Moral arguments about inclusion/exclusion of elderly people in health care

Edna Estelita Costa Freitas [1], Fermin Roland Schramm [2]

Resumo

O rápido envelhecimento populacional é a transformação demográfica mais significativa nos países em desenvolvimento. Grande parte dos pacientes internados nos centros hospitalares é de idosos, dispostos a se submeter a tratamento com a condição de retornar, após a alta, a um estado funcional de saúde semelhante ao prévio. Neste contexto, o atendimento às necessidades da população precisa de formação bioética adequada dos recursos humanos na área da saúde, voltada para a geriatria, inclusive no centro de tratamento intensivo (CTI). Mas na decisão da admissão do idoso nesses centros, os aspectos morais acabam sendo, sem justificativa cogente, subsumidos aos aspectos puramente técnicos, o que pode influenciar de maneira discriminatória a decisão, prejudicando, indevidamente, a população idosa. No presente trabalho serão abordados e criticados seis argumentos morais propostos contra a internação hospitalar do paciente geriátrico no CTI, à luz das ferramentas da bioética principialista e da bioética de proteção.

Palavras-chave: Bioética. Ética. Ética médica. Idoso. Terapia intensiva. Tomada de decisões.

Resumen

Los argumentos morales sobre la inclusión/exclusión de personas mayores en el cuidado de la salud

El rápido envejecimiento es el cambio demográfico más notable observado en los países en desarrollo. La mayoría de los pacientes que ingresan en centros hospitalarios es de ancianos que están dispuestos a someterse a un tratamiento para volver, después de su alta, a un estado funcional similar a la salud anterior. En este contexto, la atención a las necesidades de la población necesita una formación en bioética adecuada de los recursos humanos de salud que enfrentan la geriatría, incluso la Unidad de Cuidados Intensivos (UCI). Pero la decisión del anciano ingreso en la UCI, los aspectos morales llegan a ser, sin una justificación convincente, subsumido a los aspectos puramente técnicos, que pueden influir en la decisión de manera discriminatoria, dañando, indebidamente, la población anciana. En este trabajo se discuten y critican seis argumentos morales contra la admisión de ancianos en la UCI a la luz de las herramientas de la bioética principialista y de la bioética de protección.

Palabras-clave: Bioética. Ética. Ética médica. Ancianos. Cuidados intensivos. Toma de decisiones.

Abstract

Moral arguments about inclusion/exclusion of elderly people in health care

The fast population aging is the most significant demographic change observed in developing countries. Most patients admitted in hospital centers are the elderly, who are willing to submit themselves to treatments in order to return, after discharge, to a functional health status that is similar to the previous one. In this context, attention to the needs of population requires a proper bioethics training of human resources in health care toward geriatrics, including the Intensive Care Unit (ICU). However in the decision of elderly ICU admission, the moral aspects end up being subsumed to the purely technical aspects, with no cogent justification, what may influence the decision in a discriminatory manner, affecting the elderly population. In the present work, six moral arguments against the proposed hospital admission of geriatric patient into the ICU will be addressed and criticized in light of the tools of principlist bioethics and bioethics of protection.

Key words: Bioethics. Ethics. Ethics medical. Aged. Intensive care. Decision making.

1. Doctoral student eec1994@yahoo.com.br **2. Post-doctor** rolandschram@yahoo.com.br – Escola Nacional de Saúde Pública (Ensp)/ Fundação Oswaldo Cruz (Fiocruz), Rio de Janeiro/RJ, Brazil.

Correspondence

Fermin Roland Schramm – Rua Leopoldo Bulhões, 1.480, Sala 914 CEP 21041-210. Rio de Janeiro/RJ, Brazil.

They declare that they have no conflict of interest.

Research article

The rapidly aging population is the most remarkable demographic transformation observed in the developing countries from the second half of the twentieth century. Specifically in Brazil, we highlight three aspects in the process of aging population: 1) such aging has been gradual and continuous; 2) the segment of the elderly population is the fastest growing one; and 3) in 2050, the elderly population will probably represent 22.71% of the total population [1].

In this scenario, the number of elderly and very elderly patients [2] needing care is increasing quickly wear out and in two hospitals, which is a fact that requires discernment of the physician regarding the screening of vacancies that will be assigned to patients in hospitals, due to scarce of public beds available in health facilities. As many times medical professionals are unfamiliar with the necessary bioethical knowledge to deal with the context of conflict involved in the practice of screening for hospital admission, the moral aspects involved in the decision eventually subsumed to the technical ones, without a plausible justification. This ultimately influences the decision in a discriminatory way, unduly harming the elderly population [3].

