DOLENTIUM HOMINUM

No. 67 – Year XXIII – No. 1, 2008

JOURNAL OF THE PONTIFICAL COUNCIL
FOR HEALTH CARE WORKERS
(FOR HEALTH PASTORAL CARE)

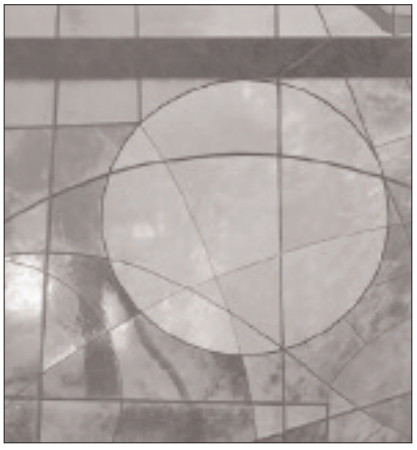
Proceedings of the XXII International Conference

Organised by
the Pontifical Council
for Health Care Workers

The Pastoral Care of Sick Elderly People

November 15-16-17, 2007

New Synod Hall
Vatican City



Editorial and Business Offices:
Pontifical Council for Health Care Workers (for Health Pastoral Care)
Vatican City; Tel. 06-6988-3138, 06-6988-4720, 06-6988-4799, Fax: 06-6988-3139
www.healthpastoral.org - e-mail: **opersanit@hlthwork.va**

Published three times a year. Subscription rate: 32 € postage included

Printed by Editrice VELAR, Gorle (BG)

Cover: Glass window Rev. Costantino Ruggeri

Poste Italiane s.p.a. Spedizione in Abbonamento Postale - D.L. 353/2003 (conv. In L. 27/02/2004 n° 46) art. 1, comma 2, DCB Roma

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The illustrations in this edition are taken from the book:
Chile, Panamericana 5
by Davide Pianezze
2006 Editrice Velar

ADDRESS OF HOMAGE TO THE HOLY FATHER

Most Blessed Father,

We thank you for your benevolence in receiving us on the occasion of our twenty-second international conference on pastoral care for sick elderly people.

As is by now traditional, we have addressed this important subject in order to direct this form of pastoral care so that it can be more efficacious throughout the Church. This direction seeks to be the one that Your Holiness gives us and of which our study is an explanation and a dissemination. Thus we draw near, with attention and devotion, to hearing your directives, Holy Father, so that the Church can implement in a more effective way this task that is decisive for the history of each one of us, namely to be accompanied by Christ, the Good Shepherd, during the last steps of our existence, in particular when illnesses, including terminal ones, knock at our door.

In our study, after an introduction on the Eucharist understood as Viaticum and as the best form of pastoral care for sick elderly people, we reflected scientifically on the reality of sick elderly people; through pastoral theology we tried to find a deepening of the subject in the Word of God on the pastoral care that we should provide to these elderly people; lastly, we sought practical ways by which to respond more adequately to this very important pastoral task.

Most Blessed Father, I have the honour of presenting you with the forty experts, from twenty-one different countries from four continents, who, with qualified expertise, decidedly offered a significant contribution to our endeavour. The six hundred people taking part in this international conference, from sixty-six countries, who are present here full of joy to see you, to listen to you in filial fashion as our infallible guide and to devotedly receive your blessing, also greet you.

Once again we thank you, Holy Father, and we assure you that we will faithfully follow all the indications that you wish to give us,

His Em. Cardinal JAVIER LOZANO BARRAGÁN,
President of the Pontifical Council for Health Care Workers, the Holy See

ADDRESS OF HIS HOLINESS BENEDICT XVI

Your Eminence,
Venerable Brothers in the Episcopate
and in the Priesthood,
Dear Brothers and Sisters,

I am pleased to meet you on the occasion of this International Conference organized by the Pontifical Council for Health Pastoral Care. I address my cordial greeting to each of you, which goes in the first place to Cardinal Javier Lozano Barragán, with sentiments of gratitude for the kind expressions he addressed to me in the name of all. With him I greet the Secretary and the other members of the Pontifical Council, the distinguished persons present and all those who are taking part in this meeting to reflect together on the theme of the pastoral care of the aged sick. This is a central aspect of pastoral health care today, which, thanks to the increase in life span, concerns an ever greater population who have multiple needs, but at the same time indubitable human and spiritual resources.

If it is true that human life in every phase is worthy of the maximum respect, in some sense it is even more so when it is marked by age and sickness. Old age constitutes the last step of our earthly pilgrimage, which has distinct phases, each with its own lights and shadows. One may ask: does a human being who moves toward a rather precarious condition due to age and sickness still have a reason to exist? Why continue to defend life when the challenge of illness becomes dramatic, and why not instead accept euthanasia as a liberation? Is it possible to live illness as a human experience to accept with patience and courage?

The person called to accompany the aged sick must confront these questions, especially when there seems to be no possibility of healing. Today's efficiency mentality often tends to marginalize our suffering brothers and sisters, as if they were only a "weight" and "a problem" for society. The person with a sense of human dignity knows that they are to respect and sustain them while they face serious difficulties linked to their condition. Indeed, recourse to the use of palliative care when necessary is correct, which, even though it cannot heal, can relieve the pain caused by illness. Alongside the indispensable clinical treatment, however, it is always necessary to show a concrete capacity to love, because the sick need understanding, comfort and constant encouragement and accompaniment. The elderly in particular must be helped to travel in a mindful and human way on the last stretch of earthly existence in order to prepare serenely for death, which – we Christians know – is a passage toward the embrace of the Heavenly Father, full of tenderness and mercy.

I would like to add that this necessary pastoral solicitude for the aged sick cannot fail to involve families, too. Generally, it is best to do what is possible so that the families themselves accept them and assume the duty with thankful affection, so that the aged sick can pass the final period of their life in their home and prepare for death in a warm family environment. Even when it would become necessary to be admitted to a health-care structure, it is important that the patient's bonds with his loved ones and with his own environment are not broken. In the most difficult moments of sickness, sustained by pastoral care, the patient is to be encouraged to find the strength to face his hard trial in prayer and with the comfort of the sacraments. He is to be surrounded by brethren in the faith who are ready to listen and to share his sentiments. Tru-

ly, this is the true objective of "pastoral" care for the aged, especially when they are sick, and more so if gravely sick.

On many occasions, my Venerable Predecessor John Paul II, who especially during his sickness offered an exemplary testimony of faith and courage, exhorted scientists and doctors to undertake research to prevent and treat illnesses linked to old age without ever ceding to the temptation to have recourse to practices that shorten the life of the aged and sick, practices that would turn out to be, in fact, forms of euthanasia. May scientists, researchers, doctors, nurses, as well as politicians, administrative and pastoral workers never forget that the temptation of euthanasia appears as "one of the more alarming symptoms of the "culture of death', which is advancing above all in prosperous societies" (*Evangelium Vitae,* n. 64)! Man's life is a gift of God that we are all called to guard always. This duty also belongs to health-care workers, whose specific mission is to be "ministers of life" in all its phases, particularly in those marked by fragility connected with infirmity. A general commitment is needed so that human life is respected, not only in Catholic hospitals, but in every treatment facility.

