report* 92 (1977), 9-19. See also, L.W. Butler and P.W. Newacheck, "Health and Social Factors Relevant to Long-Term Care Policy," in *Policy Options in Long-Term Care*, J. Meltzer, F. Farrow, and H. Richman, eds. (Chicago: University of Chicago Press, 1981), 38-77; L. Cluff, "Chronic Disease, Function and the Quality of Care," *Journal of Chronic Disease* 34 (1981), 299-304.
- (17) This example comes from an anonymous reviewer of an earlier draft of this paper. I use it with thanks.
- (18) George J. Agich, "The Question of Technology in Medicine," in *Phenomenology and the Understanding of Human Destiny*, Stephen Skousgaard, ed. (Washington, D.C.: Advanced Research in Phenomenology and The University Press of America, 1981), 8587.
- (19) Laurence McCullough and Stephen Wear, "Respect for Autonomy and Medical Paternalism Reconsidered," *Theoretical Medicine* 6 (October 1985), 294-308.
- (20) Robert Kastenbaum, "Can the Clinical Milieu Be Therapeutic?" in *Aging and Milieu: Environmental Perspectives on Growing Old*, Graham D. Rowles and Russell J. Ohta, eds. (New York: Academic Press, 1983), 11.
- (21) Hans Seyle, *The Stress of Life* (New York: McGraw-Hill, 1956), 79.
- (22) Bart J. Collopy, The Conceptually Problematic Status of Autonomy, Unpublished study prepared for The Retirement Research Foundation, December 1986, pp. 204-208; see also Bart J. Collopy, "Autonomy in Long Term Care: Some Crucial Distinctions," *The Gerontologist* 28, Suppl. (1988), 10-17.