Most patients admitted to the hospital are seniors who can be, at some time in hospital, in a condition of needing admission to the intensive care unit (ICU). For example, in the United States of America (USA) the seniors represent 42% to 52% of admissions [4]. Regarding mortality, the oldest seniors (aged > 85), with failure of a single organ, have mortality rates ranging from 30% to 70%. On those with two or more failing organs, mortality increases to > 80% [5]. Despite these results, elderly patients are more concerned with the maintenance of their cognitive function than with mortality outcomes, and they are willing to be subjected to intensive treatment, but with the condition of returning to their functional status comparable to the prior one [6].

However, some data suggest that age, as such, is a prevalent factor in the refusal of admission to the ICU, for example, in the European study that showed that [7] of 286 patients screened for a possible hospitalization in the ICU, 48 were not admitted because they were considered too ill to have benefit in the treatment. Moreover, in 11 patients the criterion was only age (> 67 years, odds ratio [OR], 9.17; Confidence interval [CI], 95%: 3.0 to 27.6) [7-10]. The use of such criteria for exclusion in the admission may be considered as morally questionable, because it is discriminatory.

Another prospective observational study of screening decisions, which received the acronym Eldicus [11] (Triage Decision Making for the Elderly in European ICUs), and was conducted in 11 ICUs of seven European countries, between September 2003 and March 2005, and assessed about 8,700 screens in more than 7,700 patients. According to Van Steendam [12], who is the researcher of the study carried out by analyzing the social map of the practices involved in ICU, three criteria seem to prevail in the choice of the patient to be admitted: a) the clinical condition on admission, in which the patient is accepted or refused; b) a set of objective selection criteria (such as the quality of the benefit of being admitted to the ICU); and c) a veiled discrimination of the elderly on admission [13].

Daily, the intensivist makes decisions about the selection of the patient to be hospitalized. The professional faces conflicts responsibly, because he knows that his decision is based on both technical factors (e.g., disease severity) and moral (as in the case of having to choose between two patients with different age and the same severity of illness) [14]. But in the hospital screening of elderly patients, there is often a relevant question in the moral viewpoint: thee refusal to admit the elderly to hospitalization, and for the simple reason of the age criterion, would not it be discriminatory and, therefore, unfair?

In this regard, Rivlin [15] lists six intuitive arguments, which are seemingly of the pragmatic type (described below), which considers inconsistent to justify the denial in health care for the elderly by health institutions, but that could actually be used for denial of admission of geriatric patients in the ICU, by the intensivist doctor, in reference to screening policies by age [7] or even as a form of discrimination against the elderly or ageism [15]: 1. Elderly people should give up their lives in favor of the younger; 2. The age is a criterion to reject / start treatment; 3. Seniors gain little with treatment; 4. The society has little gains when treating elderly; 5. Treatment should achieve its maximum benefit; 6. Age is an objective criterion.

Objective

In this study the moral arguments that can be used by the intensivist doctor in the process of decision making for the refusal of admission of elderly in ICU, which were listed above, will be analyzed and criticized from the double point of view of the tools of bioethics, especially from principialist bioethics [16], supplemented by the bioethics of protection [17]. These two analytical proposals are considered relevant and legitimate in order to discuss the issue, for

the reasons given below. It aims to demonstrate how bioethical tools can help resolving moral conflicts in medical practice, such as those ones generated by an eventual discriminatory decision on denial of admission and, in particular, to handle the conflicts in the allocation of scarce intensive care spaces for the geriatric patient.

Method

This is a work of discussion on the morality of the medical practice of inclusion or exclusion of elderly patients in the care of their health, based on literature review carried out from a research in the Virtual Health Library (VHL). The survey, which covers the period from 1992 to 2012, used the fol-lowing descriptors: 1) Portuguese: "Intensive Medicine", "Decision making", "Medical ethics", "Biomedical Ethics", "Bioethics", "Elderly"; 2) Spanish: "Intensive care", "Decision making", "medical ethics", "biomedical Ethics", "Bioethics", "Elderly"; 3) English: "Intensive care", "Decision making", "Medical ethics", "Biomedical Ethics", "Bioethics", "Aging". 40 articles in Portuguese, Spanish and English were selected, and those ones in other languages were excluded.

The theoretical framework for the discussion of bioethics in the data collected was the principialism described by Beauchamp and Childress [16], which was used to reflect on the inconsistency of the six arguments by Rivlin [15] (listed above) in the discriminatory refusal in the admission of elderly people to hospital treatment and applied in the ICU. Each argument will be analyzed according to the reasons that make it morally questionable to justify the denial of admission of the elderly, based on the allocation of places only by the criterion of age. Then it will be presented the bioethics of protection [17] as a way to help principialist bioethics to handle the conflicts in allocating scarce vacancies of intensive care for the elderly, since it is not merely a vulnerable population, but rather is vulnerable itself.