It is faith in Christ that enlightens Christians regarding sickness and the condition of the aged person, as in every other event and phase of existence. Jesus, dying on the Cross, gave human suffering a transcendent value and meaning. Faced with suffering and sickness, believers are invited to remain calm because nothing, not even death, can separate us from the love of Christ. In him and with him it is possible to face and overcome every physical and spiritual trial and to experience, exactly in the moment of greatest weakness, the fruits of Redemption. The Risen Lord manifests himself to those who believe in him as the *Living One* who transforms human existence, giving even sickness and death a salvific sense.

Dear brothers and sisters, while I invoke upon each one of you and your daily work the maternal protection of Mary, *Salus infirmorum,* and of the Saints who have spent their lives at the service of the sick, I exhort you to always work to spread the "Gospel of life". With these sentiments, I warmly impart the Apostolic Blessing, willingly extending it to your loved ones, co-workers and particularly to aged patients.

BENEDICT XVI

The Pastoral Care of Sick Elderly People

PROLUSION

thursday
15
november

JAVIER LOZANO BARRAGÁN

Pastoral Care for Sick Elderly People

The principal from of pastoral care that can be offered to sick elderly people is that of giving life back to them. This may appear to be something that is rather difficult but such is not the case if we locate ourselves in the field of faith and if in this splendid reality we strive to find the best way possible of providing sick elderly people with the best care possible, that is to say to impart to them the Eucharist in the form of Viaticum. This will not only be a psychological consolation but the highest reality which will give sick elderly people the fullness of life.

If one is speaking about pastoral care for sick elderly people it is logical to think of palliative care. Here we are dealing with therapies which in fact do not treat the sick person but, rather, tend to reduce his or her pain so that he or she will suffer less and – something that is even more important – so that he or she will be able to live in the best ways possible the most important of his or her earthly existence – death. With palliative care a sick person prepares himself or herself in the most aware way possible for this great step. It often happens that the intensity of pain does not allow space for a serene approach in which the necessary dominance of self for the moment of death is obtained.

We know that palliative cures take many forms – physical, psychological, family, social and spiritual. All of these are necessary but in this paper I will address only spiritual palliative cures.

Spiritual palliative cures are not only mere palliative cures but go beyond them, that is to say they not only mitigate pain but transform it into happiness. Christian palliative cures realise the paradox of transforming illness and death into a source of life. Through them one reaches the apex of life in which all the vital wishes of the person are met.

These wonders are actuated in a special way through the sacraments of the Church, in particular through the sacrament of the anointing of the sick and the sacrament of the Eucharist received as Viaticum.

After a brief reflection on the sacrament of the anointing of the sick, I will concentrate on a number of reflections on the Viaticum since in the Eucharist received as Viaticum the wonder of achieving the paradox that death is life and happiness is achieved to the full. After briefly listing doctrinal points with reference to the Second Vatican Council, my paper will be based on three points: the Viaticum as life, the Viaticum as communion and the Viaticum as eternity.

Seeing the Eucharist as definitive health is something which in some contexts that are overly secularised has fallen into disuse. Many people have made it be believed that to call a priest for the anointing of the sick and to bring the Viaticum is equivalent to calling the undertakers. People are very much afraid of death and obviously also of what its drawing near could mean. However, a question necessarily here poses itself: is the Viaticum really the prologue to the darkness of death? Is this something that wounds the sensibility of the man of today? What is the Eucharist received as Viaticum? Is this a lugubrious subject that worsens the already deteriorated health of a terminally-ill person?

One of the first recommendations of Pope Benedict XVI was not to forget the Second Vatican Council since its richness was such that such richness could not in the least be held to be finished.

Following this pathway, and in order to answer these questions (and others like them), it seems to me advisable to engage in a small reflection on three paragraphs taken from two Constitutions of the Second Vatican Council, namely *Sacrosantum Concilium* and *Lumen Gentium*.

With regard to the sacrament of the anointing of the sick, the Dogmatic Constitution on the Church tells us (n. 11) ‘By the sacred anointing of the sick and the prayer of her priests the whole Church commends the sick to the suffering and glorified Lord, asking that He may lighten their suffering and save them;[1] she exhorts them, moreover, to contribute to the welfare of the whole people of God by associating themselves freely with the passion and death of Christ. In the same Constitution and the same section we read: ‘In participating in the Eucharistic sacrifice, a source at the summit of the whole Christian life, they offer to God the divine Victim and with him themselves…The concretely demonstrate the unity of the People of God, which by this sacrament is adequately expressed and admirably achieved’.[2]

In the Constitution on the Sacred Liturgy it is observed that ‘We learn from the same Apostle that we must always bear about in our body the

dying of Jesus, so that the life also of Jesus may be made manifest in our bodily frame[3]. This is why we ask the Lord in the sacrifice of the Mass that, "receiving the offering of the spiritual victim, "he may fashion us for himself" as an eternal gift"'.[4]

As regards the central argument of the analysis that I am seeking to expound I would like to be allowed to begin with what I will call the contemporaneousness of the Eucharistic mandate received from Christ himself – 'do this in memory of me'. In every Eucharist our concrete time and the time of all centuries is inserted into the culminating event of history, in which everything reaches its apex – the Last Supper, the death and the resurrection of the Lord, or to be more explicit, all of the meaning on the mystery of the Incarnation in its wholeness, as established by the eternal decree of the Father, hidden prior to all the centuries, until the eternal presence of Christ at the right hand of the Father.

Following this pathway, I will try to outline certain ideas connected with the vitality, the communion and the eternity that the Viaticum represents for those who receive it.

1. Life

The Viaticum is the summit of life. The Eucharist is the total source of life because it is the contemporary presence of the whole of the mystery of Christ. This is re-creation: the new creature. In the Eucharist we are participants in the 'medicine' of immortality; however in the Viaticum, on the threshold of death, the contemporaneousness of death with the fullness of life occurs; medicine is received to defeat death with the highest irruption of life.

Our death is death as an end but through the Viaticum it is no longer an end but, rather, from being a tomb, it is transformed into a cradle, into authentic birth.

Christ on the cross abandoned himself to the hands of the Father and consigned to him his Spirit, and this sacrifice of Love, the Spirit, is the force with which the Father converted the death of Christ into a source of life, raising him from the dead. Our self-abandonment to the Father at the final moment, as an embrace of total love in the Spirit, is an embrace with the arms of Christ nailed on the cross. With Christ, in the Viaticum, our mortal embrace becomes the immortality of resurrection. Christ spoke about his hour as the hour of his glorification and in the same way the Viaticum makes our last hour the hour of our glorification.

In the Viaticum our death is joined to the death of Christ, thereby making up for what was lacking in the passion of Christ for the salvation of the world. The highest event of our existence reaches this summit when we find ourselves in harmony with Christ and we offer, with him, our lives for the salvation of the world. We thus come to give full meaning to suffering, illness and pain, which we take on to complete, in our bodies, what was lacking in the sufferings of Christ, giving them full meaning through death. A paradox that transmutes them from the funeral procession that has accompanied us for all of our lives, by the work of Christ who, in Christ and through him, gives us new imperishable life. This union between the painful precedents of the whole of our lives, which prelude death, with death itself, with the sufferings and death of Christ, is the Eucharist received as Viaticum. It gives us the contemporaneousness of the whole of our existence with the life of Christ and makes us the heirs of eternal life.

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2. Communion

People always speak about how dramatic the loneliness of death is but nobody puts themselves in the place of other people, and all of us, as individuals, have to die. This is a certain thing but for a Christian, through the Viaticum, this loneliness is not as terrible as it could appear at first sight.

