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Global Warming: An Elder response

KEN TOUT

In recent days, especially at Copenhagen, much has been discussed and decided about mankind's reaction to the projected impact of global warming. For the octogenarian writer it is difficult to connect personally with issues anticipated for the years around 2050. At the same time there are moral and academic reasons for reviewing experiential lessons where these may apply to future cataclysmic events.

In some countries the new gospel of global destruction is being driven with such emphasis as to make it seem that the very worst, among many predictions, must be believed and that those predictions will be realised imminently. The worst scenario must indeed be taken into consideration but even that presupposes a period of reprieve during which humanity can act. In programme of action attention is necessarily being given to the impact of disaster on poorer countries, some of them in greatest perceived peril.

This brief study does not take up a stance on scientific details but can only respond to the more dire warnings, such as the following. After Copenhagen a representative of one of the most prominent international agencies involved is quoted as saying, "Already 300,000 people die each year because of the impact of climate change, most of them in developing countries" Many of such statements are focussed, quite properly, on child mortality postulated as related to global warming.

However, a question which this writer has rarely, if ever, heard amid the tumultuous debate is "what will be the impact on older people in less affluent areas if the predicted disintegration of present societies occurs ?" Some recent films and television epics have conceived world disaster as being total, universal and within a very brief time span, in one instance the entire event was depicted as compressed within the year 2010. Some over-zealous global warming predictions have tended to paint almost as immediate an image. Real future disaster is likely to be much more sporadic at first, moving on to increasing frequency and intensity.

The past delineates the future

It is possible to find paradigms for such future events in the wide variety of previous catastrophes, even though earlier human misfortunes may not have been related to carbon emissions and resultant global warming.

As this study is largely experiential in focus I would like briefly to describe three different types of disaster, varying in tempo and force, in which I was involved and where I was able to observe the pattern of elder impact and response. If, and as, the earth reacts to human triggered pressures as forecast, the actual local events of the future are likely to be very similar to those of the recorded past.

Firstly, in May of 1960 several hundred miles of southern Chile were devastated by earthquakes on two successive days which registered the highest mark ever recorded on the Richter scale, 9.6. A tsunami linked to the earthquakes rolled back across the Pacific Ocean and caused fatalities on the coast of Japan, 7,000 miles away. For three weeks the shocks and weather deterioration continued to cause devastation. Human casualties, although great, were relatively less terrible than in some other seismically lesser disasters which were concentrated on more densely populated areas.



I was involved in organising rescue and relief in the city of Valdivia. For some time the area was cut off from other parts of the country. The river had risen three meters with resultant floods. Vast gaps had appeared in the earth. One remarkable effect was that the quake had opened up the foundations of a bank some levels down from the ground, ripped open the reinforced steel safes and deposited fortunes in cash at the bottom of an inaccessible pit. The unanticipated second major shock had stalled immediate rescue work as the populace waited upon further disaster. Such an extent of disaster caused by human intervention in the climate may not be projected for the immediate future; but no doubt some proponents of the most serious global warming scenario may view it as a frequent future outcome to be considered.

Secondly, from the 1950s to the 1990s I was able to observe the changes in a rapidly industrialising capital city of a developing country. During all that time there was a relatively slow accretion of population from the hinterland. People deserted poverty stricken areas, where toil was heavy and unproductive. The bright lights of the city and the prospects of industrial fortune lured many. Over the entire period there was no dramatic major event linked to the migration drift. No sudden traumatic moments of great suffering or mass panic. Even the onset of disillusionment, renewed poverty and even more burdensome toil and living conditions followed the pattern of a slow, unmanageable tide as the city swelled from several hundred thousand to many more millions of inhabitants. In this scenario the lot of the elder was quite different to the immediate experience of the Valdivia earthquake.

Thirdly, to these two personal experiences there needs to be added another paradigm. This concerns an embattled frontier town between two warring nations. Evacuated and apparently uninhabited, the only visible figures are the combatants of the side holding sway at the moment and the occasional surviving stray domestic animal. In the Valdivia earthquake nature's wrath was random and indifferent. On one side of a particular street the houses remained standing with residents lurking cautiously in doorways. Across the street the earth had swallowed two storey buildings so deeply that the peaks of the roofs remained below the level of feet standing in the street. Deep down, the front of a greengrocer's shop was visible, in the window a pair of scales still held fruit ready to be weighed. However, in the war zone the damage was total, purposeful, and final. Apparently no dwelling space survived.

Some observers may assert that the second scenario, of population drift due to global warming, is already being experienced in areas like those affected by desertification around the Sahara. The next scenario would anticipate separate dramatic episodes like the 1960 Chilean disaster or more recent 2004 Asian tsunami and 2010 Haiti quake (Richter 10). A repetition of such events would lead on to the deserted war zone state of affairs. In each of the situations already detailed the impact on the elderly, and the elders' reaction to disaster, varied considerably.

Shock: elder reaction and inaction

In my observation of the 1960 Chilean disaster some of the results were surprising. The sudden, unanticipated and extraordinarily violent nature of the disaster did not always affect elderly people in a more traumatic way than the effect on younger people. Life experience was an important element in initial human reactions.

A fairly simple illustration of this was in older person's reaction to the very brief but unique noise which can immediately precede an earthquake. It has been described as the sound of an onrushing underground train where there is no underground railway. It is unmistakable once heard but the time lag between its first rumble and the physical shock is even faster than the arrival of an actual express train. In most areas major earthquake shocks may take place only every few years or at much longer periods. An older person is therefore more likely to have acquired the ability to recognise the first sounds than a younger person who may equate them with thunder or traffic or gunfire.

Effectively in 1960 I found that most older persons had been able to react quickly in instantaneous acts such as exacuating a building without pausing to collect belongings or even to dress properly. Such prompt reaction was often the difference between life on one hand and death or serious injury on the other. This holds true with reactions to other types of disaster as, for instance, quicker recognition of a change of tide appearance in the sea. Or more prompt interpretation of cloud formations.

Yes, the elder often reacted more quickly in the first instants of emergency but then the picture changed. Stamina began to count more than awareness. This factor was brilliantly illustrated in his lectures by the celebrated elder geriatrician Sir Fergurson Anderson in Glasgow. He would inform his students that 'if a fire broke out now in this hall, my life experience would alert me before you, and I would be first out of the hall. However, after ten or twenty metres you would all have overtaken me.'

As the earth As the earth began to buckle and break apart in the Valdivia earthquakes, as great voids opened up, as the air became suffocating with dust and as the swelling river flooded in, older people began to suffer the effects of slower reflexes, physical frailty, problems of balance, and the concomitant mental frustration as the physical faculties fail to respond to the mental calculations. From being immediate heralds of disaster they deteriorated into hapless dependents. There were, of course, exceptions to the general rule, both in older people with surprising physical strength as in others of lesser mental perception who were slow to notice the early signs of impending disaster.

The general rule remains: in an area where sudden and violent disaster can be forecast, the life experience of older people is of supreme value. The value of the older person in subsequent tasks of heavy labour and high risk rapidly diminishes. In the more recent 2004 tsunami episodes science and technology had only a minimal power to forecast and inform, but initially the experience of older people was of high value.

Slower incremental family disintegration

Passing on to the situation of a slow, incremental migration away from a potential disaster area, the assessment and prognosis are very different from the sudden, ultra-violent shock experience. In the case of the 1960, 2004 and similar seismic catastrophes there was no subsequent need for a mass migration away from the disaster area to a distant location. This meant that, to a large extent, entire multi-generational families could stay, rehabilitate and rebuild together. My second scenario had the opposite effect of separating the generations, with younger cohorts moving considerable distances, and often out of the home country altogether. Older persons tended to remain in the traditional hinterland. Often contact between generations was lost entirely.

One unforgettable instance of this concerned a great-grandmother called Gonzalez, to whom I was introduced in the shantytown fringes of a vast South American city. Having lost contact with all younger members of her family she had walked for three weeks to reach the city. She had been referred to a social worker, hoping to be reunited with "the Gonzalez family". Coming from a tiny mountain settlement, it was beyond the woman's comprehension that there were probably thousands of "Gonzalez families" in the big city. A simple story but reflecting the reality of mass migration.