The principialist bioethics

To the extent that biological and health sciences evolve, according to the force of the biotechnoscientific paradigm [18] come new opportunities for intervention on people's lives. The hospital, including the ones who are in the ICU, have proved capable of changing the course of various diseases, with more or less discomfort of the patients. Consequently, it became necessary to establish criteria to decide which patients will be admitted to the ICU setting parameters for decision making and considering the variety of existing systems of values, not necessarily compatible with each other, which can result in moral controversies on the correct or incorrect attitudes that are taken – or to be taken – in concrete situations experienced by patients.

These criteria and their required critical analysis applied to conflicts and arguments involved in proposals for solutions that can help in the problematic decisions of the professional, who must correctly decide what to do, are part of the toolbox of bioethics. Thus, the task of the field will be both analytical and exactly of practical type, critically analyzing the concepts and arguments involved, trying to assess their consistence and cogency to a decision that would be considered morally correct in a given situation.

In other words, bioethics, which is understood as "practical ethics" [19], seeks to understand and try to resolve moral conflicts implied by practices in the contexts of living and health, by taking into account the context of the plurality of value systems in legitimate principle in democratic and secular societies. In particular, it can be said that bioethics has a threefold function: 1) *descriptive*, since it analyzes the conflicts in question from the point of view of a spectator under a rational and impartial principle; 2) *normative* concerning such conflicts, and this in two ways: (a) proscribing behaviors that may be considered objectionable; and (b) prescribing those ones which are considered correct and in certain situations of helplessness; 3) *protective* with respect to moral patients characterized as "susceptible" or even "vulnerable" – due to their disabilities that do not allow them to face the helplessness with their own means or other protective device [20,21].

Therefore, among the various existing tendencies in bioethics, it may be noted, firstly, principialist bioethics of Beauchamp and Childress [15]. Indeed, principialism emerged with the social movement for civil rights, which led, inclusively, to the claim of social control over the practice and medical science, according to some excavating her legitimate values. A principialist strand of Beauchamp and Childress proposed, specifically, a model based in the four principles *prima facie* of non-maleficence, beneficence, autonomy and justice.

The principialist model is considered applicable to the conflicts that can arise in inter- relationships between doctor and patient of the biomedical practice, since that it defines parameters for action:

non-maleficence requires the avoidance of unjustified injury to third parties; the beneficence values acts that provide some good to others; autonomy assigns value to free and intentional choice of cognitive and morally competent agents, and justice determines that benefits, risks and costs among the involved ones are equitably provided.

Applying such a model to assess the morality of decision to admit elderly in hospital and in ICU, among the four bioethical principles, the one of autonomy can be considered the most relevant when there is a refusal, or not, of the patient to be admitted and start treatment, implying, therefore, the respect of the free will of the owner of that life which is at stake.

Bioethical analysis of the arguments

The elderly should give up their lives in favor of the younger ones

Although it is intuitively understandable that the doctor use the above mentioned argument, in reality there is no cogent reason to force us to think that in an age difference between two people itself – the elderly and the young – justifies the inequality in the fair consideration of respective interests [19,22]. Indeed, the characteristic "age", when considered alone, cannot constitute a discrimination factor because it would violate the principle of equality and, therefore, justice, which is characterized as an ageism case.

In particular, equality is a basic ethical assumption that must be respected *prima facie* by all the citizens of a democratic society, which will also have to deal with a fair allocation of existing resources, including in the fields of health and ICU. Thus, it is possible to consider unfair the belief that seniors should give up their lives in favor of young people.

However, by taking into account that the elderly population group is, in general, one of the most fragile group of our society, it can be considered, therefore, a legitimate target of specific public policies to take account of this "susceptibility". being worthy of protection, ensuring protection of their basic rights of access to health care by professionals [21,23].

Age as a criterion to refuse the beginning of a treatment

In fact, in some ICUs, it has been a long time that age is used as a criterion [24], and considered constitutive of the attitude known as ageism when it is considered, with the appropriate attention, the fact that its continued use does not become something "natural" and therefore, in principle, morally unquestionable. In fact, such an attitude is morally questionable, because it is discriminatory and must be justified by cogent arguments, which can be analyzed and evaluated by bioethics.

Thus, during the screening of hospitalization for the treatment of the elderly, it can be verified a greater importance to traditional principles of medical ethics of non-maleficence and beneficence, which primarily concern the doctor's professional duties since at least the Hippocratic code – but they do not always consider the change of conditions in which it is currently a medical practice, due to the increasing incorporation of new techniques/procedures and incorporation of the culture of human rights in know-how of health professionals. In particular, according to Beauchamp and Childress, the principle of beneficence refers to the obligation of the moral agent to act for the benefit of the moral patient – but, in theory, according to a scale of legitimate and acceptable values by those involved – and here it is applied to the behavior expected of the intensivist staff, which must respect the free will of the elderly patient (or exercise of "autonomy").

