Spring 2006

Kantian Meadows: A Just Nursing Home Grounded in the Categorical Imperative

Faith Bjalobok

KANTIAN MEADOWS: A JUST NURSING HOME GROUNDED IN THE CATEGORICAL IMPERATIVE

By

Faith Bjalobok

A DISSERTATION

Submitted to
Duquesne University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Philosophy

2006

ABSTRACT

KANTIAN MEADOWS: A JUST NURSING HOME GROUNDED IN THE *CATEGORICAL IMPERATIVE*

By

Faith Bjalobok

This dissertation examines the structures of contemporary nursing homes and argues that the structure is conducive to the objectification (treatment of a human being as a non-person) of nursing home residents. In order to eliminate the potential for objectification, this project employs the Kantian categorical imperative as its theoretical framework. Based on that framework Kantian Meadows is created as an example of a just nursing home.

ACKNOWLEDGMENTS

I would like to take this opportunity to express my deepest gratitude to Dr. Fred Evans, Dr. Will Aiken, and Dr. Don Keyes. Specifically I would like to thank Fred Evans for all his patients and help in my dissertation process. Will Aiken for the enthusiasm and passion that he brings to the study of philosophy. Finally, I want to thank Don Keyes for agreeing to be a reader on my committee. Without your help I would have never been able to complete this process.

Preface

As I finally sit down to write my dissertation, I realize that I have reached the last milestone in what has been, for me, a life long quest for an understanding of justice. It is a quest, which for me, began as a patient in a state mental hospital and has continued through my employment in various "total institutions." The quest for an understanding of justice brought me to philosophy and to write this particular dissertation.

Like many others who have either experienced or witnessed injustice, I too am driven by a passionate desire to in some way further the cause of justice. My choice of a philosophical path is largely due to the influence of Dr. Paul Edwards and Dr. Will Aiken.

Although Kantian ethics is often criticized as being purely formal, I found in Kant's writings an understanding of the anger I felt towards what I perceive as grave injustices carried out against individuals confined in "total institutions." My decision to focus on the nursing home is the result of the four and a half years I spent as a certified nursing assistant. Of all the "total institutions" in which I have been either confined or employed I am most haunted by what I see as the systematic degradation of the individuals who are confined in our nation's nursing homes. Although nursing homes profess in theory to be places of caring, I would argue that in practice they are places of degradation.

Table of Contents

Chapter One

The Nursing Home and the Ethical Problem of Objectification

Project Overview

My aim in this dissertation is to argue for the following thesis: Nursing homes are unethical in the strong philosophical sense of the term because they erode autonomy, personhood, and human dignity, and the end formulation of the Kantian categorical imperative can provide a theoretical framework for creating a just nursing home. In order to develop the above stated thesis I will argue for six distinct but inter-related propositions.

First, the structure and characteristics of nursing homes create an environment conducive to objectification. Second, objectification is a moral evil. Third, the care perspective does not offer an adequate framework for addressing the problem of objectification. Fourth, based on Kantian ethics we have an indirect duty to treat non-rational persons "as if they were persons." Fifth, the end formulation of the categorical imperative which instructs us "never to treat humanity as a mere means, but always as an end in itself" suggests guidelines for developing a just nursing. Sixth, those guidelines have practical applications in developing nursing home guidelines and procedures. The above-mentioned propositions will be developed in the following chapters.

In Chapter One, I will develop Propositions One and Two. That is, I will examine the characteristics and structure of nursing homes in order to shed some light on the precise sense in which nursing homes are unethical. In other words, I will illustrate the

way in which the characteristics and practices of nursing homes contribute to the objectification of nursing home residents. I will also examine various literatures from a variety of academic disciplines in order to establish the sense in which objectification is a moral evil.

In Chapter Two, I will develop Proposition Three. That is, I will demonstrate the way in which the care perspective is inadequate in terms of addressing the problem of objectification. This will be accomplished based on an analysis of the basic precepts of the care perspective and their application to the Kennedy Project on Aging.

In Chapter Three, I will develop Propositions Four and Five. In developing Proposition Three, I will argue that we have an indirect duty to treat non-rational humans "as if they were persons." My position is that this indirect duty is analogous to our indirect duty to refrain from cruelty to animals. Next I will develop Proposition Four. In other words, I will argue that we have a duty both not to lie, coerce, deceive or manipulate nursing home residents and to avert potential obstacles to individual autonomy.

Finally, in Chapter Four I will develop Proposition Six and apply the principles and guidelines implied by the end formulation of the categorical imperative to the creation of Kantian Meadows. This chapter will develop guidelines and procedures that uphold the duties imposed upon nursing homes by the end formulation of the categorical imperative.

Introduction

The nursing home is supposed to be a place for the long term care of the physically and mentally incapacitated members of our society. However, rather than

viewing the nursing home as a place of care, the elderly often view the nursing home with repugnance. In a society, such as contemporary America, which is built on the Enlightenment principles of freedom and individual autonomy, the idea of confinement in a nursing home creates fear. The elderly are frequently afraid that their dignity may be forfeited along with their freedom. Therefore, the claim can be made that many of our elderly the citizens are more fearful of confinement in a nursing home than of death.

In light of the fact that this is a work in applied ethics, the reader should note that I am not speaking of the elderly in abstraction but rather of flesh and blood individuals. For example in 1999, 1.6 million elderly individuals were long term residents of America's nursing homes, while another 2.5 million were discharged after only a short term stay (Barton, 2003). It is the experience of the long term residents of nursing homes that I am concerned with in this work. Given that focus, certain sociological implications can be drawn from my philosophical analysis of the nursing home.

Besides my status as a philosopher, I have been both a certified nursing assistant and an instructor in several nursing school programs. Based on that experience, I have frequently heard the following comments in relation to possible confinement in a nursing home. "I do not want to spend my last days in a nursing home. Just let me die at home with my dignity." "They treat me like I am not a person," is a common complaint. It is a view that I myself hold after having worked as a nursing assistant for 4 ½ years. It is also a view that is commonly held by the practicing nurses in my bioethics classes. The nursing home is viewed with repugnance even though Medicare, Medicaid, and private insurance companies annually pay out enormous sums of monies to nursing homes for

the care of the elderly. Why is it the case that despite enormous financial investment and government regulations in nursing home care our elderly citizens often find their experience of the nursing home dehumanizing? It is my position that this view is based in large part on the fear of becoming objectified and the consequent loss of one's dignity.

My overall goal is to identify the characteristics of the nursing home which lead to the erosion of personhood and provide, based on Kantian ethics, some practical suggestions for a possible resolution of the problem of objectification. In other words, it is my intention to *provide the ethical framework for the development of a specifically Kantian nursing home*. I believe this project is of value because despite our best policy efforts and financial commitment to the care of the elderly the erosion of self that occurs among those confined within our nation's nursing homes remains a primary ethical concern in gerontology.

The Nursing Home

Organizational Structure and Staffing

In the beginning of the 20th century Americans died of acute illnesses. However, with the advent of medical technology many more elderly Americans are living longer and longer with disabling chronic illnesses. Socioeconomic changes in American life such as increased life expectancy and more women working outside the home have created a demand for a long term care provision in our health care system. Phoebe Barton (2003) defines long term care (LTC) as "an array of services provided in an array of settings to individuals who have lost some capacity for independence due to injury, chronic illness or condition" (p.349). The determination that an individual requires LTC is made based on two standard measures: ADL (activities of daily living) and IADL

(instrumental activities of daily living). ADLs include such things as bathing, eating, mobility, and ability to utilize bathroom facilities. IADLs include such things as preparing meals, doing housework, paying bills, and taking medications (Barton, 2003). It is estimated that about 12 million Americans require LTC (Barton, 2003). It is significant to note that LTC is provided in a variety of settings by both formal and informal caregivers. Also, that about 50% of those requiring LTC are below the age of 65 (Barton, 2003).

The nursing home is only one aspect of LTC, but in 1999 nursing homes were the place of residence for 1.6 million elderly recipients of LTC. (Barton, 2003) Nursing homes are classified as either "skilled" or "intermediate" care providers depending on the medical needs of its residents. They are distinct from acute care, such as hospitals, because they provide long term care for an indefinite period for those suffering from chronic illness or debilitating accidents. Although they may employ occupational and speech therapists, the primary care givers are nurses and certified nursing assistants. The organizational structure of the nursing home includes the nursing home administrator who has a business background, the director of nursing who oversees all aspects of nursing care, a medical doctor who acts as the house doctor, charge nurses who oversee the nursing department on a given shift, medication nurses, treatment nurses, certified nursing assistants, social workers, an activities director, dining services, maintenance workers, and cleaning personnel. Of these individuals the floor nurses and certified nursing assistants provide direct patient care. As George Agich (2003) points out, the workers themselves are often exploited. This seems to be more of a concern in for-profit nursing homes because accumulating capital is the bottom line. Because of staffing

shortages, nurses often work mandated double shifts with minimal staffing. Their jobs include providing assistance with ADLs and IADLs and frequently being the recipient of verbal and physical abuse from the residences. However, from the perspective of this dissertation the exploitation of nursing home workers is significant only insofar as it contributes to the objectification of the nursing home resident.

Federal guidelines establish the employment criteria for direct care staff as well as others. Nurses are required to have a RN or LPN certificate and licensure. Certified nursing assistants are required to undergo training and must be licensed. State laws, based on an equation which divides the number of residents by the number of staff, establish the number of hours of care required for each resident. Although most states require from 2.3 hours and upward, it has been observed that residents may receive as little as 1.7 hours of care per day (Barton, 2003).

Largely due to understaffing, the physical nature of the job, the pay rate, and mandatory overtime, there is a high turnover rate of employees, particularly nursing assistants. There is also a significant amount of physical and verbal abuse of residents by nursing staff, enough in fact, that the law requires mandatory reporting of abuse and criminal background checks for employees.

In summary the nursing home's primary function is to provide both skilled and unskilled nursing care to residents who lack varying degrees of independence. Beginning in the 1960's with the advent of Medicare and Medicaid, the nursing home became increasingly regulated by the federal government. Yearly surveys are conducted by State Departments of Aging to guarantee that state and federal regulations are upheld. Despite

the numerous state and federal regulations, legal practices specializing in nursing abuse continue to grow in number along with newspaper reports of abuse and neglect.

Nursing Home Residents

As previously stated the residents of nursing homes are individuals who through illness or accident have lost some degree of independence and require LTC. A majority of nursing home residents are elderly and suffer from a variety of chronic disabilities. Some of those illnesses include stroke, cancer, and various forms of dementia. Alzheimer patients are increasing in number and are generally housed on separate units of a nursing home because of the special problems they present in terms of care and confinement. With respect to autonomy and cognitive ability, nursing home residents range from those capable of fully autonomous actions to those, such as PVS (persistent vegetative state) residents, who lack any capacity for autonomy. Nursing home residents also require various forms of medical technology from simple feeding tubes and oxygen concentrators to dialysis machines and respirators. For the most part those in need of LTC will spend the remainder of their lives confined to a nursing home because of their physical or mental dependence either on technology or nursing staff. In light of that fact, I contend that the primary ethical concern is to ensure that they retain their dignity and do not become victims of objectification.

Chapter Outline

The primary goals of this introductory chapter are as follows. First, I will define objectification as it applies to this dissertation. Second, I will discuss the moral evil of objectification. Third, I will review the relevant bioethics literature. Fourth, I will discuss

my contribution to the ethical discussion in this area by identifying three characteristics of nursing homes which I hold are major contributing factors that create an environment conducive to objectification. Finally, I will argue that an unpacking of the "ends" formulation of the Kantian categorical imperative provides a theoretical framework for the creation of a just nursing home.

Objectification

For the purpose of this dissertation objectification refers to any circumstance in which a human being is treated as if he or she were a non-person. When the latter occurs, the individual is seen as an object that lacks dignity and autonomy. This notion of humanity or personhood is of course a Kantian way of understanding personhood. For those who reject the Kantian idea of personhood, it is my hope that this dissertation may convince them of the value of deontology. Although the Kantian concept of personhood is not universally endorsed, I believe that adopting a Kantian concept of personhood is both appropriate and justifiable within the context of contemporary American society.

Martha Nussbaum (1995) identifies seven notions that she claims can be involved in the idea of treating a person as an object:

1. *Instrumentality:* The objectifier treats the object as a tool of his or her own purposes.
2. *Denial of autonomy*: The objectifier treats the object as lacking in autonomy and self-determination.
3. *Inertness*: The objectifier treats the object as lacking in agency, and perhaps also in activity.

4. *Fungibility*: The objectifier treats the object as interchangeable (a) with other objects of the same type, and/or (b) with objects of other types.
5. *Violability*: The objectifier treats the object as lacking in boundary-integrity, as something that it is permissible to break up, smash, break into.
6. *Ownership*: The objectifier treats the object as something that is owned by another, can be bought or sold, etc.
7. *Denial of subjectivity*: The objectifier treats the object as something whose experience and feelings (if any) need not be taken into account (p.257).