In the Eucharist received as Viaticum we find ourselves in full and intimate union with Christ, who dies in the death of each one of us, but this does not take place in the shadows of annihilation but in the luminosity of resurrection. This luminosity is nothing else but the personal Truth that accompanies us during the whole of existence which, lived in Christ, reaches the merciful and benign judgement of our Saviour; it means the merciful love of the eternal Father who lives in he who dies, thanks to the Eucharist, and who is the omnipotent Love of the Holy Spirit. In the Viaticum we enter the Trinitarian communion as the last step so as to exit in the perfect way from our earthly existence and open ourselves to the highest perfection of heaven.

In Christ, the Head of the mystic Body of Christ, we enter the communion of saints with the Most Holy Virgin Mary, with St. Joseph and all the saints, with those who are in the state of purgatory and with all Christians with whom we are in communion. All of them accompany us in the definitive moment of the transit and help us to take the transcendental step towards absolute happiness.

In Christ, Alpha and Omega, the first-born of the Universe, the whole of the creation is found potentially, and at this moment, through the Eucharist received as Viaticum, the whole of the creation waits to be redeemed with us, and obtains it with the communitarian individuality of those who are at the moment when they inherit it in Christ by being in him who is, equally, the centre of the Universe, thought of and willed by the Father as the first-born of the Universe in the First-born of the Universe.[5] In the Viaticum for every Christian there arrives the culminating moment spoken of by Paul in his Letter to the Ephesians: 'For he has made known to us in all wisdom and insight the mystery of his will, ac-

cording to his purpose which he set forth in Christ as a plan for the fullness of things, to unite all things in him, things in heaven and things on earth. In him, according to the purpose of him who accomplished all things according to the counsel of his will, we who first hoped inn Christ have been destined and appointed to live for the praise of his glory'.[6]

Experiencing the loneliness of death is something that belongs only to those who do not have faith. In the Viaticum faith is sustained through the definitive presence of Christ; it is the coronation of the individual, solidarity-based and communion-based triumph of brotherhood, friendship, and total love of devotion that consists in the happiness that will come. The proportional relationship between loneliness and faith at the moment of death is inverted – the greater the faith, the less the loneliness.

3. Eternity

The definitive presence of Christ in the Eucharistic host already enables us to pre-taste eternity. Christ appears as being independent of the conditions of space and time. His dimension is transcendent in relation to any imagination which is always conditioned by external means. This is what happens in all the Eucharistic acts that we engage in, and in a very special way it is achieved in the architrave of eternity – the Viaticum.

Boethius defined eternity in classic terms as '*interminabilis vitae tota simul atque perfecta posessio*; the unending, simultaneous and perfect possession of life. In his definition we can perceive an aspect that allows us to uncover, stuttering, participation in divine life. Indeed, the boundary, so to speak, between divinity and being a creature is movement. God is unchanging; a creature is changing. One is not dealing here, certainly, with a quantitative movement, which can be measured with the co-ordinates of space and time, but, rather, of a qualitative movement which becomes progressively perfect. Divine immutability is not a static quiet lacking in dynamism but the fullness of dynamism that means omni-perfection. This is not only the concept of the immobile engine, but, rather, the fullness of devotion in an infinite giving of love which is the Most Holy Trinity. It is a movement that is not concerned to possess because it is everything; it is the giving of love without limits, glorious welcoming without end: God is Love. He is not only infinitely loveable – He loves infinitely. This immutability of the perfect joy of infinite loving is authentic divine immutability, the nature of God.

To share in the divine nature means to enter this community that is full of love; it means to enter the Trinitarian circle by defeating the mutability of desire and progressive growth in the satisfaction of the creature in the fullness of his or her capacities. It is life, as it is, alone; without adding anything at all; it is health.

The Eucharist achieves this wonder; it is for this reason that Christ says to us: 'if anyone eats of this bread, he will live forever…he who eats my flesh drinks my blood has eternal life, and I will raise him up at the last day…he who eats my flesh and drinks my blood abides in me, and I am in him. As the living Father sent me, and I live because of the Father, so he who eats me will live because of me'[7] It is the bread that is given for us and the blood that was spilt on the cross.[8]

Such is the Viaticum: to share in the body of Christ who gives of himself in death and in the blood that was spilt on the cross, and thereby to enter eternity. The boundary of created mutability is defeated in death thanks to the Viaticum because the boundary between divinity and being a creature is crossed thanks to that bridge, the cross, not a death that is feared and rejected but a loving death of configuration with the Lord Jesus who died and rose again. It is the full giving of love, the summit of all our giving, in which we do not give something but rather the whole of our lives to the Lord Jesus. This is the complete work of the Holy Spirit who communicates to us his love of devotion. We thus begin to live as Christ does for the Father because we will live for ever in him.

Conclusion

The fullness of health is death; not any death but death in Christ and with Christ, intimately joined to his death. This is the Viaticum, the fullness of health. This is why I said at the beginning of this paper that the Viaticum is that which most specifies fully pastoral care in health because it is the horizon towards which humanity advances, running after life.

When, together with Pope John Paul II, we define health as 'progression towards physical, mental, social and spiritual harmony', it is to the Viaticum that we are directing our gaze. Death is a lack of harmony, it is disintegration, but the Viaticum transforms this lack not into pure harmony but into the same thing – Christ who rose again.

The disorder of death becomes the highest order; anxiety about death becomes the greatest tranquillity. The Viaticum is the definitive guarantor of peace for each one of us at the moment of death because peace is 'tranquillity in order'. This is the greatest pastoral care that we can give to our sick elderly people.

H. Em. Cardinal JAVIER LOZANO BARRAGÁN,
President of the Pontifical Council for Health Care Workers, the Holy See.

Notes

[1] Cf. James 5:14-16.
[2] N.11
[3] Cf. 2 Cor 4:10-11.
[4] (*Missale romanum*, prayer over the offerings of Monday the eighth day of Pentecost)/*Sacrosantum Concilium*, n. 12).
[5] Col. 1:15-20.
[6] Eph. 1:9-12.
[7] Jn 6:51, 54, 57.
[8] Cf. Lk. 22:14-20.

First Session

Reality

PETER CROME

1. The History of Care for Sick Elderly People

First of all I would like to thank the organisers of this important conference for inviting me to give this talk on the history of care for sick elderly people. I am deeply honoured and look forward to hearing the other speakers. We will hear a wide range of experts on demography, clinical medicine, ethical and spiritual matters. What I propose to do is to set the present situation of care of frail older people in an historical context, from ancient sources to the present day. There may be a little, but I hope not too great, overlap with other speakers.

As the Welsh poet Dylan Thomas wrote in his famous radio verse play *Under Milk Wood* – 'To begin at the beginning'. The first men are recorded as living for a very long time: Adam, 930 years; Noah, 950 years, with Methuselah reaching 969 years. Moses did not live so long, 120 years, but this achievement of longevity continues to be celebrated in the Yiddish toast '*biz hundert-zwanzig*' (May you live to be one hundred and twenty!). In other ancient cultures longevity was the rule, at least amongst the rulers. Gilgamesh, the King of Uruk, reigned for 126 years whilst the earliest Chinese emperors were said to have reigned for thousands of years.[1] We do not know whether the principles and practices of modern geriatric medicine played a part in such longevity, but we can say that the importance of family and friends, or to use modern-day jargon 'inter-generational solidarity', which is the bed rock of a successful society, appeared to be a factor, as clearly several generations must have lived together at the same time.