However, in practice, we face an important limitation in the application of this principle, because the patient in question may find themselves incapable of opine on what he may (or not) consider beneficial (due to sedation, coma, etc..). What can be considered beneficial for doctors actually do not necessarily reflect an eventual opinion of the patient in the exercise of their autonomy. In fact, the team could be imposing to patient an unwanted treatment, and, therefore, it may be regarded as contrary to their possible "benefit" and, thus, judged by them as such. Indeed, doctors trained to use their essentially technical knowledge work in the ICU and, above all, not to leave patients without treatment after they have been admitted, in particular under the goal - often regarded as unquestionable – to "save lives".

Consequently, no matter how better the medical intentions are in ICU, as long as everyone wants to be "beneficent", it is exactly the definition of "good" inherent to this main obstacle to this attitude, because there is no universal agreement *a priori* about what is, or should be, the good [25]. Thus, the ICU may not be beneficial anymore to the extent that it is imposed on the patient preventable suffering, also going against the principle of non-maleficence. This may be the case of prolonged admission in a closed unit, when the patient is subjected to

routine procedures such as puncture for collecting blood for laboratory tests; frequent aspiration of airways, use of nasogastric tube etc., which are evasive procedures able to cause really preventable suffering, and that can be malefic if it is ministered against the wishes of the elderly (or if they are not for avoiding unwanted death).

In short, this case should be properly considered regarding the patient's will, their conceptions of good and evil, and respect for their autonomy [26], i.e., it should be sought the balance, or convergence between the power of the intensivist doctor and patient preferences, particularly when they are explicitly formulated. In this regard, it is worth to stress the importance of medical professionals from various fields to inform their patients about advance directives of the will, so that, in the use of their autonomy, may increasingly express their wishes on the different clinical situations.

Finally, there is the principle of fairness, which is applicable to the controversy regarding the use of limited spaces ICU beds, in relation to which it may have on the one hand, a conflict resulting from the use considered scarce and applied to all seniors without conditions of a complete recovery (or at least "reasonable"), and on the other, a situation that is somewhat the reverse of the above, because the patient may have expressed clearly their desire not to be submitted to treatments considered futile, and certainly questionable from the point of view of health justice if we consider the very argument of scarcity of resources.

In the first case there is the difficult question of the effectiveness of a procedure that involves the proper balancing of costs and benefits, i.e., it does not harm the legitimate interests of patients. In the second, and relatively less problematic, it is the patient himself who takes the initiative of not "wasting" scarce resources, which can be seen as a way – though perhaps indirect – to promote their fair distribution. [27]

The elderly do not have a significant gain with treatment

This argument is also questionable, because in many cases the response of the elderly to treatment is as good as that of the young. Accordingly, Jecker and Schneiderman [28] state that there is no significant age difference in the mortality and morbidity associated with the results of several interventions, including survival after CPR, coronary angiography and revascularization surgery, liver and kidney transplant and/or trans-surgeries, chemotherapy and hemodialysis, among many other procedures.

In fact, elderly patients hospitalized in the ICU, as well as the young, may have clinical complications – e.g. infections and delirium – or have to undergo aggressive or invasive procedures such as mechanical ventilation and sometimes later tracheostomy if the need for respiratory prosthesis is extended.

Indeed, such procedures have greater potential to leave permanent after-effects in elderly [9] than in the young, as worsening of cognitive ability by delirium and worsening of pulmonary capacity for prolonged mechanical ventilation. Still, during the critical hospitalization it is possible to have a chance not to worsen functional and cognitively the clinical condition of an elderly patient. It is also possible, moreover, to obtain future gain with full clinical recovery by the admission and treatment in the ICU. In such cases it would become necessary only the geriatric monitoring by ambulatorial regime after discharge, with the elderly returning to the state of health prior to the intensive care. With this, they can obtain personal gains and stay productive without after-effects [29].

Society has less earns when elderly people are treated

This argument is based on the assumption that elderly patients, subjected to many costly treatments, such as dialysis, use of broad-spectrum antimicrobial, parenteral and enteral nutrition etc., with no perspectives of recovery and resume their activities; start to be great consumer of scarce resources that could be used more effectively in patients with a greater chance of cure. In addition, the "exaggerated" use of the CTI technology in a single patient may represent a future without therapeutic options for upcoming admissions, if the speed of material replacement and the availability of place are lesser than the speed of admission.

