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The implication of autonomy on Europe's ageing population.

Abstract

Since patients' autonomy disposed medical paternalism in response to outcry of medical malpractices by about the middle of the twentieth century, it has made tremedious impact on population demography worldwide. Since inception, medical law has evolved at national, regional and global level to facilitate the effective engagement of the stakeholders into partnership in the appropriation of the autonomy model of healthcare for effective delivery. At present, a lot of the civilised world, including Europe, has made autonomy central to healthcare services. However, it is increasingly becoming apparent that, at the back of autonomy are rapid changes in demographic parameters such as increasing life expectancy and quality of life, shrinking working population; together with increasing costs of medical care in the midst of competing priorities. This calls for a perspective redefinition of autonomy in the context of demographic dynamics; a challenging task for European Health Law and other legal systems.

Key words:

Autonomy, competing priorities, decision making, Europe ageing population, implications

1. Introduction

The outcry for autonomy resulted not only in the evolution of health law, but also definition of the individual's rights has transcended various legal systems, for example, civil law, employment law and commercial law. Today the individual's rights are well enshrined in a variety of legal instruments in most of the civilised world at local, national, regional and global level. In most civilised societies the move from paternalistic approach in patients' care towards the emphasis on patient autonomy has been quite rapid. The result is that the idea of shared decision making (SDM) is, now, taking hold[1]. By this the patient and his or her doctor work together for the patient's best interest[2].

In many countries the individual's rights have become an invaluable political weapon as voters are always in the lookout for the party offering the best social welfare package. The result is that, the design and commissioning of health and social welfare programmes have become central to any political agenda in most of the civilised world, including Europe. For example the National Health Service (NHS) in the United Kingdom (UK) came into play in 1948 with a key remit to provide free quality healthcare to her citizens. Furthermore, the fast development in science and technology has led to great advancement in treatment and preventive options for disease and disability.

The overall impact of patient exercising their autonomy with respect to their healthcare and other welfare services they receive from the state, the growing centrality of health and social welfare reforms in political agendas and the advancement in science and technology; have all brought great healthcare reforms resulting in availability of and accessibility to quality healthcare, consequently increasing life expectancy in Europe and most parts of the developed world. It is at the back of these the demographic trends of Europe's population have evolved since the paramount of autonomy.

The present work sets out to outline the implications of autonomy on Europe's demographic trends, recommendations remedial to the implications of autonomy on Europe's ageing population and the strategic role of Europe's medical legal system in enhancing autonomy to keep in pace with Europe's ageing population.

This will be looked at in the context of the various stakeholders including the patient, the healthcare professionals, the public, the government and the law. It will concentrate mainly on the UK legal system while making reference to the European Union (EU) and other jurisdictions where relevant.

2. The impact of patients' autonomy on Europe's demographic trends

In Europe the outcome of the outcry for patients' autonomy has far exceeded its initial course. It was primarily to stamp out inhumane practices in biomedical research, subsequently extended to medical practice. The results have been patients having a lot of say in the design and provision of their healthcare services. It has seen healthcare providers on their toes for excellence in their service, not only to safeguard litigation for malpractices, but also for progression in their professional career pursuit. It has brought autonomy to the forefront of political arena, as healthcare and welfare reforms have since been central to any political agenda, consequently provision of free healthcare services.

Furthermore, it has been a huge haul for both intellectual novelty by researchers in biomedical science and new technologies in the advancement of medicine; not the least economic amassipation by pharmaceutical, technological and other healthcare industries. For example new technologies and the pharmaceutical industries have provided autonomous choices of better, safer and more effective treatment options, including life support machineries such as

ventilators and incubators. The result has been increase in life expectancy across the EU that far exceeds pre-autonomy era levels. The average life expectancy in the EU has increased to 80.8 years for women and 74.6 years for men; and this continues to rise. It is projected that the 60+ age population which is currently on an average of 20% will rise to about 35% in the next 50 years; and the 80+ years old will increase from its current 4% to 11% in the next 50 years[3]. The increase in life expectancy has been matched with a general increase in quality of life compare to pre-autonomy days.

At the back of this huge achievement of autonomy that has caused health and welfare reform across Europe and the civilised world, is a current outcry for the extension of same autonomy to include the taking away of life, the very 'inhumane' act it was primarily to safeguard. This self determination to take own life by the autonomous patient often results from inability to cope with some of the aftermath of autonomy such as disability and geriatric related morbidity, or events earlier in life, such as prematurity, leading to long term disabilities.