Planners at various levels are already anticipating an increase in mass migration as global warming changes conditions of life in already hotter regions. In such a circumstances there will be many older persons like Sra Gonzalez who will become separated from the younger generations. Given the type of panic which might greet increasing incidence of disaster, the possibility of such separation by age groups must be contemplated.



The steady rural to urban flow (now sometimes urban to rural) is mitigated by continued access and improving travel opportunities.

However, studies have revealed that in such migrations a significant number of younger migrants tend to lose or loosen ties with the static elder group. The increase in visible income in an urban industrialized setting is also often offset by high costs of housing, energy supplies and Food, so that remittances to the parents or grandparents have to be limited.

Total desolation: total isolation

Another totally different outcome for elders is provided by my third scenario. War or other catastrophe has caused a large area to be totally evacuated. The evacuees may have been temporarily located in camps remote from the home scene. A quick examination suggests that the disaster zone has been totally depopulated. Frequently in such cases the initial perception is far from the truth. Even in the most horrific of situations older people may still be discovered clinging to their long term homes. Some may even find ways of hiding in order to avoid being forcibly moved away from familiar surroundings.

I have already mentioned how difficult it is for a present day octogenarian to relate to "Apocalypse 2050". In that era prescient authorities may well order a total evacuation of a locality due to an imminent global warming crisis. However, such evacuation may not be reinforced by fixed bayonets or blazing machine-guns as in the war zone scenario. The compulsion may be more gentle or haphazard. The percentage of older people determined to stay and die in the accustomed style, rather than rely too much on scientific calculations, is likely to be higher. Another factor at a certain age, or in a particular culture, may be a desire to be buried where one has lived rather, and among forefathers, rather than in some unknown grave far away from normality.

Templates available for action

These are all fairly simple concepts. The complicated question which arises is "what can be done, both short term and long term, to prepare for predicted events insofar as they affect older persons?" The general answer is that experiential scenarios, such as those above, can afford planners examples of methods and systems which can be adapted to the specific physical emergencies. Some distressing tasks, such as identification of victims and disposal of bodies, are routine and become complicated only when mass of demand exceeds ability to respond.

In respect of the 2004 tsunami the British Disasters Emergency committee estimated that, of the local professionals and skilled workers who could have best responded to rescue and rehabilitation demands, about one third had themselves been lost in the cataclysm. My references to 1960 events derive partly from the fact that for some time the town of Valdivia was partly cut of the rest of the world by floods and by unique climatic disturbances, the shocks affecting not only the land and the sea but also the air above. I remember trying to send an urgent list of requirement by military radio, but discovering that we were inaudible 500 miles away. Yet the radio call was picked up and answered clearly by a radio amateur in Los Angeles, three thousand miles distant. Nature does not always respond to human schedules and systems

In such enclosed events the local police are usually totally absorbed in immediate rescue and security work, including the sad but inevitable problem of criminal intervention. In Valdivia the immediate manpower resource was the local military regiment. Composed mainly of recently conscripted recruits it had no training or doctrine for earthquake relief. My role, as representing an experienced organisation, was to advise the

future. This inevitably focuses upon disadvantages and dangers and, in doing so, often fails to ask whether there are any positives in global warming. Especially when considering the impact upon the older population of the projected finality, it is appropriate to ask if there will be any benefits, though such may be temporary and local.

The 'snowbird' syndrome is well known in northern hemisphere countries which suffer extreme cold in winter. Many more affluent persons move to the warmer south during the severe winter months and then return home in the warmer spring. In this northern winter many more deaths occur among the elderly in the cold months. Being over 80 years of age I am personally entitled to a UK government grant of 400 pounds sterling for winter heating. This is not an act of national charity. It is because the 400 pounds grant, available to the entire upper age population, is less expensive than the costs to the national health and /other services of treating the additional load of winter illness and death caused if efficient heating is not accessible to older people.

It can be assumed that, for a considerable number of people in coldest areas of the great septentrional land masses, warming of the climate may mean less illness and greater longevity for the time being.

Similar temporary and local benefits may be found locally for agriculture and horticulture, both because of a warmer climate and also due to a greater volume of carbon dioxide. The warmer weather will mean greater production of certain crops in hitherto barren areas. Equally in certain cases the additional carbon dioxide will produce more fertile soil.

Whilst these restricted benefits may pale in relation to the great universal havoc projected, they may be the reality for persons of a certain age group during the interim of increasing meltdown. In a sense, positions may be reversed and the upper age group may be the least disadvantaged, physically and psychologically, in comparison with lower age groups.

And whereas the doctrine of ageing has hitherto focussed on the need for the younger to support the older, it could now be incumbent on the older to render services of knowledge, experience, perception and resolution to "our children and our children's children", to use the expression beloved of current orators.

Prioritizing priorities

For a star-gazer a recently emerged nova, burning menacingly, is of more interest than a dormant planet which has been accompanying mankind throughout history; and a sensational "world destruction" story of this kind has recently hit headlines. It is proper that the forecasts about global warming should be given due emphasis and circulation. However, some of the more lurid declarations of campaigners, such as "three days to save the world", before the Copenhagen conference, might lead to a distortion of priorities. Present realities might be obscured by future alarms.

A case in point is the horrifying predictions about the swine flu pandemic which have been published in many countries. In my own country official statistics reveal that during a recent period the fatalities due to swine flu have been only about 2 per cent of the total fatalities due to normal seasonal endemic flu of the common strains. Over the period the amount of attention given by the media and official bodies to the swine flu variety has varied inversely as the actual statistics. Did the more horrific prediction distract from the present peril?

When considering provision and care for older persons, there is a block of population which will be affected



RESPONDING TO DEPENDENCY IN OLD AGE

PHILIPPE PITAUD

In our modern societies while at the same time **ageing** problems start to be a mass of data integrated into modes of social management of the population it is **dependency** which is registered as a new problem concerning mainly the oldest persons. The data are very clear since 2% of men, and more especially women, are already over 85 years old, an age highly concerned with dependency.

Assumption of responsibility is from now on the agenda and demands a special training course for caring staff and volunteers to provide the elderly with reception facilities, house keeping and other help. Dependency is defined as the need for assistance to achieve the elementary acts of life. It is the duality between incapacity and need for help which stimulates the concept of dependency and not the strict incapacity. Dependency should not then be regarded as a fixed stage. We can speak about a process which is supposed to be accompanied, modified in its evolution, to be prevented and reduced in its expression by an adapted environment and services.

Dependency represents a loss of autonomy: One will note that for better apprehending this kind of situation, one will consider that a deterioration of performance concerning a few but fundamental aspects of human behaviour called 'roles of survival' indicates a situation of disadvantage. Two principal aspects can be used to identify affected persons. On one hand, we can find physical mobility and on the other hand, dependency on another person for the acts of everyday life such as feeding oneself, having a wash. One can add capacity to achieve the various activities concerned with domestic management (buying, house-care, preparation of meals) to make a person a participant in budgeting. Such qualities can contribute to the economical and social environment, necessary steps in the public services.

For the achievement of these various essential acts; the dependent person will call Spoil solidarity in the diversity of its expressions.

Debates about the management of dependency as experiments are currently in hand of those who raise the question of assistance provided by the family's network or by neighbours or friends. On this theme, various research in Europe shows in a very clear way, that users of domestic assistance or nursing care at home have almost a network of assistance, whereas people living in institutions in this situation are very few. By network, one means the existence near the old person of people able to help him daily (meals, moving around, administrative steps) or very regularly.

Thus research- works carried out by the Social Gerontology Institute Marseilles (University of Provence) indicate that 89% of people not benefiting from services, have around them a natural network of solidarity (family, neighbourhood) which intervenes either very regularly, or less often but according to the needs. In such a context, and even if help is not massive, there is always an attentive and vigilant presence. In addition, one will recall that many old people live for years in their current housing and developed a number of social relations. In this way, we can speak about solidarities and family help from conceptual and practical considerations.

In this more specific concern and especially in the Mediterranean areas according to FACCHINI's research works (1933), hypotheses have been made for a long time about the growing solitude of elderly people (PITAUD -2005), and what amounts to 'dumping' by their families.