In this type of situation, it is really questioned to which extent the individual autonomy must be respected at the expense of the collective good [16]. However, just because people are older does not mean they cannot contribute their life experiences to the common good, as it is the case, for example, of the inter-relationships between grandparents and grandchildren, which, in practice, can be valuable for the very structure of the family. To the contrary, it is prejudicially believed that the most elderly do not participate directly in the production process and, consequently, they would not have, in princi-

ple, income, including their power of decision compromised by the loss of self-determination to cope with everyday activities [30].

This discussion is quite difficult and, until the moment, was not conducted in the ICU, but it shows the anguish present in the daily life of intensivist professionals. In fact, the actions of distribution of resources have limits and failures, as the resources for health are admittedly scarce, but also because the necessary moral weights do not always accompany the technical decisions and habits of those who actually decide. But it may also be argued – in accordance with the dictates of public health – that the problem would not exist if public money was used in preventive health measures, aiming the healthy aging [31].

However, and despite this argument could be *prima facie* relevant and justified – as the waste of resources is a verifiable fact and an act which is not necessarily inevitable, becoming morally problematic – it does not respond in satisfactorily to the growing demands of care health, which also depend on the aging population and the resulting needs of the protection of the elderly population, which should be guaranteed, as it is a right constitutionally guaranteed in Brazil. It is worth noting, moreover, that even with the best program of health promotion and prevention, the increase of age tends to approximate the person of the death, a situation that often involves hospitalization in ICU. Considering the already analyzed age transition of the population, this implies that the issue – inevitably – will emerge, if not now but in a short future.

Given this complex tangle, the general perception of Brazilian society is that hospital care is outdated, with a high cost and avoidable waste of resources, and that the elderly suffer from abandonment in hospitals or nursing homes, which can therefore be seen as places or inadequate devices because they are sources of additional suffering to this population, which can be avoided. To the prejudice and disrespect for the elderly, it is added the "poverty" of public investments to meet to the needs of the elderly population, such as the lack of adequate facilities and – both in quantitative and qualitative terms – of human resources for health [32].

This fact has an important moral dimension to be highlighted and analyzed, pointing to the need for change and innovation in paradigms of health care for the elderly, in order to be fair and result in proposals of differentiated actions, so the system will become more effective "with justice" and elderly people can integrally enjoy the years provided by advances in biotechnoscience [18].

In fact, it is known that this "live longer" is important to the proportion that it adds quality to the additional years of life: a quantitative dimension (more years) is inseparable from that qualitative one (not a mere survival, but life with quality). In this sense, protection, empowerment, autonomy and ability to work in a variety of social contexts, and the elaboration of new meanings to life in old age become necessary actions for a policy for the elderly can be morally and politically correct in a society that is to be minimally democratic and fair.

The treatment should reach its maximum benefit

This is a problematic statement, despite its apparent cogency in the name of effectiveness, because if doctors decided to treat only based on the supposed maximum benefit of the patient, some morally questionable decisions would be made, since many people with chronic illness or disease with a reserved prognosis would not be treated, and designing the possibility of it is some kind of a questionable omission. In particular, investing in treatment for the elderly without possibility he will return with the same skills (or at least "similar") from his previous life, through the CTI treatment options – such as dialysis, mechanical ventilation, can be considered beneficial because it meets another principle, the controversial principle of *sanctity of life* – that ensures the moral value of human life under any circumstances and it is expressed in our public legal system [33].

Therefore, it is necessary to emphasize that one should draw the line between what is the beneficent act itself and the act of medical paternalism in relation to the elderly in decision making without consulting the individual preferences of patients and reasonable, assuming that the doctor supposed to be best for them. In this case, it may happen unnoticeably of a know-how in principle "beneficent" becomes a way of exercising power, or biopower, which may be questionable for his unnecessary authoritarian and morally questionable implications [34].

This situation is not uncommon in the ICU routine, and it is very hard to manage because when decision making is reserved, the doctor (as in the case of emergencies), this, in general, is not prepared to mark the surreptitious passage attitude of beneficence to paternalism [35]. In short, according to the traditional model of the relationship between doctor and patient, the physician would represent the legitimate authority who holds the technical and scientific knowledge that would grant him the right to decide in favor of the supposedly more correct position on behalf of what he considers best for the patient and tending thereby

to inhibit the patient's participation in the moments of decision making on actions to be taken and-that concern him. Therefore, the physician-patient relationships are often explicitly paternalistic because the doctor decides the best way of treatment for a transfer of authority from the patient to the intensivist view, tending therefore to infantilize him.

