

# Health Discrimination and the Elderly

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Bernard M. DICKENS\*

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\* Ph.D., LL.D., Faculty of Law and Faculty of Medicine, University of Toronto.

## I. INTRODUCTION

The language of Section 15(1) of the *Canadian Charter of Rights and Freedoms* that proscribes "discrimination based on ... age or mental or physical disability" poses the question whether the mental and physical characteristics that are associated with advanced age are disabilities. The change in both physical and mental function that frequently comes with advanced age, and the related change in temperament, may be considered a disability; tasks that the individual once could accomplish fall beyond the person's capacity with the accumulation of years. When the evolving nature of human development and growth is recognized, however, the performance level a person can achieve may be found by measures of ability specific to age. Children and adolescents are not necessarily considered physically or mentally disabled because they lack the abilities of mature adults, and those who have passed through the stage in life when they possessed such abilities are not necessarily disabled either. Health is accordingly measured by reference to age. Elderly people who lack stamina for tasks that demand physical endurance, who cannot maintain prolonged intellectual concentration or who lose patience in the face of physical discomfort, noise or frustration more quickly than they once did are not sick or unhealthy people for that reason.

Aged people acquire their physical and mental attributes due not just to the physical and neurological consequences of longevity but also to their experiences in life. Experience may result in wisdom and perhaps tolerance of others' characteristics, but bereavement can cause feelings of depression, isolation and apprehension about the future that affect both physical energy and emotional well-being. In times of rapid technological growth and social change, experiences the elderly have acquired may be considered without value by later generations, so that the elderly have no esteemed place in their societies as sources of wisdom, and the generation gap in culture between them and their successors may be mutually alienating. Legislation compelling retirement at a given age, which itself may be lawful under the *Charter*, (see *McKinney v. University of Guelph* (1990), 76 D.L.R. (4th) 545 (S.C.C.) and *Stoffman v. Vancouver General Hospital* (1990), 76 D.L.R. (4th) 700 (S.C.C.) may aggravate loss of self-esteem and feeling of uselessness, as well as distress at economic constraints that come from dependency on a pension income. The collective impact on the elderly of their physical, neurological, psychological, social and economic circumstances may impair their achievement of "health" which is understood, perhaps too ambitiously, by the World Health Organization as being "a state of complete physical, mental and social well-being" and not merely the "absence of disease or infirmity" (Preamble, W.H.O. Constitution).

The elderly may not be considered disabled by reason of their characteristics, but may nevertheless suffer discrimination in regard to health care on other age-related grounds. Some discrimination may explicitly refer to age as the basis of disadvantage, such as when they exceed a given age. Organ transplantation may be denied elderly patients suffering organic failure, for instance, on the generalized ground of poor prognosis (meaning length of survival) even on successful surgery. Other discrimination may arise from lack of means to accommodate the special health needs of the elderly, who thereby risk receiving inappropriate care. Dysfunctional stereotyping of the elderly in health care will be addressed below. More immediate is the concern that, because health care costs are a heavy charge on governmental resources, and the elderly absorb resources disproportionate to their numbers, they will be over-represented among victims of *de jure* and *de facto* rationing of health services.

Section 1 of the *Charter* guarantees its rights and freedoms "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society". What enacted limits to freedom from discrimination in access to health care on grounds of advanced age are reasonable and justifiable in our society will ultimately be determined by the courts. If U.S. society is comparable to our own, however, regarding both the growing proportion of its population that is elderly and an emerging perception of a need to allocate health resources according to principles of intergenerational justice, age-specific limits on access to health care may be proposed in Canada. Within the last five years in the U.S. at least ten books have been published (see Appendix), including some by leading philosophers and ethicists, that address age-specific limitation of health care resources. Some make explicit recommendations that costly care be withheld from some patients on grounds only of their age. Some argue, for instance, that age discrimination differs from race or sex discrimination, which always creates inequalities between people, because age discrimination does not create inequality if used over the course of each person's lifetime. The preference the young receive is balanced by their disadvantage on grounds of age later in life. That is, the claim that the young have to health resources enhances their capacity to survive and reach an advanced age, when priority in allocation must again favor the young.

The growing tendency to justify denial of health resources to the elderly poses a special challenge to the equality provision both of the *Charter* and of provincial human rights codes. The elderly are likely to make greater demands on resources than younger people, but should not be at disadvantage in receiving resources proportionate to their needs. That is, the fact that their needs are greater than those of others may not justify a limitation in the response and expenditure *per capita* that the health care system makes in its deployment of public funds and facilities. In group terms, greater *per capita* expenditure on the elderly may be justifiable by their greater *per capita* contributions to resources. Equality is not served by limiting payments to an identical amount per person insured, since this would discriminate against the disabled generally without regard to age. To limit resources made available to the disabled who are old, perhaps on the ground that their prospects for future life are reduced, poses questions of the ethics of health care resource allocation, and of the legal impact of the *Charter*.