In recent years however various research studies have strongly modified this view, which by now seems a 'commonplace'. Although they may live alone, elderly people generally seem to be part of the networks of solidarity and family interaction. In the Mediterranean area and especially in southern Europe, this inclusion seems even more marked than in any other industrialized countries of Northern Europe and North America. (PITAUD2005 and 2006). We have recorded that "A first important datum to be underlined is that only about 3 to 4% of elderly persons live in institutions; this datum is even more significant if it is considered that this level is basically identical to that recorded in the fifties, despite the appearance of two factors which ought to have induced an increase. The first factor is that, also in countries of southern Europe, the ageing process recorded in this century has been characterized by a specific increase of 'aged personae', that is people over 75 years, who are more exposed to the risks of deterioration of their psycho-physical conditions and reduced self- sufficiency, and thus more exposed to the necessity of being institutionalized.

The second factor lies in the strong change in family typologies. In the fifties, extended families, (those in which besides the nucleus of the married couple and children there were also their relations such as grand parents, aunts and uncles, etc. making up 20% of all families, whereas, today they are now more than 20%. Here, it must be underlined that the majority of these nuclei is composed of elderly women, often widows. Therefore, despite what may be defined as the ageing of the elderly population and despite the fact that the process of nuclearization taking place in Mediterranean families has resulted in the majority of elderly people living alone (either as singles or making up an elderly couple), no strong movement towards use of institutions or residential structures has taken place. The great majority of elderly people continue to live in their own home or in that of their family. Thus we have to speak of the family as a strong hold. The family or rather a family of elderly people represents the fundamental structure for Support in care and help, forming in fact the most consistent barrier against institutionalization. If compared to the past, therefore, family support has not failed, two basic changes however have taken place which have important repercussions on the personal characteristics of the people involved in the caring relation.

The first change may be synthesized as the expression of 'verticalization' of these relations, the second with 'feminization'. Verticalization of relations is a consequence of the demographic changes recorded during the twentieth century. There are two elements which we are concerned with emphasizing here: the first is the decrease of the number of siblings - brothers and sisters; the second is the lengthening of the average life-span and the consequent co-presence, on the Emily scene of several generations (if three generations are now normal, there are also frequent cases of four and, moreover, although very rare, even cases of five generations).

This is to say that in the past, in the extended family with which relationships were kept up, it was possible to count for help and solidarity, made up of brothers and sisters and their new families, whereas nowadays the extended family with whom affectively significant relations are kept up and within which help and support is exchanged, is increasingly constituted by different generations who do not live together.

With a play of words, we may say that whereas in the past it was a 'large' family, now the extended Jollily is 'long'. And it is this lengthening which reminds us of the term we have used, 'verticalization' of the family and of the network of affection and support connected with it. But this verticalization has an important corollary concerning the persons involved in the caring relation. Those receiving help tend to be increasingly 'very' aged persons (over 80 years), as the persons who give help tend to be people of 50-60 years. In the past as Li re were more sons and daughters, looking after their parents involved only a lesser number. (One

out of four or five, the others were in various ways exempted). At present, however, the smaller number of offspring means that almost all children have to look after their parents or partners in law.

The second aspect to be pointed out concerns the 'feminization' of the caring relation. There is no doubt that women have always been central in the relationship network and in the caring relation, in our countries at least. As a consequence of division of tasks and roles within the family, they have historically been entrusted with the tasks of support and assistance. However, it may be argued that today a feminization of the persons cared for changes into further feminization of the carers.

As FACCHINI (1994) says, first and foremost we speak of feminization of persons cared for in that, in all western countries, women on average live several years longer than men; consequently, among elderly people, women are much more numerous than men. Secondly, there are specifically female pathologies, such as arthritis, osteoporosis, which tend to limit or make difficult the movements of the persons affected and often involve the need for some kind of support

This brings us back, of course, to services and their continuity; to families in their demand for services and/or the recruitment of a third person in order to satisfy needs generated by the appearance of dependency with advanced age. (PITAUD, DHERBEY – 1996, PITAUD 1995)

In a wider context, we would like to add that today it is necessary to develop a partnership between all formal and informal actors in the field of solidarity. This requires a change in attitudes and education in solidarity which is the key to the problem (GUILLEMARD - 1986)

Faced with the need to limit the growth of its expenditures, the state in developed countries continues to diversify the ways in which it intervenes. For this purpose it develops various forms of mixed economy and delegates a public service role to private agents. Thus, in terms of local economic development, contractual partnerships and partnership play an increasingly important part.

In this dynamic of state disengagement, we perceive a willingness to reduce costs starting from the idea of a civil society which would take wider responsibility for its own members, with, in the background, an idea of substitution. Here 'civil society' refers to anything which is not organised by public authority.

This raises the central problem of dialogue and indeed interaction between the formal and informal sectors in the support and care of the elderly. Moreover, we have to consider the exchanges between two references, one from Northern or Anglo-Saxon societies and one from Southern countries. We have, here, to take into consideration each cultural specificity which defines and structures the relationship....

We have here to take into consideration each cultural specificity which defines and structures the relationship of each human being to the environment. (MONTANL, PITAUD - 2006)

In this dynamic of finding the best way between Home and Institution, we have to consider solidarity as a result of a philosophy of life, a way of living which enables us to give meaning to our life. (PITAUD - 2007)

The family and neighbourhood providing resources are one way of preparing the future of our societies. This implies new forms of help to helpers and in this sector much has to be done especially in southern Europe and the Mediterranean area.



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PORTRAYAL OF THE ELDERLY IN INDIAN MEDIA

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At the Second United Nations World Assembly on Ageing (Madrid, Spain, April, 2002), the World Health Organization maintains, "It is time for a new paradigm, one that views older people as active participants in an age-integrated society and as active contributors as well as beneficiaries of development". This paradigm takes an intergenerational approach that recognizes the importance of relationships and support among and between family members and generations. It reinforces "A society for all ages" - the central focus of the United Nations International Year of Older Persons—1999.

The government of India along with civil society organisations is working towards realisation of the goals of 'active ageing and intergenerational solidarity', the spirit of which is also reflected in its National Policy on Older Persons (1999). However, cultural values and traditions determine, to a large extent, how a given society views older people and the ageing process, which may or may not be in consonance with the policy level vision and mission. Culture is a key factor that determines portrayal of individuals groups, and communities. This, in turn, influences social interactions and role and resource allocations towards people belonging to certain social groups. This is also true in the case of the elderly.

Mass media

Having said this, sociologists like Max Weber have considered media of mass communication as a barometer to measure 'cultural temperature' of a society. Undoubtedly, mass media play a crucial role in defining our cultural contours that also include conceptions of aging and roles expected from older persons. Mass media, through their various organs and with their cast of characters, provide an almost inescapable set of messages about aging and serve as one of the major sources for age-role socialization and re-socialization in the society. Thus, media are among the most important players in inculcating, amending, modifying and changing our attitudes, perceptions, values and reinforcing the stereotyped images.

Media and the elderly

Based on the image portrayed by the mass media, people tend to form an opinion, more often than not, unconsciously. Image is a contingent factor in role allocation and expectations vis-avis the elderly who are in a transition phase as their traditional roles and associated status are fading away and not satisfactorily replaced by newer role expectations. Added to this, role expectations would have a direct impact on resource allocation. If a huge section of the population (more than eight percent of elderly persons of the total population in India at present and in the next two decades, almost double the existing proportion) would be considered dependent; a spentforce, relying on scarce resources of the nation. It would reinforce ageism and negative stereotypes, perceptions and prejudices against senior citizens. This means wastage of a huge human resource potential.



Review of literature

Gantz, Gartenberg, and Rainbow (2001) note that, in four German networks, older people were heavily under-represented, especially women and those of advanced old age. Signorielli (2004) finds that Prime-time network programmes broadcast between 1993 and 2002 under-represent elderly characters. O'Hallaren (1977) finds that television, in the mid-70s, has portrayed senior citizens as “ugly, toothless, sexless, incontinent, senile, confused and helpless” thereby concluding that old age has been so negatively stereotyped that it has become something to dread and feel threatened by. Even a study almost a decade later by Dalloff (1987) brings out the 'distorted image' projected by mass media that enhance negative stereotypes. Tupper (1995) analyses that the depiction of ageing Americans in prime time television advertisements adds to their vulnerability.