Again, a reverse impact of new technologies is prolongation of life even in the vegetative state resulting in families and friends becoming stressful. Not the least the financial implications of these on welfare and health services. Not surprising, the current political debates in the mainstream of autonomy on issues such as euthanasia and life support technologies.

Also, reversal to an ageing population is declining birth rates resulting in population decline across Europe[4] This is because autonomy has made it possible for people to choose to have children when they want and how many they want, or not to even have any. The consequence is a shrinking workforce; therefore, a smaller earning stratum of the population to care for a relatively larger dependent. For example, on the average, the working: dependent ratio currently 4:1 is projected to drop to 2:1 by 2050[4].

In addition, the working female population is growing, so is family mobility which is on the increase; thus increasing number of old people staying on their own, consequently requiring support from state welfare services.

3. Implications of Europe's demographic trends

Europe faces a double challenge of ageing and population decline resulting to a shrinking workforce to support the increasing needs of the growing dependent stratum of the population. The increased number of life years for the elderly are spent in disabilities, chronic and often multiple illnesses, in addition their normal welfare needs[5]. This places further pressure on resources[6].

Although the demographic changes vary in type and degree from one member state to another, each faces the challenge of the sustainability of their healthcare and welfare systems in the current legislative framework. This is a paradox that calls for strategies, both at state and EU levels, to shape current legislature to keep in step with these demographic trends and their challenges. In particular is legislative reform to put all patients' rights in context of Europe's advancing demographic trends.

4. Recommendations remedial to the implications of autonomy on Europe's ageing population

There is need for clear and decisive policies[7] to ensure keeping balance in prioritisation of the use of resources in the midst of patient's autonomy without the sense of age descrimination.e.g. the young vs. the elderly in decision making on issues such as transplantation.

The non strategic tracking of Europe's demographic trends in the light of autonomy by policy makers suggests autonomy developed rather rapidly since its evolution without foresight of its implication on Europe demographic trends, consequently inadequate or no planning for their containment. These changes did not occur overnight, yet there are inadequate concrete plans in place for them. This suggests policy makers have been overwhelmed with the enthusiasm to implement autonomy that the lost their window of opportunity for strategic plans for its aftermaths, not the least, its impact on Europe's demographic trends[8] Such strategies should aim at balancing spending on service provision and the consequences of longevity such as increasing disabilities[9,10], with making significant investment on preventative services and research to facilitate healthy ageing[11].

New technologies and the pharmaceutical industries too have made their indelible impact on the longevity of Europe's population. However, central to them is their primary objective to make profit, which is ever maximising. For example, just a few decades ago there were no debates on life supporting equipment as they were non existent. Today they are not only available but ever on the demand and at increasing costs. Their costs are not just on procurement and maintenance but also the training required to use them. As these institutions are primarily for profit making, they should be made to make significant contributions towards the bill for their aftermath, for example, the cost of long term care of the elderly. This could be done by reviewing the relevant legislatures to, for example intellectual property law on patents, raise their taxes.

Furthermore, it would be prudent feeding back into the workforce some of the number of quality life years beyond current retirement age. For this, it is necessary to harness reshaping employment law to facilitate this. However, such legislation need not be blanket, given that the longevity also comes with a significant increase in geriatric related morbidity, frequently multiple in nature. Therefore, such laws should only apply to those in good health. For

example, employment law should extend present retirement age and encourage employers to retain such 'healthy seniors'[4]. Already the UK government has set strategy to extend retirement age for both men and women[12]. At the EU level there is an agenda to encourage older people's participation in society, including work[13,14].

These initiatives to get healthy seniors back to work would result in multiple benefits namely: revenue from their income tax, savings from the pension and other welfare packages that would have been due them and the health benefit of physical and social working life. But this has to be backup with the soliciting of the support of trade unions together with education to raise general public awareness to see the need for the public participate in this way in meeting the costs of their health services. Although, as already highlighted, there are already efforts both at state and EU level to keep in step with the current demographic trends; such efforts should be harnessed and concerted.

