

**UNITED NATIONS-REQUEST FOR INPUTS TO 11th SESSION OF THE
GENERAL ASSEMBLY'S OPEN-ENDED WORKING GROUP FOR THE
PURPOSE OF STRENGTHENING THE PROTECTION OF THE HUMAN
RIGHTS OF THE OLDER PERSONS.**

**THEME: AUTONOMY AND INDEPENDENCE LONG-TERM AND
PALLIATIVE CARE**

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INTRODUCTION

To be autonomous is to be a 'free, self-governing agent'. Autonomous agents make decisions that are uncoerced and that best express the outcomes of their own deliberative processes. The dominant cultural ideal of such agents envisions them as independent, rational, and self-interested persons.

Patient Autonomy and Independent Consent:

Expressing respect for patients' autonomy means acknowledging that patients who have decision-making capacity have the right to make decisions regarding their care, even when their decisions contradict their clinicians' recommendations, autonomy requires both 'liberty (independence from controlling influences) and agency (capacity for intentional action)" and liberty should not be undermined by coercion, persuasion, and manipulation. It requires physicians to respect patients' autonomy by giving them the information needed to understand the risks and benefits of a proposed intervention, as well as the reasonable alternatives (including no intervention), so that they may make independent decisions.

Patient often wish to take their family members' opinions into account when making medical decisions, as they would with many other important decisions. Respecting patient autonomy thus includes respecting both how patients wish to make a decision

and the decision made, even if the decision is to allow their family's desires to supersede their own.

Long-Term Palliative Care

Long-term Palliative care as a philosophy of care is designed to assist patients with no possibility of healing and seeking to consolidate a model of care that considers the process of dying as inherent to life. This philosophy is founded on the development of therapeutic projects capable to offer such patients a therapeutic, rationally oriented-care, increasing life quality, minimizing the symptoms, recognizing and respecting individual's rights. It is important to mention that family is an element that can strengthen the construction and consolidation of these projects, and which should also be assisted

In 2002, the World Health Organization presented the latest definition on palliative care, and regarded them as: "**An approach that promotes quality of life of patients and families, facing conditions that threaten the continuity of life through prevention and relief of suffering. Requires early identification, impeccable assessment and treatment of pain and other problems of physical, psychosocial and spiritual nature**".

The structure of such care model establishes intimate relation with the ethical principles considered in the shed of principles: the beneficence or non-maleficence, justice and autonomy. They are capable of supporting the opposition against the futility or therapeutic pace inherent in modern medical practice.

CONCLUSION

To truly attend to the needs and interests of frail older persons who require the care associated with residency in nursing homes, we need to change the conceptual framework within which many facilities function and be more attentive to the need to correct the damage of oppressive ageism. Such demands are especially challenging when autonomy among the Elderly is often elusive, and the barriers to autonomous choice within nursing homes are many and complex. Nonetheless, we believe that the virtues of adopting a relational approach to enhancing the autonomy of older residents in nursing homes outweigh these difficulties. As far as possible, nursing homes should

try to assist residents in maintaining control over matters of importance to them by fostering a facility culture marked by increased resident options. The responsibility for promoting and protecting the autonomy of even the most vulnerable citizens extends beyond the duties of institutional caregivers and is shared by all of society.

Resolution and Suggestion

Since the physician-patient relationship is considered to be a fiduciary relationship in which the physician is obliged to act in the patient's interests, with respect for the patient's autonomy, there is the need for:

1. Physicians to be bound by patient-physician confidentiality. When an autonomous patient's stated wishes and actions are not aligned, the physician must both respect the patient's decision and keep their wishes confidential and if the patient has asked the doctor not to disclose them.
2. Doctors should demonstrate support for their patients by continuing to advocate for patient's personal wishes, even if advocacy is done primarily at appointment in which patient's families are not present.
3. Doctors should discuss with their patient precisely which pieces of information they are comfortable with before such information are disclosed to the patient family so that the doctor do not break physician-patient confidentiality in attempts to advocate on patient behalf.
4. Also, doctors should not downplay any option with the goal of persuading the patient's family to choose a different option without the patient's express permission.
5. Finally, a best result of this suggestion would be that the patient and his family come to an agreement with regard to the patient future treatment, a better result for the Elderly in the nursing homes.