The prevention of ageing and the continuation of vitality has been a constant theme from time immemorial until the present. We laugh at most of the suggested methods of the past but occasionally they chime with modern evidence – for example the advocacy of exercise and avoidance of over-eating. Charlatan methods of the present anti-ageing movement need to be clearly differentiated from modern evidence-based approaches which really have been of benefit to older people and which I will discuss later.

Examination of the report of King David's ill health in later life shows parallels with contemporary practice. In the book of Kings we read: 'Now King David was old and stricken in years and they covered him with clothes but he gained no warmth'. He was clearly suffering from hypothermia, a serious risk in old people who have inadequate heating, particularly if they also have other illnesses. A colleague who served in the British army told me that the standard practice today, if you find someone with hypothermia out in the open, is to put them in a sleeping bag and then put a healthy person in the sleeping bag with them. This was the roughly the same treatment that King David received. The biblical text also indicates that David had a poor memory and that his 'bones wasted away', raising the possibility of that he also suffered from dementia and osteoporosis.[2] Perhaps this was the first reference to multiple pathology, a frequent finding in frail older people.

As we are in Rome I must say something about old age in Roman times. What struck me reading a recent review by Karen Cokayne was how similar attitudes to older people were then to how they are now.[3] For example, Horace in *Ars Poetica* castigates the old for being hoarders and describes them as being sluggish and greedy and giving to condemning the young. On the other hand, Cicero says, although age takes away everything else, it undoubtedly brings wisdom. These two views contrast, the celebration of older people's wisdom contrasting with negative stereotyping, what might be called ageism today. The Eastern Roman empire also established the equivalent of old people's homes – '*gerocomeia*'.

A blossoming of medicine took place towards the end of the first millennium with the famous physicians Avicenna and Maimonides who were both concerned about diseases in old age. At the same time there was a growth of religious establishments in Christian Europe which provided care for the sick, including older people. These, together with the universities which were founded at the same time, incorporated newer schools of medicine with those of ancient Greece and Rome.[4-5] There was continuing interest in ageing. Vilanova, a physi-

cian at the Court of Aragon, wrote on conserving youth and preventing old age whilst in thirteenth-century century England, the Franciscan friar, Roger Bacon, wrote his famous book *On the Cure of Old Age and the Preservation of Youth*. In the sixteenth century in England there was the creation of public systems of 'care', regarded in England as an important event which would three-hundred years later perhaps at least partially explain why the United Kingdom was one of the first countries to develop geriatric medicine as a major medical specialisation.

The nineteenth century was a time of great development in medicine. Anaesthesia was introduced, microbes were discovered to be a major cause of disease, and there was renewed interest in the maladies of later life. The great French neurologist Charcot published his book *Clinical Lectures on Senile and Chronic Diseases*. However, the story of geriatrics as we know it today really started at the beginning of the twentieth century with the publication by the Austrian-American Ignatz Nascher, in 1909, of his book *Geriatrics. Diseases of Old Age and their Treatment*. He introduced geriatrics into the medical lexicon, the word being derived from the Greek *geros*, an old man, and *iatros*, relating to the physician. In this book he describes several of the syndromes of later life, including dementia and delirium, and he makes the point that disease in later life can express itself in ways different to those to be found in younger people, just as disease in children is also different. He draws attention to the fact that there had been little research into treatments in later life and that this posed therapeutic difficulties. He correctly urged a cautious approach to drug treatment.[6-7] The issues of a deficient evidence-base for effective treatment in older people remains current today, although considerable progress in this area has been made.

I first came across Nascher's name when I started training in geriatric medicine in the 1970s. It is a custom in many hospitals in the UK to name wards after famous physicians and other notables and the Nascher ward was one of five geriatric medicine wards in the hospital. The other four were named Warren, Sheldon, Anderson and Brooke, each of whom held a distinct place in the history of geriatric medicine.

Ferguson Anderson trained in Glasgow and became the first Professor of Geriatric Medicine in the UK, possibly in the world. Subsequently he became President of the Royal College of Physicians and Surgeons of Glasgow, a position that Brian Williams, also a geriatrician, currently holds. Fergie, as he was known, trained in Glasgow with both John Brocklehurst and Bernard Isaacs, two other great future Professors of Geriatric Medicine. Fergie was a pioneer of joint working with primary care, revolutionary then and now playing an important part of a geriatrician's responsibilities in the UK and elsewhere.

Joseph Sheldon's great claim to fame was his survey of older people living at home published in 1948. He identified the inter-relationship between medical and social factors, the high prevalence of mobility disorders, and other less glamorous conditions such as foot and hearing disorders. He introduced domiciliary treatments for impaired movement and function. He became the third President of the International Association of Geriatrics. Eric Brooke was the originator of assessment at home.

However, most would regard the greatest of these four to be Marjorie Warren who invented the specialty of geriatric medicine just before the Second World War. We have recognised this by naming the office of the British Geriatrics Society the Marjory Warren House, which coincidentally is sited almost next door to the Priory of St. John, the former headquarters of the Knights Hospitaller in England. She described the development of geriatric medicine in two seminal papers published in the *British Medical Journal* and *The Lancet*.[8-9]

The dissolution of the monasteries in the sixteenth century led to the creation of poor houses, which were funded by local communities. They catered for the old, the sick and for orphans as well as for the poor. The general philosophy was that these people had brought their misfortune on themselves and the conditions were often inhumane. Families were separated and costs were severely curtailed. Charles Dickens's novel *Oliver Twist* is based on his experiences of one such facility in Victorian England. Conditions gradually improved and in the 1930s their control passed to the municipalities which by that time also had responsibilities for more acute hospitals. Marjorie Warren was given responsibility for one such hospital in a suburb of London. She advocated separate blocks for older people on an acute hospital site. She drew attention to the need for special provisions for diet, linen, trained staffing and equipment. She stressed the need for older people to have good access to all other facilities of an acute hospital such as X-rays, pathology, chiropody, ophthalmology and dentistry. In her *BMJ* article she made four simple points which have stood the test of time and are of current importance as the debate on the future role of hospitals is developed. She argued that geriatrics should be included in the medical student curriculum, that student nurses should be trained in units for old, that for the proper care of older people all the facilities of the general hospital should be available to them, and that geriatric medicine units were needed to facilitate clinical research. To quote her 'it is quite as unsuitable to treat these patients in wards for acute cases as it is to relegate them … to institutions for the chronic sick where facilities for diagnosis, research and treatment are unavailable'. She, like Nascher, drew analogies with the development of paediatrics which had only just emerged as a separate specialty and to quote her again 'until the subject (that is geriatrics) is recognized as a special branch of medicine in this country it will not receive the sympathy and attention it deserves'. She also favoured the separation of older people by physical and mental status. In her *Lancet* paper she recognised and promoted the multi-disciplinary nature of rehabilitation with physiotherapy, occupational therapy and social work involvement and made a clear statement that older people should not be admitted to care homes until they had received a comprehensive geriatric assessment.[9] A sentiment

which I am sure we would all endorse today.