It is also vital raising public awareness of need to balance their exercise of autonomy with economic reality, more so in the present global economic crisis. This should aim at reshaping public expectation and extension of their partnership with their governments and service providers, and indeed the rest of their communities, by being considerate and sacrificial in their expectations and choices. To this is now pertinent to ask the question 'For how long Europe can sustain 'free healthcare' without a crash?' This question is more pertinent now in the present wind of economic recession that is sweeping not only regionally but globally. The public should be encouraged to contribute to their healthcare. The time is ripe for Europe to beginning to explore the possibility of instituting health insurance or any form of financial contribution by the public towards their healthcare. For example the United States of America has not had a free healthcare package, and has not failed to have presidents for not instituting this in their political agenda. As the current economic difficulties facing almost all member states thus making the politicians to revise a lot of their welfare packages to tightness, it may

not be too long for drastic welfare reforms that would spontaneously bring autonomy to match in pace with realities.

Any campaign for public adjustment to their healthcare would require a backup of public education in order to carry them along any reform. The earlier such reforms start, the gradual they would be, consequently the easier and quicker the adjustment. The strategic role of education has in carrying the public along health policies based on law and regulations have been shown from numerous studies[15,16].

On Europe's shrinking workforce, currently to cope with the situation, a lot of EU workforce is being met by relaxing immigration laws to facilitate influx of skill workers from developing countries. This should be seen as only remedial antidote, while strategic plans for long term solutions embarked upon. This should also be on awareness of the need to safeguard the brain drain from the immigrants' countries that need such skill even more dearly. It is also prudent being conscious of the fact that these countries are not stagnant but developing so that time would come when the exodus of their skilled workforce would shrink to extinction because of internal consumption.

Of yet great impact on Europe's workforce is the issue of low birth rates across member states. First step is ensuring all pregnancies have maximum potential of ending in healthy term live births. This calls for further improvement on antenatal care and other preventive measure to reduce foetal loss and premature births, for example, teenage pregnancy, alcohol and smoking during pregnancy, working in hazardous environment during pregnancy and enhanced prenatal screening facilities. Some possible reasons why couples would rather not raise a family or just one child include the increasing costs of childcare and the 'family unfriendly' working conditions. These call for review of employment law for flexible working conditions such as working from home for the working family. Furthermore, childcare subsidies by government towards the cost of childcare would be great incentive. Again, public

education to raise awareness of the implications of the declining birth rates would be of significant remedial action.

All these strategies for reformation of autonomy in the face of Europe ageing population would require the backup of the concerted efforts of the different arms of legislature, both at national and EU wide levels to readdress the individual's 'rights' in the present context of an ageing population. The courts too have a significant role to play in facilitating autonomy to rhyme with Europe's ageing population.

5. The strategic role of European medical legal system in enhancing autonomy to keep in pace with Europe's ageing population.

In the face of the present speed of revolution in medical science and technology consequent of autonomy the courts are expanding their position in relation to the legislature. A good example here is the inadequacy of existing legislation to provide sufficient answers to problems raised by the ability to sustain life, quality or not, with artificial means as per Lord Browne-Wilkinson in *Airedale NHS Trust v Bland*(17) and all the associated cost implications of such life sustained. Lord Browne-Wilkinson questioned whether the judges should develop a new law to meet this wholly new situation. Already reforms have been made in legal documents such as the Human Tissue Act 2004[18] and the European Clinical Trials Directive 2004[19]. A positive factor here is that legislative reform is usually sought for by involving stakeholders, as for example public consultation. This is useful for the fact that it helps to minimise the restrictive nature of such legal instruments if they were promulgated otherwise[20].

Since the rise of the concept of patient autonomy, the medical profession and the law, both at national and international level, have come up with various Codes of Practice and legislation to harness it as has already been highlighted. Patients themselves have grasped the opportunity to exercise their rights to treatment more avidly than their commitment to the associated responsibilities that come with such rights. At times, the law, government health institutions such as the NHS in the UK and the medical profession have been sending conflicting signals. A classical example in the UK is the ruling in *R (on the application of Burke) v General Medical Council*[21] that seemed, at first instance, not to have taken account of the resource implications and competing priorities of the NHS and its general commitment to the public. It seems that the high court was more willing to succumb to the individual's exercise of autonomy than they were to professional expert judgment as well as the public interest with regards to resource management. This was of basically saying that care should be provided on demand and that the doctor was obliged to provide it - virtually saying 'what the patient wants is what he gets'.

