Autonomy or protection from harm? Judgements of German courts on care for the elderly in nursing homes

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The increase in life expectancy in developed countries has led to an increase in the number of elderly people cared for in nursing homes. Given the physical frailty and deterioration of mental capacities in many of these residents, questions arise as to their autonomy and to their protection from harm. In 2005, one of the highest German courts, the Bundesgerichtshof (BGH) issued a seminal judgement that dealt with the obligations of nursing homes and with the preserving of autonomy and privacy in nursing home residents. An elderly woman had sustained a fracture of the neck of the femur during a fall. The health insurance company held that the nursing home had breached its obligations to protect her from falling and sued the home for the hospital costs of her treatment. However, the BGH maintained that the case of the health insurance was not justified. It held that obligations of nursing homes have to be limited to normal arrangements within reasonable financial and personal effort, and that the autonomy of residents had to be protected from unnecessary interference. Permanent control or even restraining measures to reduce each risk would deprive the patient fully of her autonomy, and must therefore be hindered. Other judgments of other courts have emphasised the "protectionist" approach. The article deals with these different approaches and comments on both rationales. It will be shown that both approaches must be differentiated to establish fully autonomy and protection for nursing home residents.

those aged 65–69 years, 13.3% in those aged 80–84 years and 33% in those > 90 years.² More than 60% of the residents in nursing homes have dementia and this is likely to increase.³ These developments have not passed unobserved, particularly because the disquieting cognitive impairments of old age challenge central cultural values in developed countries, such as autonomy and individual independence. George Agich mentioned that a myth exists about long-term care for the frail in which nursing homes seem to be a sort of "pall covering the inevitable coffin that awaits us all".⁴ Not surprisingly, questions surrounding these experiences have become public and legal issues.

This paper discusses judgements by German courts dealing with cases of conflicts between autonomy and protection in mundane but important situations, such as cases where residents with confusion or dementia in nursing homes risk falling. A discussion of a precedent of the German Federal Court of Justice (Bundesgerichtshof; BGH), the highest German court of appeal, the central task of which is to deal with "fundamental questions of law",⁵ will help to clarify some concepts. The main purpose of this decision, which was to increase freedom in areas of non-interference of nursing home residents, was warmly welcomed by the public, and, I think, rightly so. Nevertheless, its arguments deserve comment. In this paper, I outline the rationale of the BGH, which was intended to balance conflicting values constituting fundamental principles of the German basic constitutional law (Grundgesetz): on the one hand, human dignity and freedom, which are indefeasible, and on the other, the "right of life and physical inviolability".⁶ As will be shown, the BGH had to balance the dignity and freedom of the frail against their right to physical inviolability by protecting them from harm. I then describe judgements of courts in opposition to the BGH, and finally comment on both approaches.

THE "LIBERTARIAN" POSITION

Case 1

In 2001, an 89-year-old nursing home resident was found lying in front of her bed during rest time. The patient was intermittently confused and visually handicapped. She had fractured the neck of the femur and was subsequently treated in hospital. Her health insurance company claimed the repayment of the costs of her hospital stay. The

Long-term care for the elderly in industrialised countries raises complex questions. The increase in life expectancy has led to more elderly people being cared for in nursing homes. In 2001, 2.04 million people in Germany were counted as being in need of care according to the so-called Pflegeversicherung (compulsory long-term care insurance), a law implemented to reach the demands of frail elderly people, whereas in 2003, 2.08 million people were so classified, an increase of 1.85%. This rise was exceeded by an increase of 5.1% in those cared for permanently in nursing homes. Most (94%) German nursing homes care for people aged >70 years. Moreover, we are now confronted with a high incidence of disorders that played only a minor role around 1900 and are classified under dementia.¹ As in other countries with increasingly elderly populations, there has been a sharp increase in the prevalence of these diseases in the elderly in Germany. The incidence of dementia is 1.2% in

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accident, the company held, was due to a breach of obligation by the nursing home. The patient had a history of falls with fractures and slight craniocerebral traumas, although no fall had occurred in the previous 3 years. The BGH had to decide on the company's appeal. The initial court case had passed judgement ordering the nursing home to pay the costs of the hospital stay, but the appeal court had revised this judgement. The health insurance company appealed this decision.⁷ Legally two issues stood in question: (1) the obligation of the nursing home to protect the physical inviolability of its residents, and (2) the question of putting the burden of proof on the nursing home because of a breach of obligation.