Literature review brings out that most of the studies are concentrated in America and western countries. There is indeed a dearth of Indian studies in this area. Since cultural context matters a lot, the results of the above studies may not be generalised to Indian society where the socio-cultural situation of the elderly is, undoubtedly, different from their counterparts in America and other European countries.

Study Objectives

In this context, the present study was carried out with the aim to examine the image of the elderly as depicted by mass media in India. Mass media for the purpose of the study were limited to print media (newspapers and magazines), electronic media, that is, television (advertisements and serials) and Cinema (Hindi Bollywood movies). The study looked into the footage and coverage in terms of proportion of time/space given to the elderly in mass media. It also analyzed the contents of the mass media in terms of roles played, ageism remarks, stereotypes and prejudices vis-a-vis senior citizens.

Findings

Print media

In the data from, print media, the study examined the contents of 416 newspapers, two English and two Hindi newspapers for three and half months (from 16th January to 30th April 2009). Data show that the **proportion of articles on the elderly is 0.84 percent** of the total of articles on various social issues in the newspapers. English newspapers were slightly better in coverage than Hindi ones. Likewise, 44 issues of two magazines (one English and one Hindi) analysed in the study contained 506 articles and the **proportion of articles on the elderly was 0.19 percent**. Further findings show that about 65 percent of the total words/phrases in newspapers taken out for analysis indicate vulnerability of elderly persons and merely 23 percent denote positive aspects of old age (and the rest were neutral).

Space distribution of news items and articles in the newspapers shows that articles reflecting positive dimensions of ageing and old age are more frequently placed in the supplements of the main papers. Research, analytical and information based articles are in the mid pages. In the magazines, the treatment of the sole article on dementia was unbalanced and highly skewed—95 percent of the article reinforced the vulnerability of the elderly, through discussion on statistics, financial implications, and care-giving burdens. Only five percent of space of the entire write up mentioned prevention and management.

Summary of findings of print media:

- Gross under-representation of elderly as a population group.
- It amounts to ignorance of the issues and concerns of senior citizens in the country.
- Elderly women taken as a subset of the elderly, as a vulnerable group and not presented as having a separate identity with differential needs and problems.
- Print media tend to omit and ignore positive dimensions of old age.

Implications:

To a common being, newspapers are meant to provide updates on socio-political happenings in the country and the world. Psychologists maintain that newspapers are important socialising agents and tell people what issues are significant for the progress and development of the society and for them as individuals. In fact, print media set priorities for readers, and provide guidance and directions to their thinking (Agenda-setting function of the Press). Printed words are taken as pure truth by most readers who do not generally pay attention to the contextualization of the news and information.

Having said this, the findings (under-representation of elderly) imply to the public that people in old age do not play any important role in society or national development. They have played their innings and are now a spent-force. Nominal visibility of concerns of senior citizens in the print media gives the impression that elderly issues are insignificant for policy makers and planners. Further, stress on reporting of vulnerability dimensions of the aged makes the readers believe that old age is associated with victimisation to crime and abuse. The public may regard that health, social and economic vulnerabilities are natural and hence common in old age.

Gross under-representation of elderly women in the print media makes them non-existent in the minds of readers. The Press tends to merge elderly women's issues in a broader category of “senior citizens”, thereby ignoring their differential needs and problems. As a result, readers assume elderly to be a homogeneous community and that issues and concerns of the elderly women are same as those of elderly men. No separate identity is given to aged women. Nevertheless, print media highlight the positive side of the elderly too — active ageing, legislations concerning them and their rights and empowerment. However, there is a need to project this positive side more frequently.

Television

In the data set two, television, advertisements, tele-soaps and discussions/special features in news channels were analyzed for representation of elderly.

Advertisements

Out of the frame of 304 advertisements, **16.7 percent commercials have featured elderly persons**. Further, the elderly most frequently (35 percent) featured in commercials marketing for food items, followed by infrastructural or household items (27 percent) and insurance (16 percent). Elderly people featuring in health



and medical facilities are merely four percent. Nearly two-thirds of the advertisements have elderly persons in lead role. Four-fifths of the products marketed by the elderly are of common use and only one-fifth cater to needs and interests of senior citizens. Next, out of the total 82 elderly characters in 48 advertisements—only 28 percent were females and 72 percent males. Thus, elderly **women constitute not even one-third of the elderly appearances** in the advertisements. In the case of elderly in lead role this proportion of female aged is reduced further to 20 percent. This shows that elderly males are portrayed four times more frequently than older women in commercials with lead role. Elderly women are grossly under-represented in the advertisements.

Advertisements have more often shown the elderly engaged in modern activities like playing cricket/cards with friends, basting at sea beach and having picnic with friends. The proportion of elderly appearing in modern activities is more than three times that seen performing traditional or conventional activities. Findings further show that the majority of the advertisements, nearly 32 percent, project old age as a period of enjoyment, relaxation and freedom from responsibilities while only four percent depict vulnerabilities of the age. Looking at the portrayal of the elderly, a little less than a half of the advertisements represent senior citizens as witty, humorous, crazy and jubilant while others are physically powerful, caring and concerned, elegant and smart.

Summary of findings of television commercials:

- Over-representation of the elderly as a population group but aged women are under-represented.
- Most of the advertisements portraying elderly persons are marketing products independent of age specificities.
- The elderly are generally portrayed engaged in modern activities.
- Aged people are more often projected as cheerful, witty, crazy and delightful.

Implications:

The portrayals of characters subtly facilitate our minds, not only towards the product being marketed but also in developing attitudes and images towards various social groups. In this context, findings suggest that the elderly are projected as important members of the Indian family, who are in consonance with our traditional values and norms. It is heartening to note that senior citizens are generally represented as jovial, joyful, witty, intelligent, graceful, confident and very well integrated in the social fabric. Such images not only give a positive dimension of old age but, at times, the younger may envy older person attributes, activities, behaviours and appearances. In the commercials, old age is taken as a golden age, in which the elderly are free from social responsibilities, tensions and hustle-bustle of daily life. They are having an important niche in the family and bond well with all family members. This portrayal of positive aspects of old age definitely, may be subtly, break the popular myths of equating old age with social, economic and health vulnerabilities and facilitates cohesive intergenerational bonds.

Tele-soaps

In the study, content analysis of representation of the elderly in ten daily soaps was done. Findings show that elderly form 28 percent of the total main characters in the serials. Also, the proportion of elderly males

and females is equal (1:1). Almost two-thirds of the elderly are represented as married whereas 13 percent elderly males and 23 percent elderly females are projected as widower/widow. Findings on age show that elderly males are more frequently depicted as young-old or in their sixties, whereas more females are presented as octogenarians. Results show that 72 percent elderly were in traditional attire, which includes all the widowed elderly.

In the study, most often elderly people were seen engaging in traditional activities like saying prayers and supervising or doing household activities. Looking at occupational status, almost all the elderly women, except one, are projected as non-workers/housewives. Older males were more often projected as economic beings as compared to their women counterparts. Coming to socio-economic status, in the serials no elderly persons were projected as poor. The elite class was most prominent followed by those belonging to middle class.

Study results show that generally the serials have portrayed the elderly as dominant. Aged females were conformist and compromising. Both older males and females are depicted as manipulative and aggressive. Findings further show that all the elderly were projected as Head of the household and decision-makers in the family or as persons capable of influencing decisions. Their insistence on adherence to traditional values is clearly depicted. Many of the elderly are also shown as affectionate, loving and caring. None of the older characters are seen as vulnerable or gullible.

Summery of findings of television soaps:

- Over-representation of the elderly as a population group, with equal proportions of males: and females.
- Typically, the elderly in tele-soaps are married and in traditional attire.
- Older males are in their sixties and females octogenarians.
- Elderly males are economic beings while females are non-workers. They largely belong to an elite class.
- The elderly are decision makers, often head the family and are dominant, aggressive, at times, manipulative. They hold high regard for their traditional value system. They have an important niche in the family and generally have amicable interactions with family members.