Commenting on the case, JK Mason and GT Laurie posed the question as to the point at which community interests set a limit to the individual's self-determination[22]. The emphasis on the patient's autonomy overriding other interests was put by Munby J thus: 'Once a patient has been received or admitted into the National Health Service hospital a duty of care arises – a duty to provide and go on providing treatment – whether the patient is competent or incompetent, conscious or unconscious. Once the duty to care has arisen, the doctor and the hospital are under a continuing obligation that cannot lawfully be shed unless arrangements are made for the responsibility to be taken over by someone else. The duty to care is, in principle, a duty to provide that treatment which is in the best interests of the patient…'

However, upon appeal, the high court ruling was turned down[23]. This suggests that the court of appeal will accept that patient autonomy cannot be allowed either to drain the NHS of

resources by insisting that doctors provide treatment against their better judgment. This call for a complete overhaul of all ramifications of legislature on patients' rights, even more so in the present Europe's demographic trend that calls for stepping up the issue of prioritisation in providing healthcare services at the back of patients' autonomy. However, any legislative reformation has to keep balance between cost saving and maintaining professional accountability that would distant the very inhumane practices that instigated the birth of autonomy.

The medical profession, like most professions, continuously undergoes self regulation to maintain professional standards. This is even more so since the rise of patient autonomy. In the UK, where health is a key political agenda, regulation of healthcare services has gone beyond the confines of the profession itself to involve the government through agencies such as the NHS. In addition to commitment to its healthcare agenda, the increasing level of government concern on healthcare services has been further prompted by the rising level of medical malpractices such as professional incompetence[24] and medical error[25]; which give rise to additional high costs[26]. The government regulatory measures are through two models, a punitive and an educational model of accountability[27]. In addition to regulating individual doctors, corporate bodies are being regulated by the Commission for Health Improvement[28].

By the Medical Act 1983 (Amendment) Order 2000[29], the GMC has been made to make significant changes to its procedures for determining who is fit to practice in the UK. By itself, the Council has evolved a number of regulatory measures including the GMC Guidance for Doctors: 'Consent: Doctors as Doctors Making Decisions Together' (June 2008)[30].

But sadly, despite all these regulatory steps, the medical profession is still, to some extent, characterised by some level of malpractices being constantly unveiled. Also, what could be said to be positive impact of novel advancement in medical science such as life prolonging

machines is currently undermining the profession as there is often a conflict between patients or their relatives and doctors as to when such machines should be switched off.

But the profession cannot defend misconduct such situations as a nurse convicted of murdering or attempting to murder elderly patients for 'bed-blocking', or in fact, a doctor struck off the coveted medical register for gross professional misconduct[31] or yet doctors convicted for protracted sexual abuse of their patients[32] or the likes of Shipman who murdered hundreds of his patients, not as a professional incidental misfortune, but by deliberate choice over a long period of his medical career[33].

The fact that all these professional ineptitudes, the very inhumane aspect of which was the original concern that brought about the ascent of patient autonomy are still happening to such degree half a century on, raises a number of questions, including: Has autonomy actually inculcated a sufficiently deterrent effect on the medical profession? Were it not for patient autonomy, to what level of degradation would the medical profession have descended to today? Would the profession continue to stand to its call to 'do no harm'? How safe is Europe's increasing frail population in the hands of the profession? How competent is the profession for self regulation? Is it the profession or is there a natural human inclination for cruelty instead of kindness? Has the patient himself or herself over-extended autonomy? What went wrong, how, when; and what are the remedies? However, positively, it should be acknowledged that, but for autonomy, these sad happenings would have occurred on much greater scales and, possibly, gone undetected. Their unveiling is evident of the effectiveness of current regulatory measures. But the ever increasing horizon for extinction of inhumane practices throws an even greater challenge to the European Health Legal System and its allies to who Europe's ageing population continues to appeal for the consummation of autonomy.