The BGH maintained that the case of the health insurance company was not justified. The nursing home was certainly obliged to protect residents from harm resulting from their disabilities or from shortcomings of the building itself, but such obligations had to be limited to normal arrangements within reasonable financial and personal effort. Obviously, this argument allows for two interpretations. If taken descriptively, it only describes the reality of nursing home care. However, if meant normatively it maintains that because there are financial and personnel restrictions, various protective measures cannot be claimed – a problematic assertion.

This reasoning was connected with another stance. The BGH held that the autonomy of residents had to be protected from unnecessary interference. Nursing homes have to preserve the independence, self-determination and self-responsibility of residents. Residents must be given room to act unrestrictedly.

As regards the question of the burden of proof, the BGH discussed a case decided in 1990. An inpatient of a hospital, who was affected by hemiplegia, had overbalanced while being helped from the toilet commode onto the edge of his bed by a nurse, and had sustained a fracture. The nurse was held to be responsible for that fall because her assistance was intended to avoid a fall. Thus, this case was different from the case under consideration, as the resident was not in a specific situation of danger that required increased obligation to protect her. Her fall was therefore in the area of “normal hazards of daily life”, which remain within each person's own responsibility. The nursing home therefore did not violate its obligations in not taking restraining measures. Alleged safeguards against injuries, such as use of mechanical restraints or side rails on beds would have had to be used permanently to prevent the danger of a fall, but this meant depriving the patient of her freedom generally, not just in the course of preventing specific risks. Moreover, the health insurance company held that the nursing home in each instance should have helped the patient to get up from her bed. The BGH, however, stated that to make such a stipulation meant complete control of the patient. This would deprive her of her privacy and would exceed what is economically reasonable for nursing homes.

Case 2

In a seemingly similar, case a health insurance company attempted to get back money for the hospital care of a resident of a nursing home.⁸ This patient, born in 1915, was admitted to a nursing home in 1997 because of three serious falls. The nursing staff of the home often pointed out to the patient the possibility of protecting her from falling by lifting her bed rails during the night, a suggestion that she always rejected. Because of her well-known tendency to fall, a toilet commode was put beside the bed. In January and February 2000, the patient had three falls with no ill effects. In early March 2000, she had another fall, during which she fractured her cervical vertebra C1/2, resulting in quadriplegia from which she later died.

The Higher Regional Court (Oberlandesgericht) in Dresden held that the nursing home had violated its obligations.⁹ The risk assessment was erroneous, as the falls in January and

February had demonstrated that the patient was “acutely threatened by falls”. Restraining measures might have been taken, not least because the patient was intermittently confused. Her risk of falling was not just part of the general hazards of life, but instead was due to the patient's frailty. Again, the BGH maintained that there was no violation of obligations. The possibility of protecting her by lifting the bed rails had been pointed out to her. Even if the patient was intermittently mentally disabled, it did not follow that she was no more capable of independently deciding whether or not to go to the toilet without help. Even if there *are* mental shortcomings in a patient, the extent of the will of the resident to act independently must be carefully assessed and should take priority. Thus, the appeal of this case in the BGH in January 2006 led to the judgement that if a resident of a nursing home refuses to take the insistent advice of the nursing staff then actions against the patient's will that restrict the right of self-determination are not allowed. Mental incapacities were not even mentioned.¹⁰

THE “PROTECTIONIST” POSITION

Other judgements have been in opposition to the BGH. These courts put the burden of proof onto the nursing homes. They emphasised protection and obligations. They assessed situations and particularly the concept of “a fully controllable range of hazards” differently and they had a different interpretation for what it means to act intentionally. An example may illustrate this.