Although Nussbaum is writing in an attempt to refute some of Dworkin's claims regarding objectification in sexual relationships, all of her notions can be applied to the treatment of nursing home residents. It should be noted that for the purposes of this dissertation the presence of any of Nussbaum's notions of objectification is sufficient to make a claim that the individual is being treated as an object. In addition, paternalism is a form of objectification under this definition because it includes a denial of autonomy. Further, for my purposes personhood is the opposite of objectification.

Based on my experience as a certified nursing assistant, I have observed that objectification occurs within the context of several types of relationships that are commonplace in a nursing home setting. The first relationship is between staff and residents. A resident of a nursing home is often perceived and treated by the staff as either a product on an assembly line or as the patient's disease, e.g. the train wreck, the

vegetable. An incident which I witnessed while I was working as a certified nursing assistant provides an illustration of treating an individual like an object. An elderly man whose variety of health issues required that he be turned and repositioned every two hours to avoid the development of decubitus ulcers was in fact developing decubitus ulcers. In order to determine that he was being repositioned, the nursing home administrator attached a post-it sticker on the man's back which read "When you turn him come and see me." The administrator as objectifier was clearly treating the man as a tool for her own purposes. I was so outraged when another nursing assistant told me about the incident that I ran to her office and began lecturing her on the moral evils of treating a person as a means. Of course it fell on deaf ears. That particular incident persuaded me to shift my dissertation focus away from the treatment of prison inmates to the treatment of nursing home residents. I came to feel the nursing home residents were actually experiencing a greater degree of degradation and objectification than prison inmates. Unfortunately, unlike prison inmates who can riot if pushed too far the frail nursing home residents are truly defenseless.

The view of the resident as an assembly line commodity is perhaps best understood within the language of nursing assistants discussing their daily assignments. "How many do you have today?" How many are showers? How many are weighs?" The resident is no longer a person or an individual, but instead she or he becomes an assembly line commodity to be dealt with in a timely and efficient manner. They are a job to be completed.

The second relationship in which objectification may occur is between the resident and his/her physician. Again I have a vivid memory of an incident which

occurred while I was working as a certified nursing assistant. A woman who was virtually paralyzed from the neck down with the exception of one hand developed an infection in her contracted hand. The infection was of course the result of inadequate care. The orthopedic surgeon she saw suggested to her that she couldn't use the hand so he might as well just amputate it. She refused. In discussing the incident with me, she explained that she had feelings, and he had made her feel like a piece of meat. For whatever reasons, physicians often tend to deny the autonomy and subjectivity of long term care patients. They speak to staff and family about the medical condition of the residents without even acknowledging their presence. This is of course both a denial of autonomy and subjectivity and in this sense the physician becomes an objectifier.

The relationship between a resident and his or her family can also result in objectification of the nursing home resident. Once an individual reaches a state of diminished autonomy and a family member is granted proxy consent the resident is often treated as if he or she is the property of his or her family. In this circumstance it is the wishes of the family that are honored. The resident's own wishes are pushed aside and she is forced to abide by the decisions of her family. Another incident which I witnessed as a nursing assistant demonstrates this concept of ownership; an ownership which I would argue is derived from an abuse of proxy consent. An elderly gentleman who had suffered a stroke which left him confined to a wheelchair loved to feed the birds. However, his wife forbade the staff to let him go outside and feed the birds. There did not seem to be any legitimate reason to deny his wish to feed the birds except for his wife's objections. Obviously in this case the individual's desires and wishes are ignored as if they were non-existent. The ethical question as I see it hinges on the question of how and

why his wife's wishes take precedence over what is in the best interest of the patient. That is to say how does proxy consent become an expression of property rights?

Still another example of abuse of proxy consent that remains vivid in my mind also occurred while I was working as a certified nursing assistant. A woman I frequently cared for and had grown fond of vehemently objected to wearing her dentures. She had lost considerable weight and they were in fact too big for her. She attempted to rid herself of them in various ways, including wrapping them in napkins and throwing them in the trash. Despite her best efforts, however, they were returned time and again and on her daughter's insistence they were glued into her mouth with Polident denture adhesive. Ultimately, I decided to dispose of them myself in the Giant Eagle dumpster. The woman admittedly had diminished cognitive capacity but she was alert and oriented. Yet her daughter was able to control every aspect of her life simply because she had proxy consent. The woman had become an object of her daughter's complete control with no regard for her desires or wishes.

Finally residents as a result of the perception others hold of them and their diminished physical and mental abilities may begin to deny their own subjectivity. They become in Hill's terms (1973) servile. His notion of a servile person "is one who tends to deny or disavow his own moral rights" (p.699). Hill's notion of a servile person will be discussed in greater detail latter. In this circumstance the individuals begin to objectify themselves in the sense that they themselves see themselves as less than a person.

I believe that the above-mentioned family scenarios frequently occur because we as a society mistakenly view family relationships from a *Leave it to Beaver* perspective. In other words, we view the family as a caring loving entity that makes decisions in the

best interest of the family member. Therefore, there are very few regulations placed on the decisions that can be made by the individual with proxy consent with regard to the care and treatment or lack of for a nursing home resident. The consequence of this frequently mistaken perception of the family often leads to an unregulated use of proxy consent that all too often leads to the objectification of the nursing home resident. People become things to do with as the individual with proxy consent desires. Good care and respectful treatment is contingent on the existence in this case of benevolent staff and an individual with proxy consent who attempts to act in place of and on behalf of the resident.

The Moral Evil of Objectification

There is a substantial amount of literature both philosophical and non-philosophical dealing with the moral evil of objectification. In order to illustrate my point that objectification is an intrinsic evil, I have drawn on a wide variety of literature which addresses the issue of objectification. I have intentionally chosen to review literature that addresses differing aspects of human relationships and differing notions of objectification. While they differ in content the common thread among them is the claim that objectification results in loss of dignity and self-respect. The question of objectification and the loss of self-respect and dignity occur in the writings of such diverse authors as Immanuel Kant, Thomas Hill, Jr., Erving Goffman, W.E. B. DuBois, and Andrea Dworkin, to name only a few.

Kant in the *Ground Work of the Metaphysics of Morals* (1785) argued:

"Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always as at the same time as an end

"(p33). This formulation of the categorical imperative assumes Nussbaum's notions of instrumentality and denial of autonomy as forms of objectification. To treat persons as means for Kant is to deny their rationality, dignity and intrinsic value. To treat persons as ends requires that we respect their autonomy and subjectivity. Objectification violates what Kant (1785) has called the ultimate principle of morality and as such it is a moral evil. The objectifier is acting immorally.

In *Servility and Self-Respect*, Hill (1973) develops the Kantian theme that we have duties to ourselves. Hill (1973) defines the servile person as "one who tends to deny or disavow his own moral rights because he does not understand them or has little concern for the status they give him" (p.699). In arguing that servility is a moral vice, Hill introduces three examples of servility: Uncle Tom, Self-deprecator, and the Deferential Wife. Hill argues that Kant equates respect for persons with respect for moral law. The moral defect of servile individuals is that they fail to respect themselves and therefore to respect others. In Hill's argument there are various notions of objectification, but for our purposes it is Self-deprecators who deny their own subjectivity that holds the most significance. That is because the conditions of the nursing home are such that it is often the case that a resident becomes a Self-Deprecator.

In arguing that institutions can create certain types of individuals Goffman (1961) in *Asylums* introduces the concept of "mortification of self." He contends, "that total institutions disrupt or defile precisely those actions that in civil society have the role of attesting to the actor and those in his presence that he has some command over his world-that he is a person with "adult" self-determination, autonomy, and freedom of action" (p.43) Although Goffman (1961) was not directly speaking of nursing homes, he

defined a total institution, “as a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life” (p. Xii). Clearly this definition includes the contemporary nursing home. Therefore, it is plausible to argue that the same characteristics Goffman observed at St. Elizabeth’s and other total institutions would apply to the nursing home.

Goffman noted that admission to a total institution results in a severance from one’s civil self. A process of mortification is one in which the severance from one’s self can result in anxiety and psychological stress. However, it should be noted that he did observe relief based on that severance in some guilt ridden individuals. According to Goffman, the new self that emerges is an institutional self. In other words, the mental hospital creates the mental patient and the civil self becomes the institutionalized self who lacks autonomy and control of his/her world. Likewise the nursing home creates the nursing home resident whose personhood is eroded as a consequence of that severance with his/her civil self.

In another area of human interaction and reflecting on the plight of African Americans in white America, DuBois (1903) in *The Souls of Black Folk* recounts a story of his youth in which a white girl refused the greeting card he offered her simply because he was black. DuBois suggests that this created a veil around the white world which shut him and other blacks out. It created a “double consciousness” which forced him to see himself through the eyes of the white world: a world in Nussbaum’s terms that denies his autonomy and subjectivity. DuBois argues that this creates a prison around the black man

which in some individuals results in hopelessness and a feeling of degradation. The white world as objectifier rejects the black man's autonomy and subjectivity.

While DuBois addressed the unequal relationship between blacks and whites, Dworkin (1974) in *Woman Hating* suggests that once there is an initial denial of autonomy, instrumentalization and ownership occur and a woman's "body is a body, in the same way that a pencil is a pencil, a bucket is a bucket" (p.62) The woman becomes an object; a non-autonomous being. She is a thing, an object to be owned and possessed. This objectification robs her of her dignity and personhood.

In spite of the fact that the above-mentioned authors phrase their articles in different perspectives (philosophy, sociology, and feminist literature), there is a common agreement among them that objectification is a moral evil because it harms innocent individuals by de-humanizing, degrading, and robbing them of their dignity. Therefore, if it is the case as I have claimed that objectification occurs within the nursing home then we as society have a moral imperative to address and resolve the characteristics of nursing homes that create an environment conducive to objectification.

Bioethics Literature

Most of the bioethics literature that addresses nursing homes does not specifically address the issue of objectification, but rather focuses solely on the notion of autonomy. This is understandable for two reasons. First, since the Helsenki Declaration and the Nuremburg Code, the primary ethical concern in western medicine has been voluntary informed consent, which assumes the autonomous nature of the individual. Second, the Belmont Principle of respect for persons drawn from Kantian ethics has been reduced to

respect for autonomy. Therefore, discussions about autonomy hold a central place in bioethics discussions.

George Agich's (1993) *Autonomy and Long-Term Care* and his revised work *Dependence and Autonomy in Old Age (2003)* remain the seminal work on addressing the issue of autonomy in long term care. Agich suggests that there is a dissonance between the liberal view of the autonomous independent person and the frail dependent elderly long term care resident. He argues that what is needed is a phenomenologically re-interpreted view of autonomy that is applicable to long term care and includes dependence as an aspect of autonomy. In developing his ethical framework for long term care, Agich wants to shift the focus of autonomy away from the liberal view of independence to the actual long term care setting where he sees dependence as a part of autonomy. Therefore, Agich's work is not so much an analysis of the nursing home and its characteristics that foster the erosion of personhood, but rather he argues that perhaps a new notion of autonomy is needed in the area of long term care.

Another equally significant work in the area of long term care and autonomy is Charles Lidz, Lynn Fischer, and Robert Arnold's *The Erosion Of Autonomy In Long-Term care* (1992). The authors provide an observational study of two types of long term care and suggest that the organizational structure of the institutions leads to the erosion of autonomy. They like, Agich, believe that what is needed is a fundamental re-thinking of our notion of autonomy as it applies to long term care. Like him, they also provide concrete suggestions on ways to increase the autonomy of elderly long term care residents.

Both of these works provide invaluable suggestions on increasing autonomy among the elderly confined in long term care facilities and I will address them in detail in Chapters Three and Four. Because their focus is primarily on autonomy, they tend to do two things. First, they neglect the other notions of objectification. For example they do not address instrumentality and denial of subjectivity. Second, they wrongly reduce Kant's notion of respect for persons to respect for autonomy. Further, I believe that denial of autonomy is too limited a notion to account for Agich's (2003) own image of long term care:

> Long-term care seems to hang like a pall covering the inevitable coffin that awaits us all. Surprisingly in our culture it is less death than long-term care that strikes us as so repugnant (p.2)

Repugnant I agree, but it is more than just denial of autonomy that results in repugnance. Rather I would argue that it is the objectification of the nursing home resident in all Nussbaum's notions of objectification that results in repugnance. It is a denial of the resident as a subject or person who has lived a life full of experiences. It is a denial of the nursing home resident as a unique person one who is not interchangeable with other objects and who has boundaries which it is wrong to violate. I contend that it is objectification in Nussbaum's broader sense, rather than, in the narrow sense held by most bioethicists who reduce objectification to loss of autonomy, that creates the repugnance.

In light of my claim, I would suggest that a broader and more detailed focus on the characteristics of nursing homes that tend to foster not only denial of autonomy, but

instrumentality, violability, denial of subjectivity, and ownership, is needed to fully understand the repugnance that is felt.