Age is an objective criterion

This argument is scientistic, because it is based on the assumption that age is an objective fact, because it is numerical or quantitative and corroborated, for example, by the epidemiology itself, which would provide the necessary and sufficient conditions in order to act properly, including the moral viewpoint. However, the argument is also highly controversial because it implies, in fact, value judgments that can promote, for example, discrimination against older people – as seen in the analysis of the second argument. Take as supposition, for example, that the cut-off point of 65 years old would be used for treatment. That would mean that a heart surgery which could give a patient of 25-30 years old a good quality of life, but a patient, who was one day after his sixty-fifth birthday, would be refused without exception? If the answer is "yes", the attitude could be seen as explicitly discriminatory, but if it is "no", the advocators of the adoption of a policy age group should make an exception. However, denying the cut-off point of 65, they would be denying their own political age group, thus losing the parameter of objectivity, which was supposedly supplied epidemiologically.

In fact, most of the population believes that more years of life are useful only if they are not accompanied by pain, disability or dementia [36]. Therefore, one cannot consider that the health status of the population is only measured by mortality and morbidity, even if they are properly studied by epidemiology. In this sense, more objective measures of health status of the elderly should be provided – besides age – which may consider carefully the concept of innovation in health care, which will require scientific studies on this new perception, which may also take into account the ways on how treatment could be evaluated also from the moral point of view of the competent patient, not only based on technical and scientific results.

The bioethics of protection

By taking into consideration all these possible criticisms of the refusal of the elderly patient in the ICU, the principialist model, although it is relevant to analyze the conflicts that occur in clinical practice, it is not still enough for the debate on the decision making of the appropriate treatment of elderly in ICU, because although it is very focused on the inter-relationship between doctor and patient and the patient's autonomy, it does not handle situations related to the community and the impact of population aging on Brazilian health resources [37]. From this perspective, we propose to use the bioethics of protection, which can be seen as a tool for bioethical discussions in the field of public health [16], including, in relation to moral decision-making in the doctor regarding the admission, or not, of the elderly patient in ICU, when such a patient is in the position of vulnerable subject [38]. In this case, protection must be prioritized before other attitudes such as those ones analyzed by principialism.

Indeed, the bioethics of protection aims the human condition in their concrete ways of effective vulnerable situation, and it can be applied both to conflicting situations of interpersonal relationships between doctors and patients as the conflicts in public health, such as those that arise between formulators of public health policies, and managers of such policies and the users of the system to be considered here, the legitimate recipients of protection, as may be the case of the elderly discriminated by age. Indeed, it is reasonable to require of a State, that is seen as morally legitimate and pragmatically efficient protective measures in principle able of realizing the fragility of life – not only before old threats (such as diseases and disabilities) but also anticipating probable and possible solutions of the vulnerability of people such as the circumstance here in examination, of ICU patients and the decisions that may affect them [16].

Thus, the vulnerability of the elderly who are unable to take independently a correct decision to ensure the best quality of life in the time they have left, could in principle be mitigated with the team's commitment to provide all the information needed to clarify the family, making use of the help of other professionals such as psychologists and even bioethicists. But here we cannot forget that their own families complain of inaccessible and authoritarian medical doctors in their decisions [39]. It seems, then, it is time for the state to intervene, by developing health policies capable of providing reasonable and fair solutions of this type of conflict, such as the screening of the elderly in the ICU. In other words, before patients considered as "elderly without therapeutic possibility" – but they should be called, more appropriately,

as "no chance of cure [40] since the possibility of extending current therapy - or those who do not want their lives perpetuated in the ICU, it seems that the time we have policies that may encourage health and palliative care aimed at comfort and preservation of human dignity as essential components of quality of life of patients harmed has come. .

Final considerations

This paper, after presenting possible moral arguments for the adoption of the controversial allocation of places based exclusively by the age of intensivists, resorted to some bioethics tools in an attempt to better reflect on the moral implications of the decision making for the admission process of the elderly in the ICU, for example, the reflection on the conflict that can occur between the argument that all decisions taken by the medical team should always seek to preserve the best interests of the elderly patient , which would be allegedly known by the doctor and staff, and the argument of that such interests may include patient preferences different from those of the team, and can therefore enter into conflicting to each other. Indeed, the respect for the autonomy of the competent patient has an important weight in the relevant decisions, because if he was able to understand the situation and communicate their preferences, he can and should participate in decisions on admission to the ICU, since manifest, directly or indirectly, such interest.