## II. AVAILABILITY OF SUITABLE CARE

Beyond the issue of the elderly receiving proportionately less care for their health needs from available services than is given to younger persons, is the issue that, in some cases, special services the elderly need are not available at all within the health care system. The unavailability of special residential care in appropriately equipped homes where they can retain a maximum of personal autonomy is an expression at the community level of our society's failure to address the needs of an aging population that is also expressed at the level of health care. The demographic fact that, with an aging population, proportionately fewer people of younger age will be available to give personal services to the elderly suggests the need to explore improved mechanical aids for the elderly, and to make aged people more reliable in administering to their own needs of routine health care and maintenance. The development of the medical speciality of geriatrics and of the background sociopsychological discipline of gerontology is leading to identification of how the elderly differ from people in the middle-aged and earlier stages of life.

This growth in the medical specialty of geriatrics may parallel in some regards the growth in pediatrics. It was once supposed that children were like adults, but smaller. They were given the same foods, in a strained form, and the same herbal and chemical medicines in the same dosages as adults received. With the growth of scientific pharmacology and, for instance, neurology, it came to be seen that the young are medically different from those of greater age. Equally, it is now being perceived that the elderly are not simply adults who have lived a long time. They are increasingly being recognized to possess distinctive physiological, psychological and, for instance, neurological characteristics that must be medically assessed in their own right, and not be considered as pathological (even if they would be if encountered in persons in earlier stages of their lives).

The elderly show distinctive tolerances of and reactions to drugs, for instance, that in time may cause drugs now prescribed with different adult and pediatric dosages to be prescribed differently for geriatric dosages. Drug dosage problems are common in the elderly, and are now being given appropriate attention. Some drugs are too toxic for the elderly when prescribed or taken at adult dosage levels, and cause harm or distressing side-effects. Others are ineffective at adult dosage levels, and deny the potential benefits they could afford unless administered at a higher dosage than is appropriate for adult patients.

Elderly persons' sensitivities to and endurance of other treatments involving physical discomfort, noise and, for instance, forms of muscular or other stimulation are similarly distinctive. Further, in the same way that the young are divisible into categories of children and adolescents, the elderly are increasingly divided into the "old" and the "old-old". The elderly have an advantage over the young regarding health care in that they can apply a lengthy lifetime of experience to their assessments of forms of care that may be available to them, and can state what services they want and what needs they feel are not being met. They can also, in principle, give legally effective consent to their participation in medical and social research to identify and respond to their special characteristics, so that improved means of management, and particularly of self-care, may become available to them.

This depends, however, on research funding being available, and on public medical and social research funding agencies affording geriatric research a sufficiently high priority over competing interests, such as the study of childhood and congenital disorders. It is not clear whether courts would hear arguments, based on the *Charter* or otherwise, regarding governmental macroallocations of resources to categories of medical or social research. Courts may consider research that is proposed, but may be unable to consider whether governmental agencies fund types of research equitably, or are sufficiently active in attracting or sponsoring types of research.

### III. CAPACITY TO CONSENT TO MEDICAL CARE

Routine legal doctrine on informed choice of medical care (see *Reibl v. Hughes* (1980), 114 D.L.R. (3d) 1 (S.C.C.)) applies to the elderly as to other age groups. In requiring that information of prospective treatments be given that is material to the choice of a reasonable, or prudent, person in the patient's circumstances, the law expects due regard to be paid to the patient's age as a feature of the patient's circumstances. For instance, if some

predictable side-effects of treatment will affect the elderly more than people of middle or earlier age, this will warrant more specific explanations to be given to the elderly. Similarly, if risks are of less significance to the elderly, such as risk of loss of reproductive capacity, they may be less discussed, although the elderly patient's interest in sexual activity should not be under-rated by insensitive or unaware stereotypical dismissal of the concept of elderly people as sexual beings.

Presentation of information regarding choice of health care will have to be made to an elderly person with due regard to the elevated anxiety the elderly may feel when confronted with the prospect of being placed in new surroundings, even temporarily, or having to make confusing choices. Written information and other documentation should be in sized print that takes into account deteriorating eyesight, and spoken information should be repeated and otherwise reinforced to accommodate short-term memory lapses. The need to adjust means to transmit material information, to allow time for the decision-making process to occur and to verify that the choice made is authentic should not be replaced by the conclusion that the anxious patient with poor eyesight and, for instance, poor memory is legally incapable of decision making and should therefore fall under the decision-making power of another person such as a relative.