Cruel and Unusual Treatment

One characteristic of the nursing home which is often ignored is the lack of a constitutionally guaranteed right to be free from cruel and unusual treatment. While we have a concept of cruel and unusual punishment, we do not have a concept of cruel and unusual treatment. I was first introduced to this distinction by Jeffrie Murphy (1985) in his work *Punishment and Rehabilitation.* The idea of cruel and unusual treatment made an impression on me, but I never really grasped the concept of cruel treatment until I worked as a nursing assistant. If one were to drag a prisoner out of bed at 3AM for a forced bath, a charge of cruel and unusual punishment could surely be leveled. Yet this is a common practice in nursing homes. No one objects because we are treating not punishing the resident. I believe that under the guise of treatment as a good, the wishes of the elderly resident are often overlooked because what competent person would not choose to be treated? The lack of a concept of cruel treatment within the nursing home fosters a paternalistic attitude among the staff. Treatment is seen as a good. It is not the infliction of harm. Therefore, it is in the best interest of the resident unlike the prison inmate who can file a legal motion for cruel and unusual punishment, the nursing home resident cannot file such a claim.

As the Dax Cowart case (2000) clearly illustrates, treatment can be very cruel. Cowart was burned over 80% of his body. Against his will, he was forced to endure

soaking in the Clorox tank. Cowart describes the tankings: “It was like pouring alcohol on an open wound. All I could do was scream at the top of my lungs until I would finally pass out with exhaustion.” (p.380). Even though Cowart was determined on psychiatric evaluation to be competent, his treatment was continued by his mother against his wishes.

Nursing home residents are frequently forced to undergo treatments against their wishes, which clearly deny their autonomy. I believe this occurs for two reasons. First, treatment is seen as a good. Second, nursing home residents are in most instances suffering from some cognitive impairment. Therefore, it is extremely easy for staff and family to deny any degree of individual autonomy and adopt a paternalistic attitude toward them and force unwanted treatments on them.

A Theory of Scientific Management

In the case of for-profit nursing homes, budget cuts and bundle pricing have resulted in a decrease in the number of staff. Such reductions are often made based on the assumption that a theory of scientific management can be applied to nursing care. In other words a nursing home can be operated in the same manner and on the same principles as a factory. In this case I am referring to a theory of scientific management such as the one proposed by Frederick Taylor. Taylor focused on cost benefits analysis, efficiency, and systemization (Robbins, 1992, p. 63-64). An example I often use in my bioethics class is based on an analogy with General Motors. GM can determine that it takes 2 minutes to tighten the lug nuts on the wheel of a new GM automobile. When this same sort of factory mentality is applied to the care of nursing home residents, states such as Pennsylvania determine that a resident is entitled to 2.3 hours of care per day. In actual practice this can equate to a resident- to- staff ratio of 25:1. The problem is of course that

people are not cars, and need more personal care. An additional problem associated with the factory perspective is that understaffing creates a situation in which the resident is viewed as a production commodity. They are seen as a project to be completed. A friend of mine who worked as a hospice nurse recently decided to switch to a nursing home. One major distinction between long term care and hospice care is that the hospice nurse can spend time with an individual patient. My friend quit the nursing home after a short period of time and returned to hospice care because she felt like she had been working in a factory and that was inconsistent with her view of the nature of nursing. While budget constraints are a necessary part of providing health care, determining staffing levels on the factory model creates an environment in which there is an increased propensity to objectify the nursing home resident.

Abuse of Proxy Consent

The final characteristic of the nursing home which I contend contributes to an environment of objectification is proxy consent. Proxy consent by definition is legally giving another individual the right to make medical decisions for someone who is not competent to make them. The problem as I see it is twofold. First, proxy consent in the nursing home is not restricted to medical decisions, but becomes all encompassing. Some individuals may not be competent to make their own medical decisions; however, that does not render them incompetent to make other decisions. The way that nursing homes are organized the person with proxy consent is free to make any and all decisions concerning a resident both medical and non-medical. One example of a non-medical decision which I previously discussed, is forbidding an elderly gentleman to feed the birds bread crumbs. Although it was the highlight of his day, the family member with

proxy consent did not find it to be an acceptable activity. The holder of the proxy consent's ability to make non-medical decisions results not only in a denial of autonomy, but also in a denial of subjectivity and an affirmation of ownership. The person becomes the property of the individual with proxy consent. This is unique to the nursing home because people are confined there 24 hours a day often for a long period of time. Therefore, every aspect of their life is subject to control by either the staff or the individual with proxy consent. On the contrary in other health care circumstances, proxy consent is limited to medical decisions. Even in the case of children it is only a temporary circumstance until they reach a stage in their development in which it is determined that they are capable of making their own decisions.

Another aspect of proxy consent which I found problematic in relation to objectification is that there are no established legal guidelines and parameters for the sort of decisions that can be made. The individual with proxy consent can decide to force or withhold treatment without any accountability. This creates a situation in which total control can result in an ownership notion of objectification. Although a health care facility can request legal intervention if a decision is deemed by the medical staff as not in the best interests of the resident, this is rarely done in the nursing home setting because for the most part people come to nursing homes to die not to get well and go home.

Conclusion

Given the unique characteristics of nursing homes, i.e. lack of a concept of cruel treatment, understaffing, abuse of proxy consent, the diminished capacity of many of the residents, I believe that there exists an enormous potential for objectification of nursing

home residents. In light of that belief, I argue that a new ethical framework for long term care is not only necessary but a moral imperative.

It is my position that the “ends” formulation of the Kantian categorical imperative provides the best basis for such an ethical framework. While Kantian ethics holds a central position in bioethics, a Kantian project of developing the guidelines and regulations for the daily treatment of nursing home residents is a project that has not been undertaken. In the next chapter I will address what I believe are the inadequacies of Mary Raugust’s adoption of the care perspective as the theoretical framework for the development of a nursing home in relation to the issue of objectification. In the chapters that follow that I will argue for the adoption of a Kantian framework based on a wider understanding of respect for persons and finally develop “Kantian Meadows,” a nursing home based on the unpacking of the “ends” formulation of the categorical imperative.

CHAPTER TWO
The Problem of Objectification and the Care Perspective

Introduction

In this chapter, I will develop Proposition Three. In other words, I will argue that the care perspective does not offer an adequate theoretical framework for addressing the problem of objectification. This argument is developed in the following manner. First, I outline the basic tenets of the care perspective and identify the ways in which it differs from the justice perspective. Next, I examine its application in the Kennedy Aging Project. Based on that analysis, I argue that the care perspective is inadequate in terms of my project because it fosters a paternalistic attitude and abandons the language of rights. Based on my conclusion and a discussion of the justice perspective, I contend that the end formulation of the categorical imperative does provide such a framework.

From the perspective of this dissertation, a careful review of the bioethics literature reveals three significant characteristics. First, as Megan-Jane Johnstone (1999) points out, bioethics is essentially medicocentric. That is, its principles are primarily focused on the arena of physicians and grounded in the justice perspective. Therefore, the focus of bioethics tends to be on issues of patients' rights, rights of research subjects, and the formulation of public policy guidelines for clinical care and biomedical research. Second, articles authored by nurses are conspicuously absent from most bioethics textbooks. In other words, open any college bioethics textbook and the majority of the articles are authored by philosophers, physicians, attorneys, and theologians. Johnstone (1999) finds this problematic because nurses, in most instances, are the primary caregivers and she believes that they have been excluded from bioethical discussion

based on the false perception that nursing is merely “the hand maiden” of medicine and as such lacks its own professional autonomy. A further consequence of this exclusion is that ethical issues specific to the field of nursing are neglected. For example, how should a nurse respond if a patient asks if she is dying? Other nursing issues deal with such questions as mandatory overtime and staffing shortages. Johnstone argues that the only way for nurses to play an active role in bioethics discussion is to educate themselves in the language of the bioethics discourse and establish the legitimate autonomy of nursing as an independent profession.

Finally, very little attention has been given to avoiding the objectification of nursing home residents. Rather the focus of the literature has been primarily on issues associated with autonomy. I believe that these characteristics are inter-related. Nursing homes are traditionally the domain of nurses and not physicians, and bioethics has traditionally focused on the domain of physicians. Therefore, with the exception of issues regarding autonomy and patients’ rights, bioethics remains silent regarding long term care facilities. An exception is the work of Mary Raugust (2000). Raugust’s short essay *Feminist Ethics and the Workplace Values* illustrates Alison Jaggar’s (2000) criteria of feminist ethics and the basic principles of the care perspective in relation to her practical experience with the Kennedy Aging Project. Prior to undertaking a discussion of Raugust’s work, it is helpful to briefly discuss the basic core views of both the justice and care perspectives.

Justice Perspective

The most prominent philosophic representatives of the justice tradition, John Locke, Immanuel Kant, and, more recently, John Rawls and Ronald Dworkin, share two

core views. Each of them is committed to personal liberty and in terms of their methodology each of them relies on the social contract model. Together these core views provide the basis for individual autonomy which is one of the distinguishing features of the justice perspective. Their concept of personhood is grounded in moral autonomy, human rights, and dignity. The focus in this tradition is placed on fairness and equality. Moral reasoning requires abstraction from the situation, deductive reasoning, and application of universal moral principles. Justice is the highest moral value. The justice perspective tends to emphasize the universals at the exclusion of the particulars.

Although there is dispute among scholars as to whether or not utilitarianism can accommodate rights, Mill's *Essay on Liberty* with its focus on individual liberty clearly links Mill to the justice tradition. Further, Mary Wollstonecraft's focus on the rights of women also clearly aligns her with the justice perspective (Kittay & Meyers, 1987). While Mill and Wollstonecraft argued for women's rights, the work of Lawrence Kohlberg, which is grounded in the justice perspective, suggests that women may lack the same level of moral development achieved by men.

Kohlberg (1981) suggests that there are three stages with two levels each of moral development. In stage 1, the pre-conventional level, fear of punishment is the primary motivator. In stage 2, the pre-conventional level, the individual is an egoist who satisfies his/her own needs and considers the needs of others when it benefits them. In stage 1, conventional level, motivation is based on the good boy/good girl concept. One acts morally to conform. In stage 2, conventional level, the motivating factor is respect for authority and the existing social order. In stage 1, the post-conventional level, the individual is motivated by a desire to maintain the social contract. Morality is associated

with rights. Finally in stage 2, post-conventional level, the individual is motivated by conscience and universal principles of justice.

In Kohlberg's studies he found that women were less likely than men to reach level 3 stage 2. Kohlberg's student Carol Gilligan took exception to these findings and suggested that women view morality from a different perspective, which she identified as the ethics of care.

Care Perspective

In her book, *In a Different Voice*, Gilligan (1977) offers empirical data that supports her hypothesis that the moral decision-making practices of women differ from those of men. Based on her studies of women she identified a six stage series marked by three levels of moral development. At the first level one is concerned with caring for ones' self in order to survive. At the second level the focus of care is toward others and many women become self-sacrificing at this level and never move beyond that stage of moral development. At level three there is a balance between caring for ones self and caring for others. This is Gilligan's highest level of moral development.

Unlike the justice perspective, the care perspective focuses on individual situations and relationships. Interconnectedness, not equality, is the primary focus. Moral decision making from the care perspective focuses on contextualization rather than abstraction. The care perspective views the self as a social self enmeshed in relationships. The primary goal of moral deliberation is to maintain those relationships. The highest moral value is virtue rather than justice. Its focus is on interdependency and dependency rather than independence. The care perspective fosters nurturing rather than respect for individualism. Particulars tend to be emphasized at the exclusion of the universals.

Diane Michelfelder (2004) in her article on technology and feminism provides the following summary of the care perspective:

> Like interpersonal ethics, feminist ethics (particularly the ethics of care) places Particular value on our relationships with those with whom we come into face-to-face contact in the context of familial and friendly relations. Its key insight lies in the idea that the experience of looking out for those immediately around one, an experience traditionally associated with women, is morally significant, and needs to be taken into account by anyone interested in developing a moral theory that would be satisfactory and useful guide to the moral dilemmas facing us in all areas of life (p.277).

Michelfelder's account of the ethics of care illustrates the importance that the care perspective places on relationships in actual situations and its focus on caring for others as a moral imperative.

Although Gilligan based her contentions regarding the care perspective on empirical studies, Annette Baier (1987) argues that the care perspective is compatible with the moral theory of David Hume. In other words Baier argues that Hume's focus on sentiment rather than reason is consistent with Gilligan's findings regarding the moral deliberations of women. Baier also argues that according to Hume the development of character traits which deal with the relations to others are the most important virtues. Therefore, she argues Humean moral theory is compatible with the care perspective. Feminist philosophers argue that Gilligan's work with the care perspective opens up a dialogue which provides a way to eliminate what they perceive as a male bias in western moral theory.

It is important to note that while Gilligan's work has opened a new dialogue concerning the role of women's perspective in moral decision-making, it is not the case that all feminists are in agreement concerning what constitutes a feminist ethic. Notwithstanding feminist disagreements, Alison Jaggar (2000) suggests three minimal criteria which must be met for any ethical theory to be considered a feminist theory.

Jaggar's Criteria

Jaggar (2000) argues that for an ethical theory to be considered a feminist ethical theory it must meet three minimum criteria. First, it must be active, engaged, and political. Second, it must be on the side of the oppressed and it must address the private as well as the public domain. Finally, an adequate feminist theory must take the moral experience of all women seriously. Note that Jaggar is not suggesting that the experience be accepted without critical evaluation. According to Jaggar, only ethical theories which meet these minimum criteria can be considered an adequate feminist theory (1989, pp.192-194). Raugust's essay nicely illustrates Jaggar's points as she applies them to her practical experience with the Kennedy Aging Project.