Therefore, the elderly patient and family should be informed and educated about the reasons for the indication or not of the hospitalization in the ICU in order to participate, when possible, actively in decision making; including favoring the wills of the elderly patient or family (when he is presented as unable alone or he chose this option) properly clarified. A severe case of moral conflict is one that can arise in an elderly patient, without conditions to recover, being admitted to the ICU, filling a vacancy that could be made available for another patient with better chances of recovery, increasingly distant possibility to die in peace and with dignity. In fact, the process of medical decision making concerning elderly patients, refers to the thorny issue of micro-allocation resources, when they are considered scarce if they are not finite. In this context, the moral discussion by intensivist health professionals in the ICU always takes the risk of being restricted to the technical field, and the medical knowledge [41].

In conclusion: only through education, for example, the inclusion of bioethics in the undergraduate course for the entire medical community and mainly for those professionals involved – directly or indirectly – to the area of intensive care medicine, the incorrect attitudes regarding the elderly in a critical health situation will be changed. In fact, patients in old age are always another, which is also unique, regardless of chronological age, disease severity, the reason for admission, the neurological and psychiatric situation and life expectancy. In short, the attention should be focused on the person and human dignity, i.e., by giving importance to stories, judgments, beliefs and preferences of the elderly, and being in favor of their well-being, having as utmost reference the cognitive autonomy of elderly and morally competent to exercise it in their legitimate decisions and concerning them, even in the last moments of their life.

References

1. Instituto Brasileiro de Geografia e Estatística. Projeção da população por idade e sexo – 1980-2050: revisão 2008. [Internet]. Rio de Janeiro: IBGE; 2008 [acesso 10 fev. 2012]. (Estudos e Pesquisas. Informação demográfica e socioeconômica; 24). Disponível: http://www.ibge.gov.br/home/estatistica/populacao/projecao_da_populacao/2008/projecao.pdf
2. Veras R, Lourenço R, Martins C, Sanchez M, Chaves P. Novos paradigmas do modelo assistencial no setor saúde: consequência da explosão populacional dos idosos no Brasil. In: Veras R, organizador. Terceira idade: gestão contemporânea em saúde. Rio de Janeiro: Relume Dumará;2002. p. 11-79.
3. Machado J. Tomada de decisão na atenção ao paciente muito idoso hospitalizado [tese]. Porto Alegre: Pontifícia Universidade Católica do Rio Grande do Sul; 2006.
4. Marik PE. Management of the critically ill geriatric patient. Crit Care Med. 2006;34(9 Suppl):S176-82.
5. Angus D, Kelley M, Schmitz R, White A, Popovich J. Caring for the critically ill patient. Current and projected work force requirements for care of the critically ill and patients with pulmonary disease: can we meet the requirements of an aging population? Jama. 2000;284(21):2.762-70.
6. Kass J, Castriotta R, Malakoff F. Intensive care unit outcome in the very elderly. Crit Care Med. 1992;20(12):1666-71.
7. Garrouste-Orgeas M, Montuclard L, Timsit JF, Misset B, Christias M, Carlet J. Triaging patients to the ICU: a pilot study of factors influencing admission decisions and patient outcomes. Intensive Care Med. 2003;29(5):774-81.