Shortly after this latter paper was published, almost all hospitals in the UK joined together to form the National Health Service which like the British Geriatrics Society is now sixty years old. Doctors had to be appointed to run the units for the chronically sick and these doctors became the first specialists in geriatric medicine, often being responsible several hundred patients. Over time the numbers of patients each specialist looked after fell but even in 1981, when I became a consultant, there were over two hundred patients in my unit. Patients were usually screened at home prior to admission in order to assess the priority of need and approaches other than admission were developed. Day hospitals were developed both as a method of preventing hospital admission and as a facility to continue rehabilitation following discharge.[10] They also provided relief and support for patients and their families. There were debates whether patients with differing levels of acuity should be nursed together or separately. Irvine advocated progressive patient care where patients moved from ward to ward as they improved. He argued different wards would allow nursing and therapy expertise to be concentrated appropriately.[11] Irvine with his orthopaedic surgeon colleague Michael Devas also pioneered the joint geriatric orthopaedic unit for patients recovering from fracture neck of femur and other trauma. Brice-Pitt and Silver established a joint geriatric-old age psychiatry unit for people who had both physical and mental illness.[12] In a further development, Tom Arie established a joint clinical and academic service which encompassed both of these services, although organisational and other changes in the NHS have meant that old age psychiatry and geriatric medicine are not working as closely together as they should be.

Marjory Warren's ambitions for the improvement of care of older people saw its fruition both in service development and in the growth of academic geriatric medicine. Care of older people is firmly embedded in the undergraduate medical curriculum and in the curriculum for other health professionals. This development was led by a number of charismatic professors whose influence continues. For example, Bernard Isaacs, Professor of Geriatric Medicine in Birmingham, coined the phrase 'Geriatric Giants' comprising instability, incontinence, immobility and intellectual deterioration as syndromes with which many older people presented to hospital.[13]

Today in the UK most geriatricians will have a special interest and many services have been developed to run alongside acute and rehabilitation wards for older people. For example, there might be out-patient falls, continence and movement disorder clinics. Palliative care is being provided for dementia and other chronic diseases as well as cancer. The British Geriatrics Society, founded in 1947, now has 2,500 members and has become a multi-disciplinary rather than a purely medical society It holds two conferences each year and published a highly successful journal – *Age and Ageing*. Uniquely, I think in the world, geriatrics in the UK is the largest specialisation within internal medicine.

I have concentrated on describing the development of specialisation in the UK but there have been parallel developments in Europe, North and South America and in Australasia. In the United States geriatric medicine developed with support from various strands. Medicare and Medicaid funded care for old and for poor people. The National Institutes of Ageing was founded in 1974. The Veterans Administration established a network of GRECCs (Geriatric Research, Education and Clinical Centers). The major medical schools established divisions of geriatrics within their departments of internal medicine which as well as conducting research offered training fellowships to aspiring geriatricians. In contrast to the UK, Canada and elsewhere, the route to becoming a geriatrician there can be via family practice as well as via internal medicine. Since the Second World War geriatric medicine has been recognised as a separate medical specialisation and there has been a similar growth in services, teaching and research.

The last twenty-five years have seen throughout the world a growth of home care programmes providing both social support and a wide range of health care (nursing, therapy etc.). The drivers for such development are principally both the desire to reduce the costs associated with hospital or nursing home care and also to respond to older people's wishes to remain independent at home for as long as possible. Ensuring quality of such services is a major issue. In most developed countries there has been a large growth in nursing homes. Most of the early homes were established by religious foundations but they are now provided by a wide range of non-governmental organisations, municipalities as well as the commercial sector. Programmes of inspection and training for staff aim

to ensure high quality care as well reducing risk of abuse. In many countries professional staff organisations support these aims whilst in the Netherlands care home medicine has been recognised a distinct specialisation.

Although the ideas for, and examples of, patient-empowered health promotion have been in existence for many years they have not really been mainstream. However, the potential for new technology to assist in this area is enormous.

International collaboration has been fostered by the International Association of Gerontology and Geriatrics which meets regularly in regional and world-wide conferences. More recently countries from the less developed parts of the world have also joined. The enlargement of the European Union acted as a catalyst to develop a European Union Geriatric Medicine Society and several leading members of both organisations are speaking here. There are numerous other collaborations that focus on more specific issues such as training and many of the more developed countries have exchange programmes with less developed countries.

The achievements of geriatric medicine have been succinctly summarised by Barton and Mulley.[14] An awareness of atypical and non-specific presentation of disease. A holistic approach to those with co-morbidity and complex needs. The importance of interdisciplinary comprehensive assessment, rehabilitation and the recognition of the needs and rights of carers. These care features have been coupled with the development of a range of inpatient and outpatient services and a robust evidence base for the effectiveness of this approach. Standard assessment tools have been developed so that healthcare workers in hospital and in the community can have a common language. Emerging areas for research include frailty, exercise, life satisfaction and empowerment as well as of course research on the specific diseases commonly found in later life.

The care of older people has benefited from all of the other advances in medical care – new medications, new diagnostic procedures and new surgical techniques such as cataract surgery and joint replacement. The impact of the evidence-based medicine approach has also been felt. Although many gaps on how best to treat older people remain, particularly because of the low recruitment of such people to clinical trials of new medications, a range of clinical guidelines have been produced both at a national and international level. Recent examples include those on diabetes, falls, delirium, pain and continence.

There is much still to do. In the UK we are considering how best to apply the principles of the European Convention on Human Rights with its clear statements on the right to life, to security, and to respect for private and family life to the care of frail older people. These are principles which had their foundation in the biblical commandment *kaved et-avicha ve'et-imecha* ('Honour your Father and your Mother') and give confirmation to the continuity that has existed from ancient times to today.

If I may finish by quoting Marjorie Warren again. She refers to the UK but I am sure her views are universal: 'If we are to maintain the right to call ourselves a great nation and a cultured civilisation we must make provision in our scheme for all members of the community, old and young, sick and well, poor and rich, helpless and independent'. I am sure that these sentiments will be amplified in the rest of the conference.

Prof. PETER CROME,
Professor of Geriatric Medicine,
Keele University,
President, British Geriatrics Society,
Great Britain.

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ANTONIO GOLINI

2. The Demography of the Elderly Population

'The next day nobody died. This fact, because absolutely contrary to the rules of life, caused great disturbance in spirits, something that was totally justified; we need only remember that such an event was not to be found in the forty volumes of universal history.'
José Saramago, *Le intermittenze della morte*, 2005

1. 'Intermissions of Death' and the Systemic Non-sustainability of the Disappearance of Death

In 2005, in his brilliant and provocative novel, *Le intermittenze della morte,* José Saramago exaggerated in paradoxical form the consequences of an unforeseen 'intermission' as regards death, which was explained pitilessly and wisely by the author as a feared but inevitable benchmark for the survival of socio-economic and political-cultural systems created around the certainty of the usual 'parameters of activity' of death. Thus Saramago, in summoning to the Ministry of the Country without Death a Grand Council to address the systemic non-sustainability of the disappearance of death leaves out nobody: economists, sociologists, medical doctors, actuaries, statisticians, insurers, farmers, philosophers, experts on bioethics, the representatives of the various religious confessions and on to the employees of undertakers and the owners of cemeteries, not to forget the ambassadors of the bordering countries, where death continued, unperturbed, to play its role as a socio-economic catalyst and which were flooded by people on the edge of death and who had only to cross the frontier to breathe their last, dragged across the border by the 'maphia' who in this way attempted to conserve the indispensable functions of mortality. Albeit in a paradoxical way and with biting narrative exaggeration, literature, as is often the case, foresees, understands and meets the challenge of addressing scenarios that may become possible in the future – in this case the scenario of an 'intermission of death'. As in the novel by Saramago, indeed, although the instinctive and healthy reaction of the Country Without Death is that of collective festivities, in parallel with the emergence of the new demographic phenomenology of the 'disappearance of death' there has also emerged at a collective level the responsibility to 'rearrange' the system of our homes and countries so that all the demographic, social, economic, cultural, political and environmental variables that assure the equilibrium of an organised human society in systems of varying degrees of complexity is achieved. This is also necessary for us in order to make sustainable the 'devastating' – because of its newness and intensity – demographic process underway, that involving the ageing of the population.