The Kennedy Aging Project

Raugust (2000) recounts her experience as the feminist director of the Kennedy Aging Project. She argues that in recent years many well-educated and talented women have left their jobs to pursue other careers because they find the values of the patriarchal workplace inconsistent with their own values. Raugust argues that there is a male bias in the western ethical tradition which often alienates female workers.

The purpose of the Kennedy Aging Project was to teach healthcare professionals how to deliver care to dual diagnosis individuals, that is, to individuals who are both

elderly and mentally challenged. In her capacity as director, Raugust placed the primary focus on providing service to her clients. However, the workplace ethic that evolved not only fit Jaggar's criteria for a feminist ethic it also illustrated the major principles of the care perspective. Unlike my project, Raugust did not set out to create a care perspective for a long term healthcare facility; rather she describes the work environment that evolved at the Kennedy Aging Project under her direction and with a staff that shared a similar political philosophy (2000, p.196).

After three years, Raugust argues that six ethical tenets evolved which exemplify feminist ethics and the ethics of care. First, relationships instead of individual rights became the priority of ethical enactment. Second, the focus was on giving and receiving care rather than the exercise of individual autonomy. Third, interdependence rather than individualism resulted in a leveling of status among the staff. That is to say all staff were responsible for direct care and one's position as an administrator did not exclude him/her form providing direct care to a resident.

Fourth, others were seen as particular others rather than the impersonal other of the justice perspective. Fifth, rather than the employment of abstract reasoning, decisions were contextualized and based on particular residents. Finally, virtue rather than justice was seen as the highest good. Raugust argues that the workplace ethic that evolved at the Kennedy project was an embodiment of feminist ethics and as such further supports the claim that women make moral decisions from a different perspective than their male counterparts (2000, pp.196-199).

Clearly, there are relevant disanalogous characteristics between my project and Raugust's project. However, they are also analogous on many relevant characteristics.

Given that feminist ethics is largely put forth as an alternative to Kantian ethics, I must undertake a critical evaluation of the ethics of care in relation to my project of addressing the moral evil of objectification of nursing home residents.

Before I do that I will briefly mention some general criticisms of the ethics of care. There are several criticisms that can be leveled at the ethics of care in general. First, it is descriptive rather than prescriptive. In other words it is premised on the naturalistic fallacy that it is acceptable to go from “it is the case” to “it ought to be the case.” Of course this also applies to Raugust’s work. Feminist such as Hilde Lindeman (2004) have countered this criticism by suggesting that there are normative aspects of feminist theory and that it is not necessarily descriptive. Others challenge the legitimacy of the naturalistic fallacy itself.

Another criticism that may be leveled at the ethics of care in general is that it is engendered relativism. In other words, care ethics appears to be making the claim that morality and moral decision-making is relative to one’s gender. Finally, the question can be posed as to whether or not the care perspective approach to ethical decision making is the consequence of gender or socialization. However, the critical discussion of these issues is beyond the scope of my project. In relation to feminist ethics in general and the ethics of care specifically, my only concern is whether it provides an adequate ethical theory. That is, one that maintains the subjectivity of the nursing home resident while simultaneously avoiding objectification.

It is my position that the ethics of care is inadequate in terms of my project because of the following three reasons. First, it promotes a paternalistic or perhaps more accurately a maternalistic attitude toward the resident/ nurse relationship which creates

the potential for the nursing home resident to be seen as an object of care, that is, dependent and child like. Second, there is the false assumption that face-to-face relations result in a caring relationship. And finally, the lack of concern for residents' rights and the shift away from justice as the highest moral value to virtue tends to undermine human dignity because the quality of care provided is contingent on the caregiver.

Priestly Model

In Robert Veatch's classic expose of the possible models of patient/physician relationships he introduces four possible models of physician-patient relationships: the **priestly model, the engineering model,** the **collegial model,** and the **contractual model.** He describes the **priestly model** as the traditional paternalistic relationship between the patient and his/her physician in which the primary decision maker is the physician (1986, pp.56-59). If we apply Veatch's models to the relationship between the nurse and resident in the Kennedy Aging Project, I maintain that the **priestly model** is the most accurate description of that relationship. The acknowledged flaw in this model is that the patient has very little input regarding their healthcare decisions. The issue of patient's rights is absent from the **priestly model** just as the focus on individual rights was replaced by a focus on care in the Raugust project. This is problematic for my project because it creates a situation in which care is viewed as the primary good and not patients' rights. It therefore creates a potential for **cruel and unusual treatment** and possible lying to the resident justified on the basis of providing care.

The nurse as caregiver believes that providing care is in the best interest of the resident and not upholding their individual right to refuse treatment. Therefore, it is a common occurrence for medications to be administered in apple sauce or pudding

without acknowledging the presence of that medication to the resident. Further, a 3AM whirlpool bath becomes acceptable because one is providing care. I maintain that in situations such as the ones described above, it is the caregiver who becomes the judge of what constitutes care and not the resident. This occurs because the focus in the ethics of care views caring as a good. Therefore, the failure of the ethics of care to acknowledge the language of rights creates a potential for the nursing home resident to become an object of care rather than a person with dignity and intrinsic value.

Face-to Face Relationships

Another problem as I see it with the ethics of care is that it assumes that face-to-face relationships result in the establishment of caring relationships. After having worked as a healthcare Aid for 4 1/2 years this seems to me to be another example of a *Leave It To Beaver* view of the world and human relationships. An experience I had with a man I will call Mr. G illustrates the point that not all face-to-face relationships result in caring. Mr. G by all accounts was a mean-spirited individual. He was abusive to his family and the staff. For example he had over the years physically and verbally abused his wife and daughter. Therefore, they rarely came to visit him. In terms of his treatment of staff, he threw urinals full of urine at aids, and verbally abused a number of staff members with degrading and often racist slurs, and had at times physically struck an aid. This face-to-face relationship resulted not in any empathy or sentiment toward Mr. G. but in fact in extreme dislike and an unwillingness by the staff to provide care for Mr. G. Unfortunately I was assigned Mr. G. and I will admit I loathed the man, but I also believed that I had a moral obligation to treat him with respect and provide the necessary care. I remember telling Mr. G. “I do not like you and you do not like me, but I will treat

you with respect and you will treat me with respect." I took care of Mr. G. for several years and although he came to like me as a person I was never able to overcome my loathing of him. While I was able to provide him with an acceptable level of nursing care, I never did care for him. The point of this example is to illustrate to the reader that not all face-to-face relationships result in a caring relationship or any sort of sentiment. Further, I would argue that in such cases the ethics of care is inadequate because it assumes an empathy or sentiment results from face-to-face relations. In other words, under the ethics of care it would appear that Mr. G's quality of healthcare care is contingent on the individual staff member's relationship with him. In instances when that relationship does not result in caring on the part of the staff his healthcare would suffer if the staff member did not make her decisions regarding his care based on another ethical perspective. In light of that consideration, I maintain that, in instances like the one I encountered with Mr. G., the impersonal justice perspective provides a more adequate framework for providing care based on a moral obligation of justice. Thus a shift in focus from rights to providing care undermines human dignity and by implication one's self-esteem. Joel Feinberg addresses the relationship between rights and human dignity.

Nowheresville

In his thought experiment concerning the value of rights, Feinberg (1970) introduces the reader to a place called Nowheresville. In Nowheresville there is benevolence, sympathy, and compassion. The people are virtuous. Kindness and compassion are the norm. Nowheresville is by all accounts a very pleasant place where people help one and other are charitable, kind, and compassionate. By analogy, Nowheresville is similar to the Kennedy Aging Project. What is missing in Feinberg's

Nowheresville is the concept of rights. Nowheresvilleans do not have rights. The rewards given to the residents of Nowheresville are contingent on the benevolence of others. As Feinberg points out Nowheresville would have little appeal for Kant. I would like to remind the reader that in Raugust's Kennedy Aging Project the primacy of the notion of rights has been replaced by the primacy of the notion of care. The issue Feinberg raises in regards to the notion of rights is whether or not the absence of a notion of rights is morally significant? Feinberg (1970) argues in regard to the moral significance of rights :

> They are especially sturdy objects to "stand upon," a most useful sort of moral furniture. Having rights, of course, makes claiming possible: but it is claiming that gives rights their special moral significance. This feature of rights is connected in a way with the customary rhetoric about what it is like to be a human being. Having rights enables us to "stand up like men," to look others in the eye, and to feel in some fundamental way the equal of anyone. To think of oneself as the holder of rights is not to be unduly but properly proud, to have that minimal self-respect that is necessary to be worthy of the love and esteem of others. Indeed, respect for persons (that is an intriguing idea) may be respect for their rights, so that there cannot be the one without the other: and what is called "human dignity" may be simply the recognizable capacity to assert claims. To respect a person then, or to think of him as possessed of human dignity, simply is to think of him as a potential maker of claims (pp. 69-70).

As Feinberg points out human dignity and respect for persons is tied to the language of rights and claiming. I agree with Feinberg that rights are a kind of moral

furniture that allows one to assert their intrinsic value. The notion of rights enables me to claim that "By the nature of my personhood I have equal moral value. I am a subject not an object." In contrast, the lack of a notion of rights makes my moral value contingent on conditions external to myself. That is I am not valuable in and of myself but only if some one else values me. For example, in feminist writings that deny the abortion debate should be grounded in the language of rights and the question of personhood, the moral status of the fetus is contingent on the fetus' relationship to the mother. In other words, the fetus has moral value only if the mother chooses to carry the fetus to term. The fetus has moral value because of her relationship to her mother. That value is extrinsic not intrinsic. There is no discussion of fetal rights versus the rights of the mother. The sole determining factor of the fetus' moral value is the relationship the mother chooses.

Independent of any judgment of the morality of abortion and without addressing the numerous ethical issues which surround the abortion debate, i.e. personhood, the right to privacy, I contend that the ethics of care, which disregards the language of rights, runs the risk of undermining human dignity and therefore creates a potential for objectification. I argue that it is precisely the turning away from the notion of rights to embrace the ethics of care that results in the inadequacy of the care perspective to address the goal of my project, which is to provide a safety net for maintaining personhood while one is confined in a nursing home.

Further, although the result is the same there is a morally significant distinction between claiming a right to something and receiving something as an act of benevolence or charity on the part of another. The moral significance between the dignity associated with claiming a right to something and receiving something as an act of benevolence or

charity is perhaps better understood if we consider the difference between welfare and social security. There are literally thousands of Americans who qualify for welfare and Medicaid. However, many of those individuals never apply for welfare because they feel it is demeaning and an affront to their pride to accept charity. On the other hand, few individuals fail to claim their social security and Medicare because they feel they have a legitimate claim to what is owed them. It is their right in a way that welfare is not. In the case of Mr. G. the notion of rights enables him to claim his right to care independent of any relationship he establishes with his care givers simply because it is his right.

These considerations support the end formulation of the Kantian categorical imperative, with its focus on respect for persons, as a more adequate solution to the moral problem of objectification in the nursing home setting than does the ethics of care. Because the ethics of care is grounded in relationships, it is not able to prevent the objectification that can result when an individual is viewed as an object to be cared for rather than as a person who has the right to accept or refuse care.

I would like to point out to the reader that I am in no way disregarding the contribution of feminist ethics to the western tradition nor am I arguing that it is not a legitimate ethical approach. I am merely suggesting that in terms of my project of avoiding objectification in the nursing home setting, the end formulation of the Kantian categorical imperative provides a more tenable ethical framework. Further, that is not to say that I am suggesting that the two ethical theories are mutually exclusive. On the contrary I contend that they should inform one another. In other words, justice should be tempered with compassion, persons require faces, women's moral experience must be considered, and oppression based on gender must be opposed.

Finally, my goal in the following chapter is to address the criticism that Kantian ethical theory is purely formal and lacks content. My intent is to unpack the end formulation of the categorical imperative in order to demonstrate that it does in fact have content. Furthermore, that content is applicable to developing guidelines for establishing a Kantian nursing home that provides care, and is also invaluable in providing guidelines which create an environment that is not conducive to the moral evil of objectification.

Chapter Three

Unpacking the End Formulation of the Categorical Imperative

Introduction

In this chapter I will develop Propositions Four and Five. First, I argue that we have an indirect duty to treat non-rational humans "as if they are persons." This argument is based on an analogy with Kant's argument regarding our treatment of animals. It is important to the development of my overall thesis because it demonstrates that the end formulation of the categorical imperative has implications for nursing home residents who lack rationality. In developing Proposition Five, I argue for two positions. First, the end formulation of the categorical imperative prohibits coercing, lying or manipulation of nursing home residents. Second, it imposes a duty upon a nursing home to avert obstacles to autonomy. I contend that combined these two positions suggest guidelines for developing a just nursing home.

In the *Ground Work of the Metaphysics of Morals* (1785/1964), Kant instructs us that we have duties both to ourselves and others:

> Act in such a way that you always treat humanity, whether in your own person or the person of any other, never simply as a means, but always at the same time as an end (p.96).