8. Hanson L, Danis M. Use of life-sustaining care for the elderly. J Am Geriatr Soc. 1991;39(8):772-7.
9. Boumendil A, Somme D, Garrouste-Orgeas M, Guidet B. Should elderly patients be admitted to the intensive care unit? Intensive Care Med. 2007;33(7):1252-62.
10. Pisani MA. Considerations in caring for the critically ill older patient. J Intensive Care Med. 2009;24(2):83-95.
11. Medical Economics and Research Centre, Sheffield. Eldicus: triage decision making for the elderly in european ICUs. [Internet]. Sheffield: MECS, [acesso 2 fev. 2012]. Disponível: http://www.mercs3510.fsnet.co.uk/Research/ELDICUS/eldicus.html
12. Van Steendam G. Eldicus studies: social map. [Internet]. Sprung C, compilador. Israel; c2006 [acesso 4 fev. 2012]. Disponível: http://www.ethics.org.il/eldicus/social_map.htm
13. Menezes RA. Difíceis decisões: uma abordagem antropológica da prática médica em CTI. Phisys. 2000;10(2):27-49.
14. Cosgriff J, Pisani M, Bradley E, O'Leary J, Fried T. The association between treatment preferences and trajectories of care at the end-of-life. J Gen Intern Med. 2007;22(11):1566-71.
15. Rivlin MM. Protecting elderly people: flaws in ageist arguments. Br Med J. 1995;310(6.988):1179-82.
16. Beauchamps TL, Childress JF. Princípios de ética biomédica. São Paulo: Loyola; 2002.
17. Schramm FR, Kottow M. Bioethical principles in public health: limitations and proposals. Cad Saúde Pública. 2001;17(4):949-56.
18. Schramm FR. Paradigma biotecnocientífico e paradigma bioético. In: Oda LM, editor. Biosafety of transgenico organisms in human health products. Rio de Janeiro: Fiocruz; 1999. p. 109-27.
19. Singer P. Ética prática. 2ª ed. São Paulo: Martins Fontes; 1998. p. 20.
20. Schramm FR. Bioética para quê? Revista Camiliana da Saúde. 2002;2(1):14-21.
21. Schramm FR. Bioética da proteção: ferramenta válida para enfrentar problemas morais na era da globalização. Rev bioét (Impr.) 2009;16(1):11-23.
22. Evans J. Quality of life assessments and elderly people. In: Hopkins A, editor. Measures of the quality of life. London: Royal College of Physicians; 1992. p. 109-33.
23. Schramm FR. Bioética sem universalidade? Justificação de uma bioética latino-americana e caribenha de proteção. In: Garrafa V, Kottow M, Saada A, organizadores. Bases conceituais da bioética: enfoque latino-americano. São Paulo: Gaia; 2006. p. 143-57.
24. Dudley N, Burns E. The influence of age on policies for admission and thrombolysis in coronary care units in the United Kingdom. Age Ageing. 1992;21(2):91-5.
25. Engelhardt HT Jr. Os fundamentos da bioética. São Paulo: Loyola; 1998.
26. Kant I. A crítica da razão prática. 2ª ed. São Paulo: Martins Fontes; 2008.
27. Medeiros M. Princípios de justiça na alocação de recursos em saúde. [Internet]. Rio de Janeiro: Instituto de Pesquisa Econômica Aplicada; dez. 1999 [acesso jan. 2012]. (Ipea. Texto para discussão; nº 687). Disponível: http://www.ipea.gov.br/pub/td/1999/td_0687.pdf
28. Jecker NS, Schneiderman LJ. Futility and rationing. Am J Med. 1992;92(2):189-96.
29. Brandstetter RD. Intensive care for the elderly: should the gates remain open? N Y State J Med. 1992;92:175-6.
30. Lima-Costa MF, Barreto SM, Giatti L. Condições de saúde, capacidade funcional, uso de serviços de saúde e gastos com medicamentos da população idosa brasileira: um estudo descritivo baseado na Pesquisa Nacional por Amostra de Domicílios. Cad Saúde Pública. 2003;19(3):735-43.
31. Veras R. Envelhecimento populacional contemporâneo: demandas, desafios e inovações. Rev Saúde Pública. 2009;43(3):548-54.
32. Veras R. Fórum envelhecimento populacional e as informações de saúde da Pnad: demandas e desafios contemporâneos. Cad Saúde Pública. 2007;23(10):2.463-6.
33. Mori M. A bioética: sua natureza e história [Internet]. [acesso 23 jan. 2012]. Disponível: http://www.anis.org.br/Cd01/comum/TextoPosGraduacao/posgraduacao_texto_07_mori_port.pdf
34. Schramm FR. A autonomia difícil. [Internet]. Bioética. 1998 [acesso 23 jan. 2012];6(1):27-37. Disponível: http://pt.scribd.com/doc/5581396/Schramm-Autonomia-Dificil
35. Häyry H. Paternalism. In: Chadwick R, editor. Encyclopedia of applied ethics. San Diego: Academic Press; 1998. p. 449-57.
36. Paschoal SMP. Autonomia e independência. In: Papaléo-Netto M, editor. Gerontologia. São Paulo: Atheneu; 1996. p.313-23.
37. Camarano AA. Envelhecimento da população brasileira: uma contribuição demográfica. Brasília: Ipea; 2002.
38. Schramm FR. A moralidade da biotecnociência: a bioética da proteção pode dar conta do impacto real e potencial das biotecnologias sobre a vida e/ou a qualidade de vida das pessoas humanas? In: S chramm FR, Rego S, Braz M, Palácios M. Bioética, riscos e proteção. 2ª ed. Rio de Janeiro: UFRJ/Fiocruz; 2009. p. 15-28.
39. Albuquerque I. Bioética, proteção e o fim da vida: o paciente como vítima e vetor de patógenos multirresistentes em UTIs [dissertação]. Rio de Janeiro: Ensp; 2007. p. 17.
40. World Health Organization. National Cancer Control Programmes: policies and managerial guidelines. 2nd ed. Geneve: WHO; 2002.
41. Freitas EEC, Schramm FR. A moralidade da alocação de recursos no cuidado de idosos no centro de tratamento intensivo. Rev Bras Ter Intensiva. 2009;21(4):432-6.

Participation of the authors
Edna Estelita Costa Freitas and Fermin Roland Schramm wrote the article and the second one revised it.

Received: 17. 8.2012
Reviewed: 21. 3.2013
Approved: 14. 5.2013