One court held a nursing home to be responsible for a violation of obligations because a female resident had sustained a fracture.¹¹ After having been put on the toilet in her room, the patient fell when the nurse went to the bathroom to clean the patient's dentures. The nurse could not see the resident from the bathroom and thus was not able to prevent her from falling. During the weeks before the accident there had been no unexpected movements, the patient was known to be mobile and could walk with help, and was in the habit of straightening up herself in her wheelchair when sitting at a table. However, the patient was in the last stages of Alzheimer's disease, thus her movements were events rather than intentional *actions*. Given that fact, the risk assessment of the nursing home was held to be erroneous; the nurse should have been ready to expect an abrupt movement.

There have been other judgements with a similar line of argument.¹² Their rationale is based on the view that dementia precludes responsible action. Possible movements must be foreseen and hindered. The will of the nurse must substitute the incapacitated will of the resident. What “protection” means must be derived from the mental and physical condition of the resident. This phrase can be understood in two ways. On the one hand, it is a mundane statement; what other reasonable criterion should there be to direct care other than the actual state of health? However, taken literally, this phrase implies that, particularly in cases of severe dementia, caring should not take into account individual wishes, because there are no “wishes” or reasonable volitions at all. It is a disease-centred view of care and protection. It is medical data, not what a confused or demented resident has in mind that counts. Thus, a certain “balancing” of values is necessary. Because there is no reasonable volition on the side of the patient with dementia, there are areas of risks that fully belong to the duty of the nursing staff, whose erroneous assessment of risks results in accidents. By definition, there can be no sphere of risk within the resident's own responsibility. Courts using this argument regard the spaces of each nursing home to be identical with spaces of controllable risks. The nursing home staff, as rulers of these spaces, must be in a position to take restraining measures to protect residents from harm.

PROTECTION, ECONOMY AND NEGATIVE FREEDOM: SOME COMMENTS

The libertarian position of the BGH broadened the area of negative freedom—that is, freedom from interfering by others into a person's own affairs. It rejected the legal concept of the burden of proof by defining two areas of risk. One area should be left in the hands of the resident. A circle was drawn showing where no interference ought to be allowed. This radius of action was to be governed by the volition of the resident, independently of their mental/cerebral state. Protection only came into question beyond that borderline. This approach centred on volition, not on disease. Obviously, this does *not* balance freedom and protection. It is not always self-evident which “precise actions” balance autonomy and protection.¹³ If autonomy reigns absolutely, there is no reason for carers to think of protection. If a resident showed any sign of refusing an action by the staff, even if the resident's competence might be dubious, then staff would not be entitled to carry out this action. The BGH thought of a clear contradiction between freedom and protection.

The elderly are particularly vulnerable to paternalism, manipulation and restriction of freedom. The relationship between the frail and their carers is asymmetrical. However, protecting a person need not be identical with patronising them. Protecting someone may imply overriding their will. Sometimes protecting does not override a person's wishes and sometimes we cannot even know whether this has been the case. The BGH even tried to dispense with weak paternalism, i.e. the “right to prevent harmful behaviour [...] when it is involuntary”.¹⁴

The protectionist approach emphasised nursing home obligations. Diagnoses should be uppermost, not individual volition. Mental incapacities could endanger actions and intervention is necessary. This approach also does *not* balance freedom and protection. The elderly are often refused the possibility of deciding independently because they seem to be no longer capable of doing so. Deciding that dementia as such precludes forming a will and acting it out is simplistic. The result may often be strong paternalism.

Thus, both opposing judgements are problematic. This is partly because they both lack essential information about dementia and what this implies in caring for the elderly.

What can the clinical evidence of dementia tell us about autonomy, competence and the risk of falling? Taking Alzheimer's disease as an example, we see the increasing deterioration of cognition, especially memory, as the main early symptom. Motor functions are only rarely affected in the early stages,¹⁵ but cognitive functions may interfere with walking, thereby increasing the risk of falls. The deterioration of visual constructive abilities impairs the orientation in space, attentiveness is less differentiated, and design and execution of actions is problematic.¹⁶ In one-third of patients in the early stages, in 50% of those in the middle stages and in almost 100% of the patients in the late stages of Alzheimer's disease, apraxia is seen.¹⁷ In stages 6 and 7 (measured by the Global Deterioration Scale and Functional Assessment Staging), there is severe restriction of normal activity. Patients in stage 7 are bedridden and unable to sit up unaided in bed.¹⁸ ¹⁹ The clinical course of Alzheimer's disease demonstrates that there is no clear-cut moment when competence passes into incompetence, and thus no moment when the requirement for autonomy is displaced by the need for protection.