This formulation of the categorical imperative referred to by Kant as the Formula of the End in Itself (End Formulation) argues that we should never treat ourselves and others as merely a means and we should respect ourselves and others as an end. This is the case for Kant because personhood is defined in terms of rationality.

A person, in Kantian terms, is a rational, autonomous, moral agent. Rational beings have absolute intrinsic value. They are capable of establishing objective goals and choosing appropriate means to achieve those goals. Their actions are not determined by instinct. Therefore, they are an end in itself and provide the basis of determinate law. In other words, persons are lawgivers. Rationality and the ability to develop objective ends that apply universally to all rational beings provides the basis for Kantian ethical theory and the Supreme Principle of morality the Categorical Imperative.

In light of the Kantian criteria for personhood, some readers may challenge my application of the end formulation of the categorical imperative as the basis for development of a just nursing home. Such a challenge undoubtedly will arise from the fact that not all nursing home residents are rational. Therefore, some nursing home residents are not part of the Kantian moral community, i.e. non-persons.

Clearly, that is the case. In any nursing home there is a continuum of rationality which spans both ends of the spectrum from the rational to the PVS patient (persistent vegetative state) who lacks all capacity for consciousness and therefore rationality. It is my intention to take this challenge by the horns and address it head on without any waffling on my part. I will undertake the issue of non-rational human beings before proceeding to unpack the duties imposed upon us by the end formulation of the categorical imperative.

Kantian Ethics and Animals

Based on an analogy with Kant's argument regarding our indirect duty not to act cruelly toward animals, I contend that we do in fact have an indirect moral duty to treat non-rational human beings "as if they were persons." Simply stated my argument is that:

If we treat non-rational human beings as “mere means” it will harm our own humanity in the same way that cruelty to animals harms our own humanity. Therefore, we have an indirect duty to treat all human beings “as if they are persons.”

Although Kant obviously did not address the question of PVS patients, he did address the issue of our duties to animals in his *Lectures on Ethics* (1770’s/1963). Before addressing Kant’s position on animals, I would like to make a few comments about the Lectures. Although the Lectures were not written by Kant, but rather transcribed either by or for three of his students, they provide a valuable insight into Kant the beloved professor and his passion for ethics. As Lewis Beck (1963) points out, the Lectures allow us to see Kant the eloquent speaker who often brought his audience to tears. Beck also argues, and I agree, that without reading the Lectures and the *Metaphysics of Morals* and seriously considering Kant’s handling of the other components of a good person, one may erroneously hold that for Kant a moral person is reducible to an emotionless “thinking machine,” a robot (pp xii-xiii).

In the Lectures Kant argues that while we have no direct duties to animals, we do have indirect duties to ourselves to refrain from cruelty to animals. These indirect duties are grounded in our duty to our own humanity. In other words because animals are not, from Kant’s perspective, rational we have no direct duties toward them. However, we do have an indirect duty to refrain from cruelty to animals because cruelty to animals damages our own humanity:

> If a man shoots his dog because the animal is no longer
> capable of service, he does not fail in his duty to the dog,
> for the dog cannot judge, but his act is inhuman and damages

> in himself that humanity which it is his duty to show towards mankind. If he is not to stifle his human feelings, he must practice kindness towards animals, for he who is cruel to animals becomes hard in his dealings with men. We can judge the heart of a man by his treatment of animals (p. 240).

In other words, for Kant we have a duty to preserve our own human feelings and therefore an indirect duty to refrain from cruelty to animals. This is the case because Kant believes that in many instances animal behavior is analogous to human behavior and cruelty to animals diminishes our empathy for their suffering and likewise our empathy for humans which is necessary in our relationships with other human beings. Kant addresses this issue again in the *Metaphysics of Morals (*1797/1996):

> With regard to the animate but nonrational part of creation, violent and cruel treatment of animals is far more intimately opposed to a human being's duty to himself, and he has a duty to refrain from this; for it dulls his shared feelings of their suffering and so weakens and gradually uproots a natural predisposition that is very serviceable to morality in one's relations with other men (pp.192-193).

It appears that Kant is suggesting that a compassionate predisposition toward fellow humans aids an individual in her moral duty. It is important to remember that for Kant (1770's/1963) duties to ones' self take precedence over our duty to others:

> A man who performed his duty to others badly, who lacked generosity, kindness, and sympathy, but who nevertheless did his duty to himself by leading a proper life, might yet possess a certain inner worth; but

> he who has transgressed his duty towards himself, can have no inner worth whatever (p118).

Therefore to engage in actions and activities which degrade one's own humanity is for Kant a serious moral offense. For example, we have a Perfect Duty not to kill ourselves.

Two questions may be raised in relation to Kant's position. First, is it a valid claim? Second, does the claim apply equally well to non-rational human beings? My answer is affirmative in both instances. First, let us investigate the empirical support for his claim that cruelty to animals leads to cruelty to humans.

It is interesting to note that there is significant empirical evidence which supports Kant's claim that cruelty to animals leads to cruelty to humans. For example, various humane societies have conducted research and published statistics on the link between animal and human abuse (American Humane Society, Humane Society of the United States, Doris Day Animal League etc.). Research on serial killers suggests that one shared commonality among them is a history of cruelty to animals. The infamous serial killers Jeffrey Dahmer, Albert DeSalvo, and David Berkowitz all had a history of animal abuse (Briggs, 1994, pp24-28).

In addition, in the Columbine case it is known that both Harris and Klebol abused animals before turning their guns on their classmates (psyeta.org). Some states consider the evidence of the correlation between animal abuse and human abuse strong enough to warrant instructions to humane agents investigating alleged animal abuse, to check on children and seniors who reside at the address under investigation.

The investigation of the relationship between animal and human abuse is a multi-disciplinary field. The field includes such diverse authors as feminist Cindy Adams

(1995) and her paper on the relationship between battering women and animal abuse to FBI profilers on serial killers. Available contemporary research supports Kant's 18th century claim that animal cruelty leads to human cruelty. Kant believed that this is the case because animal nature is analogous to human nature and cultivating kindness to animals enables us to cultivate kindness to humanity while cruelty to animals results in cruelty to humans. In the *Lectures,* Kant refers to Hogarth's engravings entitled *Stages of Cruelty* in which he sequentially depicts a child pinching a dog's tail, a man running over a child with a cart, and the final cruelty of murder.

Another point of interest brought up by Kant in the lectures on animals suggests that in England during that time period butchers and doctors were banned from juries because it was believed that their professions hardened them to death. I find this point significant because Kant is suggesting that certain professions by their very nature can harden individuals. In relation to the nursing profession, it is often the case that nurses become de-sensitized to the suffering of their patients. My goal is to create in theory a just nursing home environment in which that desensitization does not occur.

Kant further suggests that the development of tender feelings toward animals results in the development of tender feelings toward humankind and visa versa. Therefore, although animals are not part of the Kantian moral community our duties to ourselves result in an indirect duty to refrain from engaging in cruelty to animals.

Kantian Ethics and Non-rational Humans

The question which I wish to pose is whether by analogy we can legitimately extend the Kantian argument against cruelty to animals to include not treating non-rational humans such as PVS patients and other cognitively impaired nursing home

residents as “mere means”? My position is that an extension of Kant’s argument is not only legitimate, but that it holds true to an even greater degree in the case of non-rational humans because there is always the possibility of personhood. In other words, treating non-rational humans as “mere means” degrades one’s own humanity and hinders the development of tender feelings toward humankind.

Because my position makes a claim of fact about human nature, its legitimacy is contingent on empirical substantiation. The 20th century eugenics programs of the United States and Germany provide support for my position. Philip Reilly’s (1999) history of eugenic sterilization in the United States chronicles the United States’ eugenic program. The 1880 census report alarmed many people because it reported that “whereas the general population had grown by 30%, the apparent increase in “idiocy” was 200% (1999, p.517). The creation of asylums for defective women in their reproductive years was one of the first responses to this report. Although never legally implemented, several state legislatures debated proposals for mass castration of criminals. Ultimately the United States’ eugenics policy resulted in mandatory forced sterilization of the insane, criminals, and the feebleminded. The Eugenics Record Office was funded by some of America’s wealthiest families (Harriman, Kellogg, and Rockefeller). It is estimated that between 1907 and 1963 more than 60,000 persons were sterilized (Reilly, 1999). Perhaps the cruelest irony of the United States’ eugenics policy of forced sterilization is that the legal case Buck v. Bell (1927) which upheld Virginia’s mandatory sterilization laws by a vote of 8-1 was founded on a falsehood (Gould, 1999, p. 528-532). In handing down the majority decision, Supreme Court Justice Oliver Wendell Holmes wrote:

> We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the state for these lesser sacrifices….It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough (1999, p529).

Justice Holmes is of course referring to Carrie Buck, her mother Emma, and her daughter Vivian. A re-examination of the case in 1980 revealed what many had suspected, neither Carrie Buck or her daughter were imbeciles, but rather both had normal intelligence. How did a man who was viewed as a champion of the Bill of Rights come to hold such a position and completely ignore the rights of Carrie Buck? Could it be the case that it was his belief that those who are mentally challenged are defective persons and therefore can justly be treated as a means to further the goals of society? Did that belief harden him to the rights of Carrie Buck and degrade his own humanity? This case illustrates the danger of labeling some people as defective persons and then assuming that they may be treated as objects. It also, I believe, demonstrates an error in reasoning among those who hold that designation of personhood is a privileged category. In fact personhood in Kantian terms imposes duties on persons to act in a specific manner. Persons are not privileged in the sense that they may treat non-persons in any manner that they choose. On the contrary rationality and the ability to act independent of instinct imposes duties upon persons that

cannot be meaningfully imposed on non-persons. For example, we cannot meaningfully say of a group of beached whales that they have a moral duty not to commit suicide. However, we can say that persons have such a moral duty. In other words, personhood is not the assignment of privilege, but rather the assignment of responsibility.

The case of Carrie Buck, from my perspective, illustrates a misinterpretation of personhood and the duties it implies. The German eugenics program is a further illustration of erroneously viewing personhood as a privileged position.

In 1923 Fritz Lenz, a German geneticist and advocate of mandatory sterilization praised the United States' eugenics sterilization policies. Under the banner of "life unworthy of life," the Nazis began the forced sterilization of the feebleminded, insane, epileptic, blind, and deaf. Their preliminary estimates called for the initial mandatory sterilization of 410,000 persons (Liffton, 1999). Ultimately, the German eugenics program led to the final solution and the extermination of millions of people. In addressing the final solution, Heinrich Himmler (2004) in a speech to his SS subordinates in 1943 suggested the following:

> …in sum, we can say that we fulfilled the heaviest of tasks [destroying the Jews] in love to our people. And we suffered no harm in our essence, in our soul, in our character (p.97).

It is of course the actions of the Nazis which resulted in the term crimes against humanity. Can it be the case as Himmler claims that the Nazis did not degrade their own humanity? On the contrary, I would argue that Himmler's speech is a self-contradiction in the sense that his lack of remorse or moral repugnance at the extermination of the Jews reflects his lack of conscience. Himmler and the Nazis serve as evidence that cruelty to

non-rational human beings degrades one's own humanity and hardens one so that he or she no longer has as Kant argued a natural predisposition to have tender feelings toward humanity. I would like to remind the reader that the Nazis' final solution began with Hitler's "useless eater policy." The policy of first sterilizing than gassing the mentally ill and mentally challenged ultimately led to the extermination of millions of people.

In light of the above, my point is that just as it is the case with animal cruelty treating non-rational humans as "mere means" leads to cruelty to humankind. Therefore, based on the end formulation of the categorical imperative we have an indirect duty to refrain from treating non-rational human beings as "mere means" just as we do to refrain from cruelty to animals.

The Case of Dana

I believe that the cases of a young woman who I will call Dana and an elderly woman who I will call Ada provides the reader with a better understanding of why it is the case that treating non-rational humans with the respect due persons benefits one's own humanity. First I will discuss the case of Dana. Dana and her boyfriend were coming home from the senior prom when they were run off the road and hit a tree head on. Dana suffered closed head trauma and never regained consciousness. I did not become acquainted with her until several years later. At that time I was working as a certified nursing assistant and she was assigned to my care. Dana had a tracheotomy, but she was able to breathe on her own for short periods of time. Her mother visited her on a daily basis. In addition to her medical needs, her daily care consisted of bathing, dressing and being placed in a geriatric chair. Her mother often took her outside and she was provided with outside stimuli such as television and radio.

I always talked to her and treated her as if she were conscious as I performed her care. In the nightstand beside her bed was a photograph of her with her dog. I still remember the dog. It was a little brown dog and he was wearing a red bandanna. Her mother told me how much she loved animals. It was the practice of this particular nursing home for staff and others who were not on duty to dress up their pets and bring them to the nursing home on Halloween. I brought my black lab Shane dressed as a cowboy. My main reason for doing so was to introduce him to Dana. Shane was a very affectionate and kind dog. When I took him in Dana's room he jumped on the bed and licked her face. She smiled and of that I am sure. Whether or not her smile was an involuntary response to Shane's lick or an expression of pleasure I will never know. However, what I do know is how her smile affected me. In Kant's terms I had tender feelings toward Dana. I believe as Kant did that the development of tender feelings towards in this case defenseless others develop in us "humane feelings toward mankind" that aids us in fulfilling our moral duties. Our duties towards non-rational humans, then, "are indirect duties towards mankind." Therefore, we have a duty to treat the non-rational nursing home resident "as if he or she is a person." To treat Dana as the vegetable in room 2 may or may not harm Dana, but it does harden the nursing staff and degrade their humanity. In addition to the example provided by Dana's case, the case of Ada further demonstrates the inherent danger of treating human beings as objects.