Implications:

Television is a powerful and ubiquitous organ of mass media that is influencing its audience in myriad of ways. Appearance, roles and behaviours of the elderly shape mental images of older persons as among the audience telling them what to expect from aged persons and how to behave with them, what roles do they play in the family and society. Based on these images? younger people develop their perception about old age. In the serials, the elderly occupy a vital role in the functioning of the family. They are depicted as Head of the household and crucial decisionmakers, which indeed may facilitate their integration in family and society. However, their projection as dominant and aggressive may hamper younger people's attempts for cordial intergenerational relations. In fact, tele-soaps are not producing any typified image of the the elderly.

They are depicted in diverse shades—as friends and also as conspirers. A more humanistic perspective is shown as far as depiction of the elderly is concerned.



Cinema

In data set three, fifteen movies were analysed for depiction of the elderly in cinematic materials. Results show that many movies, now-a-days focus on a diverse range of elderly issues. The elderly comprised **43 percent of the main characters in the movie**. Older males are more than double the proportion of elderly females in the cinema. Further, **30 percent of the elderly occupied central characters in the movie storyline but none among them were female**. Aged women more often are seen in supporting roles or minor roles.

In the study of cinematic material, 54 percent of the elderly were depicted as married (in the beginning of the story) and the rest were widowed/unmarried/unspecified. Also, 86 percent of them were in traditional attire. Data on occupational status show that elderly males were retired or in business/service and females were mostly housewives. The elderly in cinema are predominantly in middle/upper middle class.

Coming to health vulnerability, the elderly, in the movies, were seen suffering from many physical and mental ailments—high blood pressure, arthritis, diabetes, cancer, Alzheimer's disease. Deteriorating body strength and cropping up of ailments were portrayed and considered a natural part of old age. As a corollary, medication and restrictions on foods for aged people appear in the movies.

Occurrences of elderly abuse (perceived and actual) are depicted in the movies. Life of older persons in old age homes was also mirrored in the cinema. Relationships between inmates in old age homes were more often characterised by friendship, fulfilling elderly people's psychological needs of support and companionship.

In some movies, the elderly are depicted as emotional, romantic beings who come in conflict with social expectations and their personal desires. Retirement, in cinema, is shaded with desires of relaxation and enjoyment of life with no burdens of responsibilities and shattering of these desires due to hostile behaviours of the children of older persons.

Cinematic material under study has shown congruent as well as incongruent relationships of elderly with their sons and also patching up after initial conflicts. Romantic relationships (outside marriage) of elderly are discouraged in movies. In movies, the elderly persons are seen struggling for searching aims or purpose in life, particularly those who lose their relationship with children. The psychological relevance of reminiscence for elderly people is highlighted in cinematic materials. Losing zest is taken as one of the characteristics of old age. On the contrary, reduced expectations, attitudinal adjustments, financial management and enthusiasm in life are reflected as sutras of happy ageing. Older people are shown as having strength of character, fighting for the human values and resilience.

Summary of findings of Cinema:

- Gender stereotypes are stronger than age-based stereotypes.
- Mental strength is independent of age.
- Psychological self at times over-rules social-self.
- From power equation perspective, the elderly lose out in social relations.
- Social construction of the elderly is largely defined by the young who describe socially expected behaviours of the elderly.
- Reduced expectations, change in perception, financial management, findings of newer roles and aims in life would go a long way to bring happiness and well-being in old age.

Implications:

Indian cinema, one of the salient socialising agents, has implied reinforcement of gendered stereotypes. Makers of films have been innovative and creative in showing older males beyond the boundaries of the stereotypes but not in the case of females. This gives a myopic view to the public of socially expected and accepted roles and boundaries of elderly women. Further, Indian cinema depicts health vulnerabilities in terms of ailments, medication, reduction in stamina and strength, changed food habits, and death as usual aspects of old age.

It clearly omits the other side of the picture—active and healthy ageing, the elderly as healthy, strong and full of energy. This is likely to substantiate negative stereotypes of the elderly in society.

CONCLUSIONS:

To conclude, no uni-dimensional, clear cut, definitive image of the elderly emerged from the analysis of various data sets. Newspapers have portrayed vulnerability dimensions of the elderly while the advertisements depicted them as healthful, cheerful, jovial and lively. Television serials have highlighted their traditional ascribed authority even in contemporary times whereas the cinema brought to light various social and psychological challenges faced by ageing people and their resilience and ability to overcome age related tests.

SUGGESTIONS:

As advertising, cinema, news and tele-soaps play a bigger role in the socialisation of youth, the images of the elderly that they see as children will be the images that they reproduce as adults. Based on the findings of the study certain suggestive measures may well be delineated that would indeed facilitate positive and favourable image construction.

- In the light of the study results, it may be put forward that elderly issues need to be highlighted more frequently in the newspapers and magazines. Print media should not preoccupy itself with excess highlighting of vulnerabilities of old age and representing elderly as susceptible, dependent, miserable human beings. Initiatives and strategies for happy ageing as well as noteworthy case studies depicting positive side of old age should be presented at least in equal proportions.
- Results have shown that elderly women have been in double jeopardy—one that they are under-represented and two, that their images are fixated in gender stereotypes. Elderly women should be given a fair chance of representation in advertisements. Aged females are shown more frequently in stereotyped manner in terms of their activities, attire, occupation, roles and behaviours. These images need to be challenged. There is a need to present older persons in varied economic activities, especially women so that traditional myths associated with elderly women as non-workers (and not as retired) and elderly men as spent-force may be shed away. This would help the younger generation to synthesise image of the elderly with capabilities and strengths and not merely with vulnerabilities.
- * Data bring out that in television serials, the elderly are more often reflected in negative contours—as dominant, aggressive, rigid, authoritarian, conformist and sometimes manipulative. The positive side (as companion, friend, flexible, understanding) of an older person finds less footage and coverage. Care should be taken to avoid undue stress on the negative shades of personality among the elderly.
- * Gerontologists and social scientists need to keep a vigil on the “social construction” of old age by the mass media and should take proper action if any negative stereotypes are perpetually displayed.



* There is a need for extensive research work in this area, to examine images and stereotypes, conceptions and social constructions about old age and older people in a larger context so that findings could be generalised.

The mass media has great potential to influence our attitudes and behaviours. It can be used as a powerful advocacy tool to dispel the myths of helplessness and vulnerabilities that surround old people and to encourage images of empowered, self-reliant, happy, contented elderly people and thereby becoming an active stakeholder in ensuring realisation of the goals of “active ageing and intergenerational solidarity ” put forth by the United Nations.

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BIOPSYCHOSOCIAL and END-OF-LIFE CARE: Timely Intervention for the Elderly

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ABSTRACT

End-of-Life decisions are not only about palliation and advanced directives. The biopsychosocial model is a paradigm which helps identify the psychological and social factors and barriers which help towards a realistic balance towards the end of life. Spirituality in particular, is not merely religious practices and the presence of pastoral care, but is about achieving balance, harmony and meaning. New models can help for the elderly in extending the concept of palliative care at the very end of terminal diseases to more chronic and disabling conditions which affect the outcome. Physicians are not trained to hear stories and narratives and often fail to elicit many of the patient's nonmedical concerns. Indeed many question the legitimacy of the physicians' role as being guides for patients. Yet changes in medicine are reflecting a progress in addressing holistic approaches and a shift of incorporating care into cure, if indeed to cure is also to care. Whilst for many physicians an illness may be a routine incident in a daily round, to the patient it is a crisis in life; for many a crisis of meaning. To help patients transcend this suffering in the realm of old age, a metamorphosis of a doctor from a 'doer to helper. There is much to be argued in favour of not confusing end-of-life with mere aging. We usually speak about end-of-life when a typical case as discussed in the beginning of the article presents itself. Even in such circumstances one can postpone end-of-life decisions as palliative care until such time as is needed 'biologically'. Aspects of the biopsychosocial model, spirituality and healing, and a Timely and Longitudinal (TLC) model are discussed.

End-of-Life decisions are not only about palliation and advanced directives. The biopsychosocial model is a paradigm which helps identify the psychological and social factors and barriers which help towards a realistic balance towards the end of life. Spirituality in particular, is not merely religious practices and the presence of pastoral care, but is about achieving balance, harmony and meaning. New models can help for the elderly in extending the concept of palliative care at the very end of terminal diseases to more chronic and disabling conditions which affect the outcome. Moreover one should not consider end-of-life decision based merely on age, but in the case of the elderly palliation and other biopsychosocial decisions which would otherwise be-directed only in terminal illness, need to be considered earlier.