2. The Ageing of the Population: an Unstoppable Demographic Process

The strong demographic ageing of the population, which is a cardinal demographic development and revolution of the twenty-first century – is near to the complexity of the 'intermission of death' that has been narrated in literature. This is because the victory against unwanted births is only a very recent fact that has advanced with medical-cultural developments that are still not completely globalised, and the extraordinary victory over early death which has been unceasingly pursued by man and has even involved the search for immortality, have over the space of a few decades represented a concrete achievement of the 'intermission of death'. The increase in longevity, indeed, has over recent decades been so intense and so rapid that it has gone beyond all the forecasts or charts that were attempted in the 1960s and 1970s. In particular, *average life spans* within populations have grown,[1] given that early mortality, as has already been pointed out, has been almost completely eliminated. At the same time, however, living beyond the age of 110 remains exceptional, a testimony to the fact that the maximum age of individuals has not grown.[2]

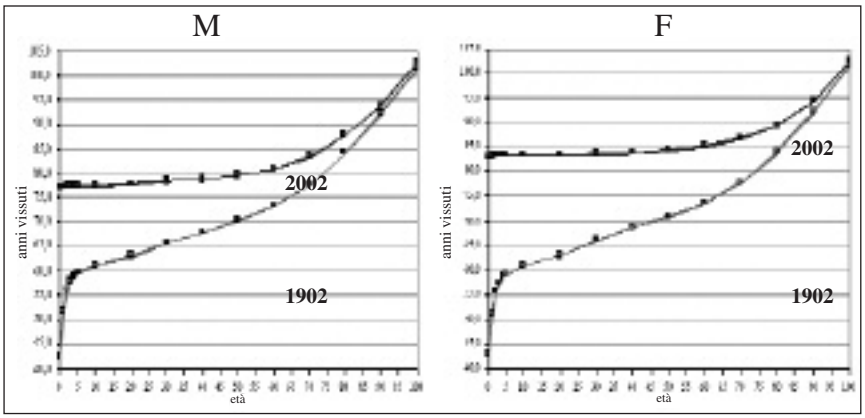
An equally important observation to be made is that during the eighteenth century people who died over the age of a hundred were registered as being a *unicum*: 'in every country, in every estate of life, some people, although they are rare, go beyond the age of a hundred. In these notes…there are four aged a hundred and six'. This illuminating quotation is taken from the *tavole di vitalità* of 1787 by G. Toaldo who two hundred and twenty years ago addressed the question of early mortality as an obstacle to an increase in the average life span of people within a population and which had a deformed impact on the 'mountain parishes', the 'town' parishes, and the 'plain' parishes (those that were most affected). With reference to the high incidence of male mortality he noted how 'with more males than females born, at all ages there are more females than males and this longevity of females in general is repeated by the abundance of damp, by the contents of vases and fibres which leads to a later contraction of senile dryness' (Toaldo, 1787).

Here it is extremely interesting and especially instructive to observe how demographic ageing involves an overall increase in aver-

age life spans which derives from an almost complete elimination of early mortality (figure 1). In other words, the dramatic achievement of a hundred years of demographic history has involved the substantial aligning of average life spans, as result of which each individual between the ages of 0 and 80 can expect on average to live the same number of years (putting together at every age the years that have been lived and the years that can be expected to remain). The differential of average life spans by sex emerges again in a game of horizontally parallel nets which indicate a differentiated average life span by sex as regards the years that are on average lived (with men in the year 2002 at about seventy-seven years of age and women at about eighty-three years of age) but one that is homogenous within each sex. Only for those who live more than the age of seventy-five to eighty, both in the case of men and in the case of women, do we encounter again a diversification of average life span. This attests to the fact that for those who go beyond the entrance into old age, the concluding point of life reaches 100-105 years and beyond this people do not go except in the case of extraordinary individuals, whether male or female (figure 1).

As is well illustrated by table 1, the second half of the twentieth century witnessed throughout the world an increase in average life span, expressible in terms of life expectancy, which from 47 years in 1950-55 reached 65 in 2000-2005, with an increase equal to 18 years of age and + 38% compared to the line of departure of the period under examination (Table 1).

Figure 1. Overall life span according to age reached, Italy, 1902 and 2002



Source: Istat, *Annuario statistico*, various years

Table 1. Average life span (or life expectancy) in some regions of the world, 1950-55-2000-05

Region or country	1950-55	2000-05	*Increase*	*Increase %*
World	**47**	**65**	***18***	***38***
Developed countries	***67***	***78***	***11***	***16***
Europe	66	78	*12*	*18*
Japan	64	82	*18*	*28*
United States	69	77	*8*	*12*
Canada, Australia, New Zealand	69	80	*11*	*16*
Transition economies	***63***	***65***	***2***	***3***
Union of Independent States	69	65	*2*	*3*
South-East Europe	57	74	*17*	*30*
Developing countries	***41***	***63***	***22***	***54***
Latin America and the Caribbean	51	72	*21*	*41*
Eastern Asia and the Pacific	41	7	*29*	*71*
South Asia	39	63	*24*	*62*
West Asia	43	68	*25*	*58*
Africa	38	49	*11*	*29*
Max-min difference	*31*	*33*		

Source: calculation from data: DESA, 2007

It is immediately clear how the 'gain in average life years' in the macro-region 'world' reflects increases that are not homogenous both at the level of the number of years added to average life spans and in terms of speed of acquisition: the 18 years of gain of the second half of the twentieth century represents the average gain of a range of levels from 2 (the Union of Independent States) to 29 years (East Asia and the Pacific); an average life span of departure between 38 (Africa) and 69 years (the United States); and an average life span at the end of the period of between 49 (Africa) and 82 years (Japan). It is interesting to link the demographic trend, both by regions (for example developed countries, transition economies, developing countries) and by individual countries, to the parallel evolution of political-economic and socio-cultural developments, so as to observe a substantial reciprocal osmotic and dependency relationship between population trends and the system in which each population lives and undergoes transformation.

In this picture, the trend of the average number of children for each woman (table 2), which between 1950-1955 and 2000-2005 underwent a decrease at a world level equal to 48% (-2.4 children on average for each woman) certainly corresponds to a more or less synchronised and articulated development of economic, media, cultural and political processes which in the interaction of their changes reshape each others' trajectories. It is also very interesting to stress that in this sphere the shift from an average 5 children for each woman in 1950 to the 2.6 average children in 2000 at a world level constitutes an intermediate measurement between decreases equal to 69% (East Asia and the Pacific: from 6.1 to 1.9 children for every woman) and less notable decreases equal to a minimum of 25% (Africa: from 6.7 to 5.0 children for every woman).