The Case of Ada

I intentionally left my experience with Ada out of the first draft of this chapter because it forces me to admit that despite my efforts to the contrary I am guilty of treating a human being as an object. Ada suffered from Parkinson disease and numerous

other ailments. She was contracted and stiff from the neck down. She was fed through a feeding tube. Basically, she lay in the bed twenty four hours a day seven days a week. The nursing assistant's care of Ada amounted to turning and repositioning her, changing her bed and giving her a whirlpool bath. We often spoke about Ada's condition while providing her with care. I remember saying "I would rather be dead then lying there like that." I assumed as did the other aids that Ada was not aware of our conversation. However, one day I turned off her television and Ada said "leave it on." I ran to the nurses' station to report that Ada could speak. I was told that they were aware that Ada could speak. I realized that Ada had heard my comments. I ran back to apologize to her and she told me it was okay. However from my perspective, it was not okay. I am still bothered by my lack of concern for Ada's feelings. I believe that my experience with Ada reveals how easy it is to treat a human being as an object when one assumes that they are a non-person for whatever reason.

My suggestion that our humanity is harmed when we treat human beings as "mere means" is not without support in American culture. For example, our elaborate funeral practices. The deceased is clearly a thing, but we show it respect. I argue that is the case because callous treatment of the dead is harmful to our own humanity.

In the case of biomedical ethics, Americans take great care to protect the interests of the non-rational individual. The case of Terri Schiavo illustrates this fact. Although they disagreed, both parties (husband and family) appeared to be concerned with Terri's best interests. The question is why when the woman had been in a PVS state for years was there so much public concern over the removal of her feeding tube. I maintain that

the reason is our treatment of the Terri Schiavos of the world is a reflection on our own humanity.

A reading of the bioethics literature on euthanasia illustrates a strong desire on the part of humankind to distance ourselves from the Heinrich Himmler's of the world. The Helsinki Code with its focus on the need for proxy consent for the incompetent stands as a testimony to the belief that the way we treat non-rational humans is a reflection of our own humanity.

I have, I believe, clearly stated my position in regards to non-rational human beings: We have an indirect duty, based on Kantian ethics, to treat them "as if they are persons." To treat them as persons means within the context of this work to uphold the duties imposed by the end formulation of the categorical imperative. I will address the specific application of this position within the context of the nursing home in the final chapter. I now wish to address the duties imposed upon us by the end formulation of the categorical imperative.

The Formulation of the End in Itself

Prior to unpacking the end formulation of the categorical imperative, I believe it is helpful to comment on several key features of Kantian ethics. First, Kantian ethics is an ethics of duty, not as some suggest an ethics of rights. Normally rights theorists argue, based on the correlativity thesis, that rights imply duties. However, not all Kantian duties have corresponding rights. For example there is a Kantian duty of benevolence, but there is not a corresponding right to benevolence.

Second the focus of Kantian ethics is on motivation not consequences. Kantian ethics is concerned with the maxims we act upon. Maxims are the underlying principles

upon which we act. Therefore when the categorical imperative instructs us that we should "act on only that maxim which we can at the same time will to be universal law," Kant is telling us that the principles upon which we act have to be universally applicable to all persons in morally similar circumstances.

Finally, although Kantian ethics usually focuses on the actions of individuals, its scope can be extended to institutions or organizations in which there is a decision making body. In the present case the governing body of the nursing home or legislatures who enact legislation that establishes the guidelines for operating a nursing home.

Kant develops the end formulation of the categorical imperative in the *Groundwork* at 64-69. In regards to the end formulation, Kant tells us we have a duty not to treat humanity either in ourselves or in others as a "mere means". It is important to note that Kant is saying a "mere means" because of course we all use one another as a means in some way or another. In the case of the healthcare worker the resident is a means of obtaining a paycheck. The nurse is a means of receiving care for the nursing home resident. What Kant means by treating a person as a "mere means" is that through coercion, deception or manipulation a person consents to an arrangement that she would not otherwise consent to. Kant provides two illustrations of using one's self or another as a mere means (66-69). These are the Perfect Duties. His first illustration is suicide. Kant argues that if one commits suicide to remove herself from a painful situation she is using herself as a mere means. Therefore, persons have a Perfect Duty not to kill themselves.

Kant's second illustration is of the individual who makes a false promise. Kant argues that the person who makes the false promise is using the other person as a mere

means: he intends "to make use of another man *merely as a means* to an end he does not share" (68). Therefore, we have Perfect Duty not to lie.

Although there are numerous examples in medical research of using persons as "mere means," perhaps the most glaring example in the history of American medical research of using persons as "mere means" is the Tuskegee Syphilis Experiment. In this case the research subjects were coerced, manipulated, and deceived into agreeing to participate in the Tuskegee experiment. This manipulation was possible because the participants, due to their extreme poverty and race, were a vulnerable population. The researchers clearly treated the study subjects as "mere means" (objects). From a Kantian perspective, the Tuskegee Syphilis Experiment can be judged to be highly immoral.

In addition to the moral prohibition against using persons as "mere means," Kant argues that we have a duty to treat persons as "ends in themselves." For Kant this means that we must treat persons as rational autonomous beings. As Onora O'Neill (1993) points out:

> In doing so we must remember that (as Kant repeatedly stressed, but later Kantians have often forgotten) human beings are finite rational beings in several ways. First, human beings are not ideal rational calculators. We standardly have neither a complete list of the actions possible in a given situation nor more than a partial view of their likely consequences. In addition, abilities to assess and to use available information are usually quite limited. Second, these cognitive limitations are standardly complemented by limited autonomy. Human action is limited not only by various sorts of physical barrier and inability but by further sorts of (mutual or asymmetrical) *dependence.* To treat one another as ends in

> themselves such beings have to base their action on principles that do not undermine but rather sustain and extend one another's capacities for autonomous actions. A central requirement for doing so is to share and support one another's ends and activities to some extent. Since finite rational beings cannot generally achieve their aims without some help and support from others, a general refusal of help and support amounts to failure to treat others as rational autonomous beings, that is, as ends in themselves (p.262).

O'Neill suggests that Kantians are required to do what they can to remove obstacles that limit the possibility of autonomous action. In her case she is addressing world hunger and the duty of Kantians to do what they can to reduce hunger.

In other words the end formulation of the categorical imperative prohibits Kantians from using persons as a "mere means" and also requires Kantians to act in such a way that when possible they act to remove obstacles that limit the possibility of autonomous action. As O'Neill argues in regard to world hunger and poverty, "Kantians are required to do what they can to avert, reduce, and remedy hunger. They cannot of course do everything to avert hunger: but they may not do nothing" (1993, p.262). O'Neill's position is consistent with and supported by Kant's notion of beneficence as an Imperfect duty:

> This is, however, merely to agree negatively and not positively with *Humanity as an end in itself* unless every one endeavors also, so far as in him lies, to further the ends of others. For the ends of a subject who is an end in himself must, if this conception is to have its *full* effect in me, be also, as far as possible, *my* ends (69).

In other words we not only have a negative duty to refrain from treating persons as a "mere means" but a positive duty to do what we can to promote the possibility of autonomous action in other persons. Although the end formulation cannot provide us with specific policies, it does provide a method of judging the justness of policies. Policies that treat persons as "mere means" are unjust and those that promote the possibility of autonomous action are both just and required. In that sense there is content with determinate implications in the end formulation of the categorical imperative.

Obviously, Kantians are not required to further the ends of every person. However, in the case of the Kantian nursing home which I will call Kantian Meadows the special duties imposed as a consequence of the contract to provide care impose both a legal and moral duty on the directors as well as all the care givers to further the ends of all those individuals placed in their care. In light of the above, the next task is to identify barriers to the possibility of autonomous action.

O'Neill (1993) primary focus is on world hunger and poverty which she claims that Kantians must attempt to avert. Although they are not writing in relation to nursing home residents, Henry Shue and Anita Allen suggest other obstacles to the possibility of autonomous action that are particularly relevant to nursing home residents.

Shue (1989) in addressing the justification of human rights suggests that basic rights are a necessary condition for the exercise of human rights (pp. 152-171). The reader may ask how the concept of human rights is related to the possibility of autonomous action. In discussing human rights there are three generations of human rights. The first generation rights are liberty rights. Clearly, liberty is a necessary condition of autonomous action. Therefore, if there are basic rights necessary for human rights, and liberty is not only a

first generation human right but also a necessary condition for the possibility of autonomous action, it follows that basic rights are necessary for the possibility of autonomous action.

Shue identifies subsistence and security as basic rights. Shue argues (1989):

> If any right is to be exercised except at great risk, physical security must be protected. In the absence of physical security people are unable to use any other rights that society may be said to be protecting without being liable to encounter many of the worst dangers they would encounter if society were not protecting the rights (p. 158).

That is, physical security is necessary in order for people to exercise any right. Shue further maintains that subsistence or minimal economic security, which he defines as "unpolluted air, unpolluted water, adequate food, adequate clothing, adequate shelter, and minimum preventive public health care," is a necessary condition for the exercise of any right (1989, p. 159).

Shue's position on the necessity of physical security and subsistence is consistent with O'Neill. In other words, the lack of physical security and subsistence are obstacles to the possibility of autonomous action because persons become vulnerable to manipulation. Anita Allen in her work suggests that privacy is a necessary condition of personhood.

Allen (1988) writing concerning the value of privacy for women in a free society, suggests that privacy in relation to personhood has both a person-creation and a person-enhancement value. Allen quotes Edward Bloustein to support her contention that

privacy has moral value. Bloustein's (1979) observations are particularly relevant to the nursing home setting:

> The man who is compelled to live every minute of his life among others and whose every need, thought, desire, fancy or gratification is subject to public scrutiny, has been deprived of his individuality and human dignity. Such an individual merges with the mass. His opinions, being public, tend never to be different ; his aspirations, being known, tend always to be conventionally accepted ones; his feelings, being openly exhibited, tend to lose their quality of unique personal warmth and to become the feelings of every man. Such a being although sentient, is fungible; he is not an individual (p.42).

Therefore, it can be argued that the lack of privacy is also an obstacle to the possibility of autonomous action and as such Kantians have a duty to avert it.

Allen suggests because of the moral value of privacy that institutions "that promote individual privacy can be justified on the grounds that privacy is crucial to sustaining and enhancing personhood in the moral sense" (1988, p.46). Individual privacy becomes something that Kantian Meadows has a duty to promote.

While the end formulation of the categorical imperative cannot provide us with specific policies or a way to rank policies, it does provide us with a method of judging the morality of proposed policies; we cannot adopt policies that treat persons as "mere means" and Kantian Meadows has a duty to avert obstacles to the possibility of autonomous action. Based on the above discussion it may be argued that a lack of

physical security, economic subsistence, and individual privacy constitute obstacles to the possibility of autonomous action. Therefore, the policies of Kantian Meadows must avert those obstacles.

Finally, in the following chapter I will construct Kantian Meadows based on the duties imposed on Kantians by the end formulation of the categorical imperative. I will leave it to the reader to decide the appeal or lack of appeal of Kantian Meadows after they have read the final chapter.

Chapter Four
Kantian Meadows: A Nursing Home Dedicated to the Ethical Treatment of the Elderly

Mission Statement

It is the philosophy of Kantian Meadows that all residents deserve to be treated in an ethical manner. To ensure our commitment to the ethical treatment of our residents Kantian Meadows will enact only those policies and procedures that prohibit the treatment of residents as "mere means" and promote those policies that treat residents as "end in themselves."

Introduction

In this chapter I will develop Proposition Six. That is, I will develop, in theory, a nursing home whose policies and procedures are consistent with the end formulation of the categorical imperative. The purpose of this chapter is to demonstrate that the end formulation of the categorical imperative does have a practical application in the development of a nursing home. Therefore, I will argue for guidelines, procedures, and practices that uphold the duties I argued that are imposed upon a nursing home in chapter three.

This project is undertaken in order to guarantee that the individuals who enter the doors of Kantian Meadows will not be subjected to the moral evil of objectification and that the environment of Kantian Meadows will remain conducive to retention of a resident's dignity and personhood. It should also be remembered that Kantian Meadows endorses the policy of treating non-rational human beings "as if they were persons." Now let us imagine a place called Kantian Meadows.

Brief Description

Kantian Meadows, a 100 bed long term care facility, is located on 2 acres of land in Anywhere USA. Kantian Meadows has a twenty five bed secure Alzheimer unit complete with its own courtyard. It is a non-profit facility.