Biopsychosocial model

The biopsychosocial (BPA) model had been described as a paradigm in the philosophy of family practice and is quite acceptable in curricula and methodology today (McWhinney 1997). However when it comes to end of life, there is considerable discussion of 'healing' and other psychosocial issues such as spirituality, that it is quite appropriate to use this paradigm also within the hospital and/or hospice setting. It may also be the case that for the elderly especially the buck stops within the realm of family practice. Of all health care professionals it is the primary care physician who is best situated to assist the elderly patient and is ideally suited to take into consideration intrinsic factors such as illness and extrinsic factors such as family concerns and wishes and indeed the settings of care and financial considerations (Taler & Waymach. 1989). Whilst death is an impending inevitability it is recognized that obtaining consent can be a problem (Rikkert et al. 1996).



The first difficulty in many cases is what amount of information to tell the patient. Families may frequently be against the concept giving bad news to their elderly parents. Whilst this is often a first reaction to protect their loved ones from emotion burden, there are instances where it is entrenched in different ideals. The concept of truth telling has centred around Western ethics, but may vary with different cultures (Crane, M., Wittink, M. 2005). Searight and Gafford (2005) list four primary reasons for nondisclosure: Certain cultures which view discussion of serious illness as disrespectful

- Certain cultures which view open discussion of serious illness as provoking depression or anxiety which the patient can do without
- Cultures which view that disclosure may eliminate hope, and
- Cultures which assert that speaking or alluding to serious illness can indeed bring about death or bring about terminal illness because of the power of the spoken word.

They point out literature that indicates that many Asian cultures, for example, perceive it as unnecessarily cruel to directly inform a patient of a cancer diagnosis, and that even amongst European Cultures, such disclosure is disrespectful and inhumane. The authors quote this amongst Bosnian-American and Italian-American immigrants and moreover noticed that Bosnian immigrant doctors 'go around' a diagnosis. When considering truth telling, the Western assertion that many patients actually want to be told the truth, has to be balanced against the harm to health which may be caused by someone who is already suffering pain and now is given an emotional burden. It would be interesting to have a comparative study of attitudes of patients and doctors in different European countries, singling out Europe since it is usually classified as Western when it comes to discussion of ethical values.

The Biological

Much End-of-life decisions and discussions have to do with the 'biological', such as Advance Directives and extraordinary treatment. However very few Americans, for example, have Advance Directives (Crane & Wittink, 2005) and it is presumed here that the number decreases in Europe and even more in other continents. It is appropriate therefore to discuss the wishes of the patient in advance and where the patient lacks decision-making capacity, to discuss these issues with family members (Lang & Quill, 2004). The ethical, legal, familial and communication issues are complex. Without legal guidance, Lang & quill note that the most frequent hierarchy used in the United States is the spouse, then the adult children, and then the parents. Of course physicians are guided to encourage the persons acting on behalf of patients to act in their best interests, especially acting upon what the patients would have wished, or what they thought they would have wished. It has been shown that this not only decreases feelings of guilt afterwards should difficult decisions be taken but discourages family members to make decisions based upon their personal values alone (Ibid., p. 720).

Lang & Quill recommend that the family are made to appreciate the clinical situation and the prognosis and be prepared to provide support if the expectations are higher than the situation allows. Questions such as 'Do you want to have everything done for your (parent)?' should be avoided and everyone would presumably want the best done for a loved one (Ibid., p. 721). These should be substituted by a discussion of the differences and expectations of whether everything should be done for comfort or for survival. Often families feel undecided about feeding and hydration as they fear that the patient is being deprived and induced into feeling thirst or greater distress. It should be helpful to discuss that interest in food decreases towards the end and that medical observation has shown that artificial nutrition often increases the patient's awareness of discomfort and distress rather than allowing one to fall gradually into a coma; therefore stopping of feeding

can indeed decrease distress (Ibid., p. 721). Discussing 'how to decide' is therefore important to be done before discussing 'what to be done'. One should establish how and by whom decision are to be taken, making it clear that there is also a difference between a 'substituted judgement' and a decision in 'the best interests of the patient'. Substituted judgments can be laden with values of who is making the decision. Lang & Quill also note that it is important to recognize, that when one is faced with an Advance Directive, a decision not to be put on a respirator or some other form of artificial treatment, may have been referring to a particular circumstance, such as a massive cerebral haemorrhage and may not have meant to apply to all situations.

Many families appreciate their physicians' input and advice and may indeed seem to be relinquishing their autonomy. It should be understood that if the physician has understood and listened to all concerned and has shared his or her opinion, following the physician's recommendation is another form of exercising one's autonomy as, once information and good communication has occurred, it is on a voluntary basis that one chooses to act under the influence of someone deemed to be more competent in such choices (Beauchamp & Childress, 1994).

Reichel (1999) points out that family practice as a specialty has a great deal to contribute to end-of-life care and it is strategically placed and indeed family physicians are numerous enough to provide such care. He quotes Byock (1997) who spoke of 'dying well', 'living while dying', and 'physician-assisted living', so as to change our attitudes of death to one of being a time of 'love and reconciliation, and a time of transcendence of suffering'.

Psychosocial

Celler et al (2004) suggest that a multidisciplinary research study designed to monitor changes in simple measures as mobility, sleep patterns, washing and toilet facilities, utilization of cooking etc can bring about timely and cost-effective intervention of medical and community based services. But whilst even family physicians can help dying patients and their families to focus on pain management and increased home care, increased advance directives etc., the frequency of the latter proved unlikely to improve the care of the dying patient and that the support of better communication and more comprehensive health care planning legislative frameworks can help the family physician facilitate this process (Reichel 1999). In this regard it is interesting to note studies which show that patients desire even spiritual discussions with their physicians and that patients felt that physician inquiry about spirituality or religious beliefs is appropriate. In a study to determine the appropriateness of physician enquiry into these areas, and the reasons why patients would wish their physicians to know about their spiritual beliefs and indeed what they would wish for their physicians to do with such information, (McCord et al, 2004) found that patients do indeed desire these discussion and that 13% up to 73% of patients (from out-patient studies) want physicians to have knowledge of their spiritual or religious beliefs but that these discussion were indeed rare. Amongst the problems which physicians raise for this include departing from traditional medical agendas, lack of spiritual training, and whether it is ethical to have physicians as pastoral counselors. There is also the possibility of doing harm, time constraints and invasion of privacy issues and also in determining which patients would want to talk. The study was intended to help physicians with these issues. It showed, amongst other points, that many patients want this sort of discussion so that:

- The doctor can understand how one's beliefs influence one's decisions
- The doctor can better understand the patient



- The doctor can provide compassion
- The doctor can refer to a spiritual advisor if necessary.

The percentage of those welcoming the inquiry increased with the severity of the illness. The authors thus argue that strict scientific approaches overlook the importance of the meaning of life and hope to patients' well-being. They indicate that their sample was overrepresentative of white population and better educated women. The study also found that those over 60 years were more likely to participate in the study than those between 30-64 years of age, observing that this group were usually significantly sicker, which is why they refused to participate. This may have implications for elderly who are ill and in their management of this problem.

Spirituality in Health Management?

In a qualitative analysis, Daaleman et al (2008) concluded that clinicians and other health professionals consider spiritual care at the end-of-life as a series of interpersonal process in the context of human values and experiences, rather than a prescribed role. It is more a recognition of "human value, dignity, and shared decision-making, rather than through shared practice (ie, prayer), or through discussions of religious or theological issues at the bedside." Daaleman and Frey (2004) also tested a useful research tool (the Spirituality Index of Well-Being (SIWB)), and found it to be a valid and reliable instrument, that can be used in health-related quality-of-life studies.

The distinction between spirituality and religiosity is made. Daaleman, Perera & Studenski (2004) found that religious practices are much associated with functional status in the elderly and that "geriatric out-patients who report greater spirituality, but not greater religiosity, are more likely to appraise their health as good". They acknowledge that religion and spirituality are important psychosocial factors in the lives of elderly, but distinguish that religiosity is viewed as the various organized, individual, and attitudes of various religious traditions. These are usually traditional practices. Spirituality is the expression of meaning and purpose (as discussed in this paper). Religious service attendance is significantly associated with functional status which accounts for the variation in reported health status. Elders with greater religiosity were less likely to report good health status than those with greater spirituality. However race, physical functioning and quality of life can all affect religious practice (Ibid.).