In every context it is thus of fundamental importance to analyse not only the push and resistance factors in the evolution of a specific demographic variable but also in what way other factors that exert an influence play their part in this inter-

action. In Africa, for example, it is plausible to posit that women maintain an accentuated persistence in having a high number of children for every woman both because of cultural traditions and because of economic necessities. In the more economically developed countries, instead, the same synergic action of cultural and economic factors in bringing about reproductive behaviour (1.6 children for every woman) lower than the level that assures a mere continuation of the population (equal to 2.1 children for every woman), on the one hand, and a cultural development that has exalted the values of the centrality of the individual, of female emancipation from the role of the angel of the hearth, and of the prolongation of the age of youth free from family responsibilities, on the other hand, has created a socio-economic context that encourages forms of behaviour that are particularly restrictive at a reproductive level, not least because of its inability to assure family budgets that are not overly stressed because of the low number of family members.

In focusing in on the decline in the average number of children per woman in the European context (figure 2), in the period of time between 1980 and 2002, there is further confirmation of how in the planetary decrease in fertility in general the continuing presence of advanced developed countries – amongst which are to be placed those in Europe – that are well below the threshold of population replacement, has without doubt constituted a fundamental variant in bringing about the shift of a consistent percentage of the world population during the stage of the second demographic transition.

The two subjects analysed, namely the decline of mortality and the decline of fertility, have characterised in the demographic scenario of almost all countries the *first demographic transition* which in numerous advanced developed countries has been followed over recent decades, as has already been observed, by the *second demographic transition*, which is due to, and characterised by, a lasting very low level of fertility and by a further decline in mortality especially concentrated in the most advanced age groups, and which will lead in the long term, as regards the principal demographic consequences connected with it, both to a rapid and intense decline in the population and a 'devastating' change in its structure in terms of age.

From a demographic, economic and political point of view, the consequences of differences at the moment of emergence and in the speed of these two demographic transitions are very great. These are consequences that principally express themselves in a different temporal and territorial sequence of the inevitable three demographic peaks – of the young population, of the population of working age and of the elderly population. Thus there today co-exist – for the first time in the history of humanity – societies and economies that are characterised by a population with large groups of young people and societies and economies characterised by a population with large groups of adults, with these last societies and economies characterised by a population with large groups of elderly people.

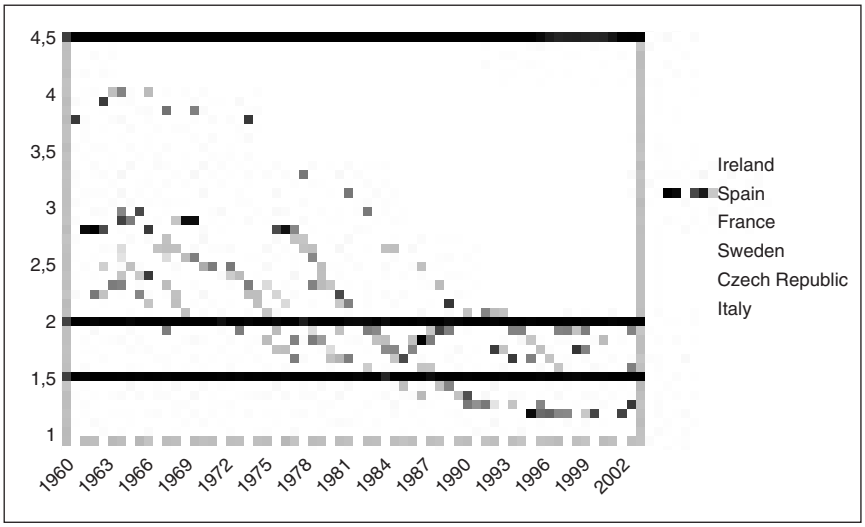
As regards the decrease in fertility and its permanence at very low levels, there seems for populations to be a lower limit of around 0.7-0.8 children for every woman (Golini, 1998), and this is by now a point

Table 2. Average number of children for each woman in some regions of the world 1950-55-2000-05

Region or country	1950-55	2000-05	*Increase*	*Increase %*
World	**5,0**	**2,6**	***-2,4***	***-48***
Developed countries	***2,8***	***1,6***	***-1,2***	***-43***
Europe	2,5	1,4	*-1,1*	*-44*
Japan	2,8	1,3	*-1,5*	*-54*
United States	3,4	2,0	*-1,4*	*-41*
Canada, Australia, New Zealand	3,5	1,6	*-1,9*	*-54*
Transition economies	***3,1***	***1,6***	***-1,5***	***-48***
Union of Independent States	3,1	1,6	*-1,5*	*-48*
South-East Europe	3,7	1,6	*-2,1*	*-57*
Developing countries	***6,2***	***2,9***	***-3,3***	***-53***
Latin America and the Caribbean	5,9	2,5	*-3,4*	*-58*
Eastern Asia and the Pacific	6,1	1,9	*-4,2*	*-69*
South Asia	6,1	3,2	*-2,9*	*-47*
West Asia	7,0	3,5	*-3,5*	*-50*
Africa	6,7	5,0	*-1,7*	*-25*
Max-min difference	*4,0*	*3,7*		

Source: calculation from data: DESA, 2007

Figure 2. Average number of children for each woman in some European countries



Source: Eurostat, 2003

that has been reached by certain populations. The notable margins in present conditions that exist for a further increase in age span which are well brought out by the incidence of those people who go beyond sixty-five years of age in every thousand births (table 3), as well as the residual life expectancy at the age of sixty-five (in this case calculated with reference to the Japanese population in 1950-55 and 2005 and the Italian population of 2003), demonstrate how survival to the age of sixty-five in Japan is by now near to 1,000 in every 1,000 individuals, with an incidence of residual life equal to 17.7 years for men and 22.9 years for women. The levels for Italy, although they stand out in a world context, demonstrate margins of further advance which can be concentrated almost exclusively in advanced age groups for places with low or very low mortality.

Table 3. Survivors at the age of 65 and their further life expectancy, Japan, 1951 and 2005, and Italy.

Year	Numbers of Survivors at 65 (out of every 1,000)	Lenght of residual life at 65 (in years)	Total increase in years 1951-2005	Increase in months for every calendar year
Males				
1950-52	900	11,4		
2005	994	17,7	6,3	1,4
Italy 2003	*850*	*16,8*		
Females				
1950-52	908	13,4		
2005	996	22,9	9,5	2,1
Italy 2003	*922*	*20,6*		

Source: for Japan: http://www.ipss.go.jp/p-info/e/S_D_I/Indip.html; for Italy: Istat, *Annuario statistico italiano 2006*

Table 4. The total population in thousands of inhabitants of the over 60, over 65 and over 80 age groups in the world and groups of continents and as a percentage of the total population, 1950 and 2005.