Opened in 2006, it is dedicated to the preservation of the dignity of all its residents. Its architectural style is circular with all resident rooms facing inward toward a central nursing station. Kantian Meadows has several professionally landscaped courtyards that are fenced for resident security. Therefore, in most ways Kantian Meadows resembles other American nursing homes. However, Kantian Meadows is distinct from other nursing homes in that the end formulation of the categorical imperative serves as the basis for judging the ethical or unethical nature of all institutional policies. In order to guarantee that the principles of the end formulation of the categorical imperative are upheld Kantian Meadows has in place an oversight committee. Let us, now take a more detailed look at the organizational structure of Kantian Meadows.

Non-Profit Status

We at Kantian Meadows have chosen to become a non-profit facility because we are concerned about the potential for a conflicts of interest had we chosen a for-profit status. Although we are not of the opinion that there is necessarily an inherent injustice in capitalism, we do believe that a commitment to profit maximization is not in all cases consistent with the requirements of the categorical imperative. For example, a bottom line of profit maximization would only require that state and federal staffing minimum requirements are upheld. However, as will be explained later those requirements are not sufficient if Kantian Meadows is to guarantee that residents will not be treated as “mere

means" and treated as "ends in themselves." Therefore, in light of Kantian Meadows commitment to its philosophy, a non-profit status has been chosen. In furtherance of our philosophy we have also chosen a circular architectural design.

Architectural Design

Although the categorical imperative does not support one architectural design over another, Kantian Meadows has chosen the circular design because within a circle everyone is equidistance from the center and as such we believe that the design promotes a sense of equality among our residents and visibility to the head nurse. On the other hand, the common choice of a linear design tends to create a sense of inequality. That is, commonly nursing homes and other institutions are constructed in such away that long linear hallways run off the central nursing station. Therefore, a hierarchical structure is created in which individuals may feel isolated from the group. Based on my own experience as a nursing assistant, it is often the case that the more demanding or troublesome residents are placed as far away from the nurses station as possible. Those residents who occupy the rooms at the end of the hall tend to be isolated from other residents and the activity which surrounds the nursing station. In this way there tends to be a structurally created inequality that the choice of a circular design mitigates. Based on this consideration, Kantian Meadows has purposely chosen a circular design in the hope of promoting a sense of equality among our residents. The individuals who occupy Kantian Meadows span the spectrum from those who are capable of autonomous action to those who lack any possibility of autonomous action.

Resident Demographics

There are only two restrictions that Kantian Meadows places on admittance. First and foremost, we must have the ability to provide the potential resident with all necessary care. Therefore, because of the specialized nature of caring for respirator dependent residents, Kantian Meadows will not accept respirator dependent residents or those individuals suffering from spinal cord injuries that require specialized care.

And of course, the second restriction is the availability of bed space on an appropriate housing unit. That is, we would not accept someone who is not suffering with Alzheimer disease and place him or her on an Alzheimer unit because there is an available bed. We believe that this decision is consistent with the categorical imperative because to do otherwise, we believe, would amount to treating the individual as a "mere means;" a body to fill a bed.

In light of our admission criteria, the ability of autonomous action among residents of Kantian Meadows is greatly varied. There are those residents for whom autonomous action is possible because they suffer only from physical limitations that prohibit independent living. A significant number of our residents have limited autonomy. Others lack the possibility of autonomous action altogether because they remain in a persistent vegetative state. Finally, twenty-five percent of our residents suffer from of Alzheimer disease. This results in varying possibilities for autonomous action. However, I would like to remind the reader once again, it has already been argued that Kantian Meadows will treat all human beings "as if they were persons." In order to guarantee Kantian Meadows' commitment to the categorical imperative is upheld, it is necessary to establish an oversight committee.

Configuration and Qualifications of Oversight Committee

The committee will consist of two Kantian bioethicists, two attorneys, two nurses, two physicians, a diversity of clergy, and two pharmacists. The bioethicists will be experts both in the area of healthcare ethics and Kantian ethical theory. Their primary responsibility will be to ensure that the policies and procedures adopted by Kantian Meadows are consistent with the moral duties imposed by the categorical imperative. That is, they will ensure that no residents are treated as "mere means" and that Kantian Meadows as much as possible averts obstacles to the possibility of autonomy. The case of Ada discussed in Chapter Three illustrates how easily, even for Kantians, it is to treat a person as a "mere means." In addition, the policies and procedures of Kantian Meadows will avoid as much as possible any policies and practices that threaten the security, subsistence and privacy of our residents. This is the case because as discussed in Chapter Three the lack of security, subsistence, and privacy acts as an obstacle to the possibility of autonomous action. In light of Kantian Meadows commitment to the ethical treatment of all its residents, the bioethicists will retain the final veto power over any and all practices. The other consideration in relation to the legitimacy of policies and practices is of course the legal aspect.

The presence of two attorneys on the committee will ensure that those requirements are met. One attorney's expertise will be in the area of non-profit rules and regulations. He or she will retain veto power over all issues relating to Kantian Meadows non-profit status. The other attorney will be an expert in the field of healthcare law. Therefore, he or she will be responsible for guaranteeing that all legal requirements are met and as such will retain veto power over all issues directly relating to healthcare law.

The purpose of the presence of clergy, physicians, and nurses on the over sight committee is to ensure that in what Kant called the empirical realm of the sensible, the subjective choices of non-rational residents are respected. That is, whereas the categorical imperative functions in the intelligible realm and goals are objective, personal choice functions in the empirical realm where goals are subjective. If the reader recalls Nussbaum's notions of treating someone as an object, she will be reminded of notion number seven: *Denial of Subjectivity.* According to Nussbaum, this *form of* objectification occurs when we fail to take someone's feelings and experience in account (1995, p.257). It is this aspect of personhood that bioethics has largely ignored. Given its dedication to ensuring that its residents are not treated as "mere means," Kantian Meadows cannot ignore the realm of subjective goals. The problem Kantian Meadows faces is how to decide those subjective questions in the cases in which individual residents are either not capable or limited in their ability to express their own subjective choices.

Best Interest Standard

In terms of health care decisions, where the individual is capable of autonomous action the principle of voluntary informed consent will be maintained as the standard. Admittedly, voluntary informed consent is in some ways a flawed concept. However, it is the legal standard supported by the 1993 Patient Self Determination Act. Further, in the case of rational residents it appears to be the most justifiable standard of respecting resident autonomy. Autonomy within this context may be defined as allowing competent residents to exercise their liberty. However, Kantian Meadows is not only committed to respecting the autonomy of competent residents, it is also committed to respecting their

autonomy after they become incompetent. Therefore, the "best interest" standard will be adopted in the case of incompetent residents. In consideration of the fact that what is in an individual's best interest is not necessarily an objective medical determination, the input of family, physicians, nurses, and clergy is needed to determine what is in the "best interest" of a specific resident. For example, in the case of pancreatic cancer the possibility of a cure is extremely rare. An objective medical decision dedicated to the curative approach would recommend radiation and chemotherapy as what is in the "best interest" of a patient. However, given the low success rate for that particular form of cancer and the side effects of treatment someone may reasonably choose to refuse treatment. While inconsistent with an objective medical decision, this decision is not inconsistent with the categorical imperative. That is, while Kant prohibits suicide there is not a prohibition against passive euthanasia. Therefore, in this case the "best interests" of the individual suffering with pancreatic cancer might be passive euthanasia.

Another example which is actually based on the experience of my friend's grandmother, who I will call Athena, further illustrates the error in assuming that the "best interest" standard is synonymous with an objective medical standard. Athena is an elderly Greek woman who has practiced vegetarianism for over 60 years. In her late eighties she has become the victim of Alzheimer disease and as such suffers from cognitive impairments. She no longer eats very well and as result has become anemic. The decision was made that in her "best interest" she should be fed iron rich meat products. Her family was not consulted about this decision. They were extremely disturbed to learn that their grandmother was being fed meat. Their annoyance with this decision was based on Athena's life long belief that it is morally wrong to kill animals.

Obviously, in this case as in the previous example the determination of what is in the "best interest" of Athena goes beyond a medical determination of the best medical treatment. Therefore, in order to address the sensible realm of subjective choice the oversight committee must include professional, religious, and gender diversity.

It should also be noted that the committee is responsible to make sure that in determining the "best interest" of the resident they do not cross the line between respecting the subjective choices of a resident and adopting a paternalistic approach. Admittedly, this can be a difficult responsibility but is a necessary responsibility if the end formulation of the categorical imperative is to be upheld.

Non-medical decision making also poses a problem for Kantian Meadows in terms of residents with limited rationality. In order to address this issue, Kantian Meadows will adopt the legal concept of the "reasonable person" standard.

Reasonable Person Standard

Unlike the "best interest" standard, which is utilized within the medical context, the "reasonable person" standard is used within the legal context to determine the justifiability of a defendant's actions. In other words, is a particular action one that a "reasonable person" would engage in? Within the context of Kantian Meadows the standard of a "reasonable person" will be employed in order to determine the reasonableness of non-medical subjective choices made by those residents who have limited autonomy. Such residents are those who lack the capacity for making medical decisions but have the ability to make choices in other areas. For example, the reader may recall the woman who chose not to wear her dentures. The job of the oversight committee is to apply the "reasonable person" standard in order to determine if her choice should be

respected over her daughters' objections. The necessity of committee diversity becomes clearer if we consider Kim Scheppele's (2004) discussion of the need for a "reasonable woman" standard in relation to the rape case Rusk v State (pp. 456-460). Scheppele argues, successfully I believe, that gender is a relevant factor in determining whether or not the victim consented to sexual intercourse. In this case Scheppele maintains that a "reasonable woman's" perception of the circumstances leads to a different decision than a "reasonable person" standard with a male bias. In other words, the victim's belief that her life was in danger is a reasonable belief from the perspective of the "reasonable woman" standard. Schepple's point is that historically the legal standard of a "reasonable person" has had a male bias. She argues that in the Rusk v State case the male perception of the circumstances were not necessarily the perception of a "reasonable woman." In other words, Schepple is suggesting that in rape cases the court should recognize that the criminal nature of a defendant's conduct is sometimes dependent upon the victim's point of view. Scheppele's suggestion of a "reasonable woman" standard has been applied by the courts in sexual harassment and assault cases.

My point in referring to Schepple's argument for a "reasonable woman" standard is to demonstrate the need for gender diversity as well as professional and religious diversity on the oversight committee. Admittedly, great difficulty is encountered in attempting to utilize any standard of substitute judgment. However, if Kantian Meadows is to keep its commitment to treat all residents as "if they were persons," a substitute standard must be adopted. Although the "reasonable person" standard is not infallible, combining it with diversity in the oversight committee at least provides a legitimate method for determining the reasonableness of subjective choices by those with

diminished rationality. In addition, if the oversight committee is to be effective, the scope of proxy consent must be restricted to its original intent.

Proxy Consent

In Chapter One I addressed the abuse of proxy consent that frequently occurs in the nursing home setting. That is, adult children who obtain proxy consent for their parents often use it to become dictators interfering and making decisions for every aspect of their parent's life. The original intent of medical proxy consent was for the person with proxy consent to stand in the place of someone who lacked the cognitive capacity to make their own medical decisions. At Kantian Meadows, we will honor that original intent and go one step further. The oversight committee at Kantian Meadows will also review proxy consent decisions in relation to medical decisions to ensure that those decisions are in the "best interest" of the resident. This characteristic of Kantian Meadows distinguishes it from other American nursing homes because in most cases the decision of the person with proxy consent is accepted without question. Again I would like to remind the reader that the function of the oversight committee is not paternalistic in nature, but rather its goal in this case is to treat non-rational human beings as "if they were persons." Therefore, an oversight of decisions made by the person with proxy consent is necessary in order to prevent the resident form being treated as a "mere means." The discussion of the justification for restricting proxy consent having been completed, I will turn my discussion to the function of the pharmacists on the oversight committee.

Pharmaceutical Justification

Many drugs used in the treatment of long term care residents may be used either to diminish or promote autonomy. For example, drugs like Haldol may be used to treat mental disorders but it can also cause confusion and hallucinations. Drugs like ativan, depending on the prescribed dosage, may have a mild tranquilizing affect or be used as a chemical restraint. In light of Kantian Meadows commitment to avert obstacles to autonomy, it will be the responsibility of the pharmacists to review the prescribed medications of all residents to ensure drugs are not being prescribed in order to chemically restrain residents.

In addition, the oversight pharmacists will be responsible to review resident prescriptions to guarantee that there is not the possibility of confusion induced by drug interaction. I have attempted to demonstrate why the particular configuration and qualifications of the oversight committee have been chosen, I will now turn the discussion to the issue of treating a resident as a "mere means."

Avoiding Treating a Resident as a "Mere Means"

As has been previously argued treating a person as a "mere means" results from deception, manipulation or coercion. Therefore, it is necessary to ensure that these practices do not occur at Kantian Meadows. I contend that Kantian Meadows has gone along way in ending family manipulation and coercion by restricting the use of proxy consent. Kantian Meadows will also need a policy to address verbal and financial abuse of residents by family members. This policy must clearly state what counts as abuse and reporting requirements. In addition to addressing the issue of family treating residents as "mere means," Kantian Meadows must examine its own policies and practices.