Healing

If one focuses on the phase of life when one is elderly as part of an approach towards an end-of-life process, one should perhaps concentrate on a process of 'healing', as there often is no cure for ailments which afflict the elderly population, such as decreased mobility due to arthritis and neurological conditions such as Parkinson's, and cardiac and respiratory condition, etc. If helplessness is one of the unpleasant experiences which induces suffering, this must not be overlooked in the elderly and therefore in the management by physicians and health care workers and their understanding of suffering and healing. Hsu et al. (2008) studied various groups, including patients, nurses and primary care physicians, in focus groups in a qualitative analysis. They found that healing is a multidimensional process which involves physical, emotional and spiritual dimensions. The key 'themes' were that:

- Healing is multidimensional and holistic
- Healing is a process (or a journey)
- The goal of healing is recovery or restoration
- Healing requires the person to reach a personal balance and acceptance
- Relationships are essential to healing.

This implies that if physicians show a lack of capacity for empathy, communication, and relationship, then they are not in a good position to contribute to healing (Ibid.) The authors understood that their basic assumption that many people would expect healing to come from within the realm of alternative and / or spiritual practices, to be false, implying of course that participation of the healing process is part of the phenomenon and expectation of the doctor-patient relationship.

Hsu et al showed that physicians do understand that a lot of the healing process occurs without their intervention. They usually function not as agents but as facilitators. Many people which form meaningful relationships can therefore participate in the process of healing. Also, healing is a dynamic process of recovering from trauma or illness. In this regard, the process is achieved by 'working towards realistic goals, restoring function and regaining a personal sense of balance and peace'. As facilitators, a key component imparted by clinicians and staff in the clinical setting is a feeling or caring, connection and warmth (Ibid.).The importance of 'time' was emphasized and that therefore the time the physician or carer spends with the person is essential; whilst patients expressed that it is the quality of time rather than quantity that is important. Professionals' own experiences of healing indeed facilitated the process. Conversely it was simply the absence of positive facilitators that provided the mayor barriers to an effective healing process. A negative encounter even at a front desk was described as having a negative effect on the overall healing process whilst in the clinic setting. However both patients and physicians emphasized that a mayor barrier can be the patients themselves and that they therefore bear the central responsibility for healing.

In the study, few participants spoke of faith healing and divine intervention, but more of a wholeness of mind, body and spirit, notwithstanding that in much literature spirituality is central to the healing process. Also participant focused less on suffering and more on restoration of function, (which can have important implications for the elderly population). In this study participants were mostly white, and spoke about relationships with primary care physicians. They were generally described as being more educated and less religious than in many regions. However the research raises fundamental questions about the goals of health care and medicine.

Conversely, Egnew (2005) interviewed renowned authors in the field of goals of medicine and palliation. These included Eric, J. Cassell, Elisabeth Kubler-Ross, and Dame Cicely Saunders amongst others. In these interviews, the premise was that healing in a holistic sense has faded from medical attention and is rarely discussed in medical literature. Indeed the nursing literature reflects increasing concern with healing and it is pointed out that the fact that medicine has no accepted definition of holistic healing is a 'curiosity', and that if healing is a core function of medicine, then exploration of its symbolic meaning compels more organized research into the phenomenon. The definition of the above three interviewees all included the concept of 'wholeness', whilst others related to a state of mind and other spiritual experiences such as harmony between mind, body and spirit. Egnew notes that the term healing is derived from the root haelem, and a condition of being in hag which means wholeness. To heal is therefore to make 'sound or whole', and therefore defining the process of healing as one involving a search for wholeness is indeed well-founded. 'III persons undergo transformation in which they are unable to be he persons they once were. This threat to wholeness generates suffering and involves the physical, social, psychological, and spiritual dimension of personhood. . . Suffering is an inherently unpleasant experience reflecting perception of helplessness'. One cannot help note how this definition would encompass many elderly people who have also underwent this transformation.

Timely, Longitudinal and Collaborative care

Jerant et al. (2004) have identified five fundamental problems with current palliative care, which are discussed briefly here. They write in the context of extending our normal definitions of palliative care for terminal



disease and incorporate it in an earlier phase of life, which can thus be adopted for use in the elderly population, who may suffer from chronic and disabling disease. The first problem they identify with current palliative care for elderly is thus that it is considered a terminal event rather than a longitudinal process. This could be an unintended consequence of hospices and hospice movements who defer palliative care to when the patient is expected to die soon. But older patients typically have more chronic and slowly progressive illness with multiple acute episodes, but which nevertheless can cost considerable distress. The result, they argue, is a missed opportunity for the use of palliative care as well as late referrals to hospices. Whilst admitting elderly to hospices at an early stage may not however be the main objective of hospices, the authors are right in not allowing such a term to be the exclusive field of the final stages of a terminal illness. A model for palliation in the elderly can easily be adopted in homes for the elderly and indeed in community care.

The second problem identified is that palliative care is defined within causal and symptom/sign-specific realm. They argue that palliative care is often defined therefore within a 'false dichotomy' of symptom and disease. Whilst it is true that this argument holds to the extent that palliative care starts late in the disease process, it is only arguably true that once it has started, it is. Nevertheless the definition of when to start palliative care is indeed dependent on the disease progress. Extended palliative care to the elderly would thus mean looking beyond such a definition of when to start and consider starting earlier. The authors submit that only treatment intent distinguishes palliative care from normal treatment which is usually oriented to saving life and preventing death. In palliative care it is mainly symptom relief and less for extending life. Taking a decision to start this form of treatment earlier thus can have considerable quality of life implications for elderly with chronic and disabling conditions. One needs to contend that this is not necessarily strictly true for medical treatment, whilst it is definitely true for the psychosocial element. Take, for example, treating conditions which require increasing use of opioids. In the terminally ill one is not necessarily concerned with addiction and invocation of the principle of double effect is legitimate; i.e. bringing about the death when the intention was intending palliation. Would this be legitimate in treating severely disabling conditions like arthritis, or would this be considered a form of euthanasia. One may contend that unless one is to use such strong medicines earlier, then palliative treatment already occurs, for treating arthritis, for example one does not necessarily intend prolongation or saving of life.

Thirdly, the authors argue that the decision to authorize and focus on palliative care is not usually explicitly negotiated but is a decision taken by health care teams. They argue that although there is a tacit negotiation between physicians, patients and family members, the negotiation should be more explicit. They present a linear relationship between the amount of palliative care and time. As time moves along, there is more change of a tacit agreement to shift curative to palliative care. More explicit agreements may shift this linear relationship to the left and bring about choices to negotiate palliation earlier on. Fourthly, it seems to the authors that when it comes to respecting the autonomy of patients in treatment choices, we tend to concentrate more on curative options; that is, when we are not yet in the palliative stage. Thus asking patients whether they want invasive and advanced forms of treatment when there is no chance of survival may not be the appropriate approach to elderly either and allowing people to come to terms with their illness trajectory may allow for a better quality of life oriented approach and to a palliative care rather than life-saving care.

Finally, palliative care occurs outside the usual processes. There come a point when one decides to stop normal curative treatment and 'shift' to palliative care. The authors suggest a more integrated process for 'palliative care delivery to become an integral part of daily clinical practice, and to facilitate deeper, less hurried, longitudinal palliative care dialogues'. The key here is the longitudinal process rather than an immediate (transverse) change from one form of therapy to another.

The TLC (Timely/Team, Longitudinal, & Collaborative/Comprehensive) model which the authors present



is based therefore on bringing in palliative care earlier, with an evolving balance (longitudinal) of curative vs palliative and more collaboratively. This model helps significantly with the case discussed in the beginning. If we start with 'collaborative', the concept of truth telling becomes something which the family dialogue can negotiate more effectively rather than seeing truth-telling merely from a Westernized 'rights' approach. This allows for more cultural input, giving this ethical concept a more 'comprehensive' twist. Naturally the 'team' approach would include the family as part of the team but any necessary input on patients' rights and the advantages thereof may be brought in without undue pressure by the physicians themselves. A more timely introduction of palliation of course intends it to be earlier and in good time, whilst at the same time not intending that the transition is directly from a curative to a palliative but a gradual 'longitudinal' one.