Reference

1. Cornuz J, Junod N, Pasche O, Guessous I Cancer screening in clinical practice: the value of shared decision-making. *Rev Med Suisse* (2010), 6:1410-1014

2. Tibballs J The legal basis for ethical withholding and withdrawing of life-sustaining medical treatment in children. *J Law Med* (2006), 14:244-261

3. Christensen K, Doblhammer G, Rau R, Vaupel JW Ageing populations: the challenges ahead. *The Lancet* (2009), 374:1196-1208

4. Derek R Ageing and work: an overview. *Occupational Medicine (Oxford, England)* (2010), 60:169-171

5. De Luca d'Alessandro E, BonacciS, Giraldi G Ageing populations: the health and quality of life of the elderly. *La Clinical Terapeutica* (2011), 162:e13-18

6. Buckley BM Healthy ageing: ageing safely. *European Heart Journal* (2001); 3 Suppl N:N6-10

7. Walker A Aging and politics: an international perspective. In: *Handbook of ageing and the social science.* Binstock RL, George LK, eds. Amsterdam: Elsevier; (2006). pp.339-359

8. Spidla V Preparing for EU's ageing population at heart of new expert group. Press release 11 June 2007; Available@Http://ec.europa.eu/commission_barroso/spidla/index.cfm?pid=whats_new&sub=news&langId=en&id=79.(Press release IP/07/89).

9. Nuae U, Kroll T Bridging policies and practice: challenges and opportunities for the governance of disability and ageing. *International Journal of Integrated Care* (2010), 10:e041

10. Westendorp RGJ, TBL The biology of ageing. In: *Ageing in Society*. Bond J, Peace S, Dittmann-Kohli F, Westerhof G, eds. London:Sage Publications; (2007). Pp. 15-37

11. Lunefield B The ageing male: demographics and challenges. *World Journal of Urology* (2002), 20:11-16

12. The secretary of State Employment Equality (Age) Regulations 2006, @ http://www.opsi.gov.uk/s//si2006/20061031.htm (Accessed 14 September 2011)

13. European Commission. Europe's Response to World Ageing: Promoting Economic and Social Progress in the Ageing World – A Contribution of the European Commission to the 2nd World Assembly on Ageing. Brussels, Belgium: Commission of the European Communities; (2002)

14. European Commission. Dealing with the Impact of an Ageing Population in the EU (2009 Ageing Report), Communication from the Commission to the European Parliament, The Council, The European Economic and Social Committee of the Regions. Brussels, Belgium: Commission of the European Communities; (2009)

15. Deccache A, van Ballekom K From patient compliance to empowerment and consumer's choice: evolution or regression? An overview of patient's education in French speaking European countries. *Patient Education and Counselling* (2010), 78:282-287

16. Hoving C, Visser A, Mullen PD, van den Borne B A history of education by health professionals in Europe and North America: from authority to shared decision making education. *Patient Education and Counselling* (2010), 78: 271-281

17. Lord Browne-Wilkinson in *Airedale NHS Trust v Bland* [1 A11 ER 821 @ 878, (1993) 12 BMLR 64 @ 124

18. Human Tissue Act 2004

19. European Clinical Trials Directive 2004

20. Mason & Laurie, Smith's Law and Medical Ethics (2006), at 1.57, 7th ed Oxford, Oxford University Press.

21. *R (Burke) v General Medical Council* (official Solicitor intervening) [2004] EWHC 1879 (Admin); [2005] QB 424

22. JK Mason, GT Laurie Personal autonomy and the right to treatment: a note on *R (on the application of Burke) v General Medical Council* [2006] QB 273

23. *R (on the application of Burke) v General Medical Council* [2005] EWCA Civ 1003; [2006] QB 273

24. Report of an Inquiry into Quality and Practice within the National Health Service arising from the report of Ledney Ledward (2000)

25. Vincent C, Neale G, and Woloshnowych M Adverse events in Bristol Hospitals: Preliminary retrospective record review *British Medical Journal* (2001), 322; 517

26. Comptroller and Auditor General, NHS (England) Summarised Accounts 2000-2001 H.C. 766 (2002).

27. Davies ACL Mixed signals: using educational and punitive approaches to regulate the medical profession. *Public Law* (2002) Win, 703-723

28. Commission for Health Improvement @ http://www.healthcarecommisssion.org.uk/homepage.cfm

29. Medical Act 1983 (Amendment) Order 2000)

30. GMC Guidance for Doctors: Consent: Doctors as Doctors Making Decisions Together (June 2008).

31. Burrows J Telling tales and saving lives: the role of professional colleagues in protecting patients from dangerous doctor. *Medical Law Review* (2001), 9: 110-129

32. Independent 10.09.2004

33. The Shipman Inquiry: First Report Volume 1, *Death Disguised* (2002)