I believe that a lot of nursing home practices that result in treating a person as a "mere means" are the result of inadequate staffing. In other words, understaffing creates an environment in which residents are viewed as tasks to be completed in a timely manner. For example, the previously mentioned practice of waking a resident up during the middle of the night for a shower or bath. The residents chosen for these midnight baths are always those who either cannot speak or suffer from some form of dementia. If we apply the categorical imperative, i.e., are we using the person as a "mere means?" I believe the answer must be YES. That is the case because I do not believe than someone would willingly agree to the practice without being coerced or manipulated. Therefore, from a Kantian perspective the resident is being used as a "mere means." In light of this consideration, Kantian Meadows' staffing levels will be determined based on the acuity level of the residents rather than on state and federal minimum requirements. The difference is that under state guidelines a resident is entitled to so many hours of care per day. In Pennsylvania, for example, it is 2.3 hours of care per day. This level of staffing is determined in the following manner. The number of residents housed in a particular nursing home is divided by the number of staff in a twenty-four hour period. The resulting number must meet or exceed the state requirement. In practice this does at times equate to the following scenario. On a unit with 60 residents it is possible that 2 nursing assistants, one medication nurse, and one treatment nurse are left to provide all required care including feeding residents who are unable to feed themselves. Therefore, the dining room often resembles an assembly line in which one aide simultaneously feeds three or four residents. In light of Kantian Meadows commitment to the categorical imperative, our level of staffing will necessarily exceed state and federal staffing requirements.

Kant also prohibits lying. Alzheimer residents present a significant challenge to this aspect of the end formulation of the categorical imperative. I have personally agonized over this particular issue for some time. When I was a certified nursing assistant working on the Alzheimer's unit, I was instructed to orient the residents to reality. In other words, if a resident asks you, "Is the bus coming?" we were to answer truthfully. I often thought to myself that this was a ridiculous practice. The residents had their own reality and nothing I said could alter that fact. However, as I approach the issue from the perspective of this project, I believe that the answer is quite clear. In the case of Alzheimer residents, if we are to treat them "as if they were persons," we must answer them in a truthful manner. Admittedly, some residents will become upset at the truth. However, to avoid the truth in order to prevent them from becoming upset is to adopt a paternalistic position which is clearly a violation of the duties imposed upon us by the end formulation of the categorical imperative. Therefore, at Kantian Meadows our policy is to be truthful with all our residents.

Restraints both physical and chemical create another area in which the potential for treating residents as "mere means" exists. In order to avoid this problem, the oversight committee must be diligent in ensuring that no form of restraint is employed for the benefit or convenience of the staff. For example, it is not permissible to restrain a resident because they are annoying the staff. In recent years the use of restraints has been severely restricted due to the numerous deaths that have resulted from the use of physical restraints. At Kantian Meadows the use of any form of restraint will be extremely rare and only approved after a complete investigation by the oversight committee. The above examples illustrate only a few examples of possible treatment of residents as "mere

means." These examples are not in anyway intended to be exhaustive in terms of policies or practices that could result in the treatment of a resident as a "mere means." The last issue I wish to discuss is Kantian Meadows commitment to avert whenever possible obstacles to the possibility of autonomy.

Obstacles to the Possibility of Autonomous Action

In Chapter Three we discussed, the lack of subsistence, security, and privacy as potential obstacles to the possibility of autonomous action. Within the context of the nursing home malnutrition can be equated with the lack of subsistence. "This is no way to live. I wish I were dead and buried" (Burger, Kayser-Jones, & Bell, 2000). This is a quote from a 76 year old man who died weighing 69 pounds in contrast to his ideal weight of 150 ponds. A study of malnutrition and dehydration undertaken by Burger, Kayser-Jones, and Bell in 2000 found the following:

> Studies using a variety of measurements and performed over the last five to 10 years on different nursing home subgroups have shown that from 35 percent to 85 percent of U.S. nursing home residents are malnourished. Thirty to 50 percent are substandard in body weight (vii).

In their conclusions they listed the following as contributing factors:

> Structural factors within the nursing home setting that contribute to malnutrition and dehydration include lack of individualized care, inadequate staffing, high nurse aide turnover, and lack of professional supervision of aides (viii).

Again the issue of inadequate staffing plays a significant role not only in creating an environment with the potential for treating a resident as a "mere means," but also one

in which the obstacle of a lack of subsistence is present. In light of Kantian Meadows commitment to the end formulation of the categorical imperative and the empirical evidence that inadequate staffing is contrary to the duties imposed by the categorical imperative, Kantian Meadows, as previously stated, will adopt an alternative staffing policy.

In addition to the obstacles created by the lack of subsistence, the threat of physical abuse also creates an obstacle to the possibility of autonomous action. Most of the threats of physical abuse come from nursing home staff. In an attempt to avert that possibility, Kantian Meadows will adopt a strict hiring policy. All potential employees will under go a criminal background check similar to the background check implemented by the public school systems. In other words, the background check will include federal as well as state criminal background checks. There will also be a ZERO tolerance policy in place and any suspected abuse will result in immediate suspension until an investigation can be completed. Further, all suspected abuse will be handed over to the local police for investigation.

Finally, Kantian Meadows will address the need for individual privacy as a means of personhood enhancement. While HIPPA provides legal protection for privacy in regard to medical information, Kantian Meadows will provide privacy in other areas where possible for all its residents. For example, the practice of drawing curtains and knocking on doors before entering will be rigorously enforced.

Conclusion

The goal of this project has been to identify the need for nursing home reform in terms of the treatment of nursing home residents. In furtherance of that goal I have

argued for the following thesis: Nursing homes are unethical in the strong philosophical sense of the term because they erode autonomy, personhood, and human dignity and the end formulation of the Kantian categorical imperative can provide a theoretical framework for creating a just nursing home. To develop that thesis I have argued for six distinct but inter-related propositions.

To recapitulate: In Chapter One I developed Propositions One and Two. That is, I argued that the structure and characteristics of American nursing homes create the potential for the objectification of nursing home residents. I defined objectification in relation to Nussbaum's seven criteria: instrumentality, denial of autonomy, inertness, fungibility, violability, ownership, and denial of subjectivity. Next, based on an interdisciplinary literature review I argued that objectification is a moral evil.

In Chapter Two I developed Proposition Three. Based on a critical examination of the care perspective as a possible theoretical framework for a just nursing home, I found the care perspective lacking in its ability to protect personhood and dignity. That conclusion was based on three characteristics of the care perspective. First, it fosters paternalism. Second, it erroneously assumes that face-to-face relationships result in a caring relationship. Lastly, its abandonment of the language of rights undermines human dignity. Finally, I argued that the "end formulation" of the categorical imperative can provide such a theoretical framework for the creation of a just nursing home.

In Chapter Three, I developed Propositions Four and Five. That is, I argued based on an analogy with our indirect duty to refrain from cruelty to animals, that we have an indirect duty to treat non-rational human beings as if "they were persons." I then unpacked the "end formulation "of the categorical imperative to examine the duties it

imposes on us. I argued that not only do we have a duty not to treat persons as "mere means" but that we also have a duty to avert obstacles to the possibility of autonomous action. Therefore, a just nursing home has similar duties to its residents.

Finally, in Chapter Four I developed Proposition Six and created, in theory, Kantian Meadows; a nursing home dedicated to the ethical treatment of the elderly and grounded in the categorical imperative. One purpose of creating Kantian Meadows was an attempt to illustrate how a nursing committed to the ethical treatment of all its residents and grounded in the categorical imperative might be organized. Another purpose was to demonstrate the practical application of the categorical imperative in terms of what policies and procedures it might endorse and what policies and procedures it would necessarily reject. The policies and procedures I argued for were derived from the duties imposed upon us by the end formulation of the Kantian categorical imperative. I do not any claim that these suggestions are not without difficulty or that they are an exhaustive list of potential reforms. However, I do claim that a commitment to justice requires that we undertake such a reform. A reform which I will argue that must begin with a reassessment of our staffing requirement and a commitment to the ethical treatment of all nursing home residents. I believe that the fictional Kantian Meadows can provide a starting point for that reform. However, unfortunately it has been my experience that American nursing homes more closely resemble a General Motors assembly line than Kantian Meadows. From my perspective, this is problematic because human beings are not objects and therefore should never be treated as if they were objects.

BIBLIOGRAPHY

Adams, C. (1995). Child abuse, domestic violence, and animal abuse: linking the Circles of compassion for prevention and intervention. West Lafayette:Purdue Press.

Agich, G.J.(2003). Dependence and autonomy in old age: an ethical framework for Long-term care. Cambridge:university Press.

Agich, G.J. (1993). Autonomy and long-term care. Oxford University Press.

Allen, A. (1988). Uneasy access:privacy for women in a free society. Rowman & Littlefield.

Baier, A. (1987). Hume,the woman's moral theorist? In E. Kittay& D. Meyers (Eds), Women and moral theory (pp. 37-55). Rowman &Littlefield.

Barton, P.L.(2003). Understanding the u.s. health services system 2nd ed. Chicago: Health Administration Press.

Beck, L. W. (1963). Foreward. In L. Infield (Trans). Lectures on ethics. (pp. xi-xv). Cambridge: Hackett Publishing.

Bloustein, E. (1979). Individual and group privacy. Transaction Books.

Briggs, A. (1994). Because we love them. National Humane Education Society.

Burger, S., & Kayser-Jones, J., & Bell, J. (2000). Malnutrition and dehydration In nursing homes: Key issues in prevention and treatment. The Commonwealth Fund.

Cowart, D. (2000). In R. Munson (Ed.), Intervention and reflection: basic issues in medical ethics (pp. 378-381). Wadsworth.

DuBois, W.E. (1998). The souls of black folk. In R. Wolff (Ed), About philosophy (pp. 34-36). New Jeresey:Prentice Hall.

Feinberg, J. (1989). The nature and value of rights. In M. Winston (Ed, The philosophy Of human rights (pp. 61-74). Belmont:Wadsworth.

Gilligan, C. (1977). In a different voice. Cambridge: Harvard University Press.

Goffman, E. (1961). Asylums. New York: Doubleday.

Gould, J. S. Carrie buck's daughter. In T. Beauchamp & L. Walters (Eds), Contemporary issues in bioethics 5th ed (pp. 528-532). Wadsworth.

Hill, T. (2000). Servility and self-respect. In L. Pojman (Ed), The moral life (pp. 651 663). New York: Oxford Press.

Himmler, H. (2004). 1943 SS speech. In L. Pojman (Ed), The moral life 2nd ed. (pp. 96-97). New York: Oxford Press.

Jaggar, A. (2000). Feminist ethics: Some issues for the nineties. In R. Wolff, About Philosophy (pp. 192-194). New Jersey:Prentice Hall.

Kant, I. (1956). Groundwork of the metaphysics of morals (H.J. Patton, Trans.). New York: Harper.

Kant, I. (1963). Lectures on ethics (L. Infield, Trans.). Cambridge: Hackett.

Kant, I. (1998). Metaphysics of morals (M. Gregor, Trans.). Cambridge: University Press.

Kittay, E. F.,& Meyers, D. T. (1987). Women and moral theory. Rowman & Littlefield.

Kohlberg, L. (1981). Essays on moral development. San Francisco: Harper & Row.

Lindemann, H. (2004). An invitation to feminist ethics. New York: McGraw Hill.

Lidz, C., & Fuscher, L., & Arnold, R. (1992). The erosion of autonomy in long-term care. Oxford University Press.

Liffton, R. J. (1999). Sterilization and the nazi biomedical vision. In T. L. Beauchamp & L. Walters, (Eds). Contemporary issues in bioethics 5th ed (pp. 533-540). Wadsworth.

Michelfelder, D. P. (2004). Technological ethics in a different voice. In D. Kaplan, (Ed). Readings in the philosophy of technology (pp. 273-283). Rowman & Littfield.

Murphy, J. G. (1985). Punishment and rehabilitation. Belmont: Wadsworth.

Nussbaum, M. C. (1995). Objectification. Philosophy and Public Affairs, 24 (4), 249-291.

O' Neill, O. (1993). Ending world hunger. In T. Regan (Ed), Matters of life and death: New introductory essays in moral philosophy (pp. 235-275). New York: McGrawHill.

Raugust, M.C. (2000). Feminist ethics and workplace values. In R. Wolff, About Philosophy (pp. 194-199). New Jersey: Prentice Hall.

Reilly, P. (1999). Eugenic sterilization in the united states. In T. L. Beauchamp & L. Walters, (Eds). Contemporary issues in bioethics 5th ed (pp. 516-525). Wadsworth.

Robbins, S. P. (1992). Essentials of organizational behavior. New Jersey: Prentice Hall.

Scheppele, K. L. (2004). The reasonable woman. In J. Feinberg & J. Coleman (Eds), Philosophy of law 7th ed (pp. 456-460). Wadsworth.

Shue, H. (1989). Security and subsistence. In M. Winston (Ed), The philosophy of human rights(pp 152-171). Belmont: Wadsworth.

Veatch, R. M. (1986). Models for ethical medicine in a revolutionary age. In T. Mappes & J. Zembaty (Eds), Biomedical ethics (pp56-59). New York: McGrawHill.