However, there are more problematic arguments involved. The “protectionist” approach does not reasonably conceptualise the principle of respect for autonomy. Some measures to “protect” the elderly may harm them, potentially with ill effects. The use of side rails may result in deaths and injuries.

Aggression and confusion are worsened. Side rails diminish physical abilities, the likelihood of pressure sores is increased and the likelihood of falls is not reduced.²⁰ Finally, putting of the burden of proof onto nursing homes could mean fatal results. The rationales of the different health insurance companies were economic. Germany's compulsory health insurance system is in a difficult financial situation. Each opportunity to save money is welcomed. There are >1000 similar cases pending in German courts. If the BGH had accepted putting the burden of proof onto nursing homes three possibilities would have been open, each of which is unacceptable.

(1) Nursing homes would be forced to document each detail of each action.

(2) Nursing homes might tend to embellish their care when documenting it.

(3) If each fall belongs fully to the responsibility of the home then avoiding falls is only possible by avoiding movements; each resident would have to be kept restrained in bed.

The guideline from the BGH is a seminal contribution to improve negative freedom. Unfortunately, it was coupled with the economic argument of limiting costs. Connecting the problem of negative freedom with that of allocating resources is perilous. If autonomy is the reigning principle in the care of the elderly, then cost-intensive therapies (such as physiotherapy to widen the radius of action or training of cognition) are necessary. Leaving patients alone to fulfil their wishes without improving their capacities is unethical. Financial restrictions in particular lead to desolate states of long-term care, violating human dignity and restricting freedom; for example, in one case, staff shortage led to patients being put to bed at 6 or 7 pm. because there was only one night nurse.²¹ The rules of the nursing homes decide how much freedom is allowed, thus exculpating the nursing homes from having to prove that they have not violated obligations may have adverse effects, and negligence may result. Therefore, controlling nursing homes can help to improve both autonomy *and* protection of the elderly. The judgement of the BGH needs to be complemented by “protectionist” elements. Thus, in the late stages of Alzheimer's disease protection can take first place, to protect rudimentary forms of autonomy and choice. To know whether old Mr Smith (who does not know his name anymore) likes grape juice and detests rose-hip tea implies patience, time and well-trained carers, and therefore funding to increase Mr Smith's tiny sphere of autonomy.

CONCLUSION

Different measures need to be taken to complement both approaches. First, we must know more about the risks of falling. Each action involves reasonably estimating means to ends. In the elderly, linking means to ends deteriorates gradually and risk may increase. Even assessing the prospective risks of an individual is problematic, and further research is needed to improve protection and autonomy.²² Second, if “competence” means that a person is able to “select means appropriate to reach” ends, we should look closely at each given case. It is right to state that competence serves a “gate-keeping function” in autonomy. Applying the concept of “competence” in cases of confused or demented patients must imply (1) a diligent understanding of what dementia means, (2) of what it means in the given case, and therefore (3) a diligent appreciation of the patient's remaining competence. Old Mr Smith then may wander around the corridors of the nursing home demonstrating that in wandering he has linked means to ends in a reasonable way. The task of carers would then be to perceive at which moment this fails and harm could result. Third, it is necessary to note that strengthening autonomy and

protection must imply increasing finance for the care of the elderly, a challenge that must be faced by all industrialised countries.

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Correction

In the article by Epstein (*J Med Ethics* 2007;33:473–4) there were several errors, which are listed below.

Page 473, column 1: "Rather, the debate will remain focused on the orthodox bioethical arguments..."

Page 473, column 2: "Free, uncoerced, people..."

Page 473, column 2: "It is true that some forms of coercion are, like the dilemma they impose on people, simply tragic."

Page 473, column 2: "the prospect of having to choose, autonomously or non-autonomously, ..."

Page 473, column 3: "Well, it does."

Page 473, column 3: "After all, people see their labour power as an alternative to abject poverty only because they are deprived of the freedom to sell the products of their own labour (or that of others)."

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