Studies are of course necessary to assess outcomes and satisfaction by bringing in palliative care earlier and gradually. There are however good moral arguments from a patient-dignity point of view. Death is not seen as something to fight, and treatment of cancer becomes something to deal with plaintively as well. But it also means that realistic goals are given to family and patients alike accepting the inevitability of death and that everything is (being) done' for these goals, rather than for (often unrealistic) goals of trying to cure an illness. Admittedly the latter seems to give the perception of allowing more hope to patients. But we know that such hope is false and deceptive and is given only charitably because of our fears of causing distress. We have seen however that truth telling is something that must be negotiated as well rather than imposed. One does not necessarily need to invoke a right and it is the responsibility of the care-giver to find the weight the patient attaches to this right. Conversely it should be noted that studies do show that, when asked whether palliative care referral was done 'too late' or not, relatives of patients of young patients were less likely to say that referral was 'too late', and moreover respondents of deceased who suffered from chronic condition such as obstructive lung disease as well as respondents with higher education were more likely to believe that the hospice referral was late as well (Williams. 2008). It is also recognized that most specialties are treating an increasing number of elderly and that there are managements decisions beyond simple diagnosis and treatment to make the ethical and legal issues of elderly very important (Vassallo 2004), especially in the management of dementia.

Conversely timely discussion with relatives can bring about less stress to the carers. Robinson & Thurnher (1979) had shown that deterioration in family relationships can begin early especially with a parent's mental impairment. Providing adult children with better awareness of mental impairment circumvents this problem. Confinement of the adult children also contributed to stress. Confinement can mean also the infringement on life-style which the care of the parent brings about. A comprehensive approach would contribute to a better understanding of how the illness/aged person interacts with the family to bring about better outcomes in choice of (timely) available resources.

Conclusion

There is much to be argued in favour of not confusing end-of-life with mere aging. We usually speak about end-of-life when a typical case as discussed in the beginning of the article presents itself. Even in such circumstances one can postpone end-of-life decisions such as palliative care until such time as is needed 'biologically'. One needs to ask how such models affect the case scenarios; for if one is to change a paradigm of action, it will need to be considered in every case.

Physicians are not trained to hear stories and narratives and often fail to elicit many of the patient's non-medical concerns. Indeed many question the legitimacy of the physicians' role as being guides for patients. Yet changes in medicine are reflecting a progress in addressing holistic approaches and a shift of incorporating care into cure, if indeed to cure is also to care. Whilst for many physicians an illness may be a routine



incident in a daily round, to the patient it is a crises in life; for many a crises of meaning. To help patients transcend this suffering in the realm of old age, a metamorphosis of a doctor from a 'doer to helper' and from an expert problem solver and fixer to a companion (Egnew, 2009) is necessary in the bag of clinical skills needed to manage a growing population of chronically ill patients, many of whom are indeed our elderly population. A shift in the timing, administration and comprehensiveness of palliative care plus a participation in the psychosocial aspects and importance of wholeness and healing can have improved outcomes on end-of-life approaches to the elderly population. Certainly this may fit well into the philosophy of family medicine.

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that ageism dehumanises individuals into stereotypes and a move away from the medical model to view ageing as a continuum of life needs to be made.

In an exercise in analysing the range of issues related to ageing and human resource development Khan (Chapter S) remarks on the lack of a culturally appropriate vulnerability index for the elderly (p. 194) and the need for lifelong education about ageing and retirement preparation in order to maintain role identity and prepare family expectations. In this way Khan believes that the nuclear family can retain some traditional family values in spite of urbanisation creating psychological as well as physical distance. The valid suggestion is made for better utilisation of resources through self-help groups with formal institutional support providing a framework for training, advocacy and collaborative efforts on best practice.

The final two chapters by Bhatia, and Rajan and Prasad, compare the social security structures available in the informal and formal working sectors. While the formal sector accounting for some 10% of workers made up predominantly of civi of more than 20 employees provide an established pension, the pressure of early retirement coupled with increasing longevity place pressure on this system, making it potentially unsustainable. The growing informal sector, apart from insecurity of tenure, unskilled work and low income, is beset by a dearth of data and lack of policies; "fewer than 5% of this group are consciously preparing for retirement" (p. 241). The National Old Age Pension Scheme introduced in 1995 (p.272) pays on average RS200 (equivalent to around US\$4.3) per month and only reaches a small proportion of those who would be entitled (p. 272), however budgetary constraints and arcane bureaucracy prevent more widespread distribution resulting in lack of equity across different sectors of society.

"Status of Ageing in India: Challenges and Opportunities" is described by Cherian as a "maiden academic venture" by HelpAge India (p. v.). Edited by Nair, it sets out to address the literary gap on ageing in India, and far from considering itself to be prescriptive, it is looked upon by all involved as a starting point for future discussion and research. Giving a sorry portrayal of older adults in India as powerless and disenfranchised and widowhood as an economic calamity each chapter raises several issues of relevance to legislators, policy makers and researchers, and of course to older adults themselves.

However, several of the contributing authors recognise that the elderly must take responsibility for their future and sustainable positive change in the way the elderly are viewed cannot occur without the input and active contribution of the elderly themselves. Many of the chapters are rich in statistics, giving scientific basis to the issues raised. A number of tables and diagrams also give a visual depiction of the examples being used, enhancing comprehension, and all chapters are very well referenced. The book works hard at providing much needed data for open debate and future research, and in doing so focuses entirely on the unique cultural context of India. It would be exciting for future research to make more links with ageing theory, thus setting the issue within a global perspective.

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INIA'S ACTIVITIES 2010



- 1st - 9th May 2010 Training programme in Malta for Officials from the Social Welfare Centre, Ministry of Civil Affairs, China (SWC) and from the Support and Nursing Committee for the Elderly (SNCE).
- 15th - 16th July 2010 South East Asian Conference on Ageing 2020, "Improving Well being in Later Life" Holiday Inn Melaka, Malacca, Malaysia.
- 18th - 24th July 2010 Training programme in Social, Medical & Economic Issues of AGEing in collaboration with the Institute of Gerontology, University Putra Malaysia, Selangor, Malaysia.
- 26th July - 3rd August 2010 Eleventh ASEAN Gerontology Course, Singapore.
- 1st Oct 2010 - 1st June 2011 International **Post Graduate Diploma** in Gerontology and Geriatrics (European Centre for Gerontology, University of Malta)
- 11th - 22nd October 2010 International Training Programme in **Policy FORMULATION, PLANNING, IMPLEMENTATION AND MONITORING OF THE MADRID INTERNATIONAL PLAN OF ACTION ON AGEING.**
- 24th - 30th October 2010 Second Training Programme on "Strategies for Population Ageing" in collaboration with the Guangdong Research Centre on Public Affairs for the Elderly (GRCPAE).
- 1st - 7th November 2010 Training programme for Officials from the Beijing Civil Affairs Bureau (BCAB), Jingmin Hotel, Beijing, China.
- 8th - 14th November 2010 Training Programme for Officials from the Social Welfare Centre, Ministry of Civil Affairs, China (SWC) and from the Support and Nursing Committee for the Elderly (SNCE), ZhongMin Plaza, Beijing, China.
- 29th Nov - 10th Dec 2010 International Training Programme in **DEMOGRAPHIC ASPECTS OF POPULATION AGEING, POLICIES AND ITS IMPLICATIONS FOR SOCIO-ECONOMIC**, Policies and Plans.

MERCK INSTITUTE FELLOWSHIPS



The International Institute on Ageing, United Nations – Malta has received a grant from the Merck Institute of Ageing and Health, Washington D. C. for Training Programmes, which are held in Malta. for 2 participants in the 9-month Postgraduate Diploma Course in Gerontology and Geriatrics at the European Centre for Gerontology, University of Malta.

Applications for the above Fellowships will be received by Professor Joseph Troisi, Director of the International Institute on Ageing, United Nations – Malta, 117, St. Paul Street, Valletta VLT 1216, Malta.

The closing date of applications can be obtained from the Institute's website, www.inia.org.mt.