Similarly, the paternalistic conclusion that an elderly person should be relieved of decision-making responsibility in his or her best interest is legally suspect. Over-reaching, arbitrary and vague legislation intended in part to serve the apparent welfare of patients has been found to violate the *Charter (Thwaites v. Health Sciences Centre Psychiatric Facility (1988), 48 D.L.R. (4th) 338 (Man. C.A.))*, and similar practice in public hospitals based on interpretations of the common law may equally be found suspect, under provincial human rights codes that prohibit discrimination on grounds of disability. The same approach founded on hospital management regulations made under express legislation may be open to challenge under the *Charter*. Excluding elderly patients from decisions affecting them because of the belief that they should be protected from decision-making or that they lack competence to make decisions on account of their age would appear to be discriminatory and in violation of *Charter* principles and/or provisions of provincial human rights codes, unless supported by compelling clinical evidence specific to the contemporaneous capacity to function of the patient proposed to be treated according to another person's decision.

No less offensive than the supposition that elderly persons lack decision-making capacity is pressure brought to bear against them to influence the decisions they make. Free choice is as legally necessary as adequately informed choice of health care. Because of their dependency on others, elderly persons may be denied maximum autonomy in decision-making. Institutional personnel and also family members may mould elderly persons' preferences to their own ends in ways to which those who lack the characteristics of the elderly would not be subjected. Courts are therefore required to be vigilant lest the elderly may suffer discrimination from this source in exercise of their fundamental and legal rights regarding direct health care and matters that affect their health indirectly.

#### **IV. TERMINAL CARE DECISIONS**

The thrust of the argument of such respected and indeed leading U.S. ethicists as Daniel Callahan (see Appendix) is that health care for the aged should be limited at some point to relief of pain and suffering and that "heroic" measures should not be used once the "natural life span" has been achieved, which he suggests is in "the late 70s or early 80s" (p. 171). Despite evidence of good clinical outcomes of such procedures as organ transplantations in the elderly, Callahan's thesis would make them unavailable. Whether cardio-vascular resuscitation is "heroic" would be a matter of particular concern to elderly patients capable of resuming a life of human interaction that they could find satisfying. The austere approach to rationing health care that Callahan proposes, presumably applicable primarily to those whose health care is supplied from public funds, directly challenges laws opposing discrimination based on age, and also presents an indirect challenge in that the approach may condition public institutions and the elderly themselves to accept that, beyond a given age, patients lose entitlement to expensive medical procedures.

As against this, elderly patients who have been accustomed to being in charge of their lives may fear losing charge at the end, and becoming subject to the wishes of others. In particular, they may fear the use of life-sustaining technologies that deny them natural death and postpone the event through infliction of massively invasive treatments during which patients denied death hope only to be unconscious and unaware. The Supreme Court of Canada has given emphasis under the *Charter* to the need to respect individuals' "own priorities and aspirations" (per Dickson C.J.C. in *Morgentaler v. The Queen* (1988), 44 D.L.R. (4th) 385 at 402)), disregard of which may lead to profound bodily interference and thus violation of security of the person protected by section 7.

Elderly persons may strike the balance between immediate discomfort, medical invasion or, for instance, amputation and the prospect of survival and future capacities differently from the way in which younger people do. They may prefer to succumb to disease or disorder in relative peace rather than be required to fight to survive. Aged persons are entitled to be considered as the individuals they are, and not be regarded either as people incapable of independent health care decision-making or as people whose age characteristics can be discounted in favour of generalized treatment. That is, their age should not be a source of disentanglement to individual consideration, nor be disregarded as a factor in how they wish to be treated.

No Canadian jurisdiction has legislation concerning so-called "living wills". Most U.S. states have Natural Death Acts under which terminal care directives (refusing artificial or mechanical means of sustaining life) are legally enforceable. Nevertheless, most non-statutory declarations of this nature and more widely operating advance directives regarding health care would seem legally enforceable against public hospitals in Canada. In *Malette v. Shulman* (1990), 67 D.L.R. (4th) 321, in which the Ontario Court of Appeal unanimously upheld the legal force of a Jehova's Witness case refusing blood products, the Court said that its judgment did not necessarily apply to living wills. It is obvious, however, that if a person not wishing to die may have the risk to do so, a person wishing to die would be afforded the same power to refuse unwanted treatment. Where provincial Power of Attorney legislation does not permit a competent person to make provision for his or her incompetence (that is, where the legislation does not accommodate a "durable" power of attorney), a challenge may be mounted on the basis of discrimination on grounds of (prospective) disability. Legislation not permitting a durable power of attorney may be challenged, for instance, for denying equal

protection of the law to people when they lose competence to express their wishes and must rely on others they trust to express their wishes for them. Regarding the exercise of choice regarding terminal care options that may fail to be invoked during a patient's mental incapacity, provisions of the law on non-discrimination on grounds of age and disability may be invoked jointly, although the latter may appear more relevant.

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