Region or country	1950	2005	*Increase*	*Increase %*	1950	2005	*Increase*
World	**2.519**	**6.465**	***3.946***	***57***	**100,0**	**100,0**	
60+	205	672	*467*	*228*	8,2	10,4	*2,2*
65+	131	476	*345*	*263*	5,2	7,4	*2,2*
80+	14	87	*73*	*521*	0,5	1,3	*0,8*
Developed countries	***647***	***984***	***337***	***52***	**100,0**	**100,0**	
60+	79	203	*124*	*157*	12,2	20,6	*8,4*
65+	53	153	*100*	*189*	8,2	15,5	*7,3*
80+	7	39	*32*	*457*	1,1	4,0	*2,9*
Transition economies	***191***	***302***	***111***	***58***	**100,0**	**100,0**	
60+	19	47	*28*	*147*	10,0	15,7	*5,7*
65+	13	37	*24*	*185*	6,7	12,4	*5,7*
80+	2	6	*4*	*200*	1,0	1,9	*0,9*
Developing countries	***1.681***	***5.179***	***3.498***	***208***	**100,0**	**100,0**	
60+	107	422	*315*	*294*	6,4	8,1	*1,7*
65+	65	286	*221*	*340*	3,9	5,5	*1,6*
80+	5	41	*36*	*720*	0,3	0,8	*0,5*

Source: calculation from data: DESA, 2007

Table 5. Calculations on the maximum longevity that can be reached by an entire population

Source	Limit	Date of publication	Date broken	Country and sex of limit break
Fries	85,0	1980/1990	1985	Japan, women
Olshansky et al.	85,0	1990	1996	Japan, women
Banca Mondiale	90,0	1990		
Nazioni Unite	87,5	1999		
Olshanzky et al.	88,0	2001		

Source: E. Barbi (2007)

The joint action, as was observed at the beginning of this paper, of a decline in early mortality and the control of unwanted births is expressed in a very strong ageing of the population, confirmed by population developments, once again for the years 1950-2005, of the over 60, over 65 and over 80 age groups. Although the world's population during the last decades of the twentieth century experienced an increase equal to 57%, passing from two milliard and a half of inhabitants to almost six milliard and a half in 2005, the increases in the more advanced age bands have been even more notable (table 4). Indeed, we may observe how over the same period of time the over 80 section of the population increased by 52%, more than doubling its percentage proportion of the overall composition of the population (from 0.5% to 1.3%). Less intense, but also strongly marked, were the percentage increases in the over 60 and over 65 age bands (+228% and +263% respectively), which brought about a significant percentage proportion of the world population equal, respectively, to 10.4% and 7.4%.

With respect to the ageing of the population, beyond the incontestable value and significance of the overall figure in global terms, we need, more than ever before, details on the groups of the various continents of the world where a very important fact stands out which tells us that the demographic phenomenon of the ageing of the population, albeit globalised, takes place at two different and parallel levels – speed and intensity. Although, in fact, in developed countries the process of ageing began earlier, producing as a result percentages in the composition of the elderly population that are decidedly higher than those to be encountered in developing coun-

tries, nonetheless these last 'are ageing and will age' at a much higher speed.

3. What Future for the Demography of Ageing?

Although the present, as regards direct demographic determinants and indirect contextual determinants and their scale and diffusion, appears to be sufficiently graspable from the various interdisciplinary trajectories that work together to describe, interpret and explain the phenomenological origins and evidence of the ageing of populations, it is extremely difficult and problematic to sustain a projection that can be farsighted in relation to the uncertain definability of the maximum life span of an entire population and developments as regards the average number of children for each woman.

As regards the first question, indeed, although since the 1950s authoritative scholars have challenged themselves at a scientific level to calculate the highest levels of life expectancy, some of those levels have already been demonstrated to be fallacious, undone by the positive impact of human survival in breaking the age limit that has been applied now and then applied to the most advanced age bands (table 5). It is interesting to stress here how the calculations of Fries (1980) and of Olshansky *et al.* (1990) were overtaken by Japanese women, respectively in 1985 and 1996, representatives of the country which still today has the longest life expectancy on the planet.

When, therefore, will the new age limits established for human longevity concentrated between the ages of 87.5 and 90 be broken? And for that matter is it really the case that these calculation will only constitute transitional thresholds towards further 'temporary' limits to human longevity?

According to the calculations made by the UN 2007 (table 6), over the next forty years, with regard to the population of the world, the increase in average life expectancy could be ten years (+ 15%), reaching 75 years as the average to be expected between the 65 African years and the 88 Japanese years. Although it is comforting to observe how the range between the most long-living country and the least long-living is growing narrower with time, going from 33 years to 23 years, Africa could in 2045-2050 have an average life expectancy (65 years) that was already reached or exceeded in 2000-05 by almost all of the countries on the planet. Although the increase in Africa is expected to be decidedly the most notable over the decades to come, with 16 years gained on average for each life (+33%), on average a Japanese would expect to live at least 23 years more than an African. In the UN projections, in fact, Japan will reach the threshold of 88 years in 2045, a threshold indicated by the same UN calculations and by Olshansky as the maximum threshold for the longevity of a population. If this calculation turns out to be exact, projections placed even further ahead in time would envisage countries growing nearer to the threshold of 88 years on average with a diminishing increase until total elimination of such an increase took place once the age calculated to be the highest for maximum average life span had been reached. For that matter, if the speed of the recovery of differentials in terms of average longevity were to occur with the rhythms already expected for the next decades, the time periods for the homogenisation of the world's countries in this respect would appear to be much more reduced.

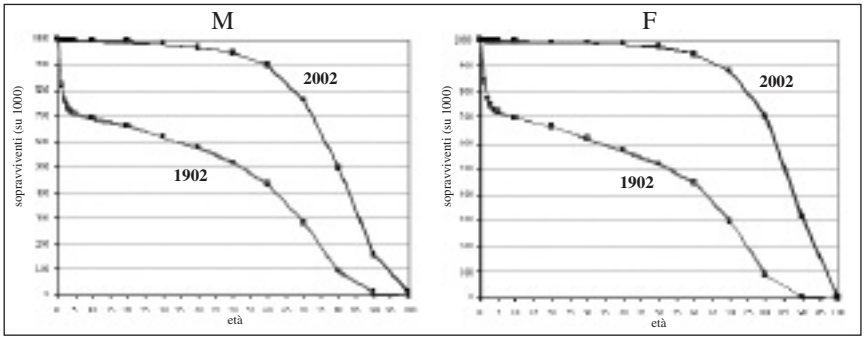
The potentiality in terms of 'gain in average years lived', in relation to a calculation for the maximum threshold of average life span, can be well visualised by analysing the curve of survivors by classes of age with a sort of 'life area' (figure 3) constructed as the surface of a 'rectangular age for survivors'. One can intuitively observe that if out of the

Table 6. Average life span in years in some regions of the world, 2000-05 and predicted for 2045-50

Region or country	2000-05	2045-50	*Incremento*	*Incremento %*
World	**65**	**75**	**10**	**15**
Developed countries	***78***	***84***	***6***	***8***
Europe	78	83	*5*	*6*
Japan	82	88	*6*	*7*
United States	77	82	*5*	*6*
Canada, Australia, New Zealand	80	85	*5*	*6*
Transition economies	***65***	***74***	***9***	***14***
Union of Independent States	65	74	*9*	*14*
South-East Europe	74	80	*6*	*8*
Developing countries	***63***	***74***	***11***	***17***
Latin America and the Caribbean	72	79	*7*	*10*
Eastern Asia and the Pacific	70	78	*8*	*11*
South Asia	63	75	*12*	*19*
West Asia	68	78	*10*	*15*
Africa	49	65	*16*	*33*
Max-min difference	*33*	*23*		

Source: my own calculation from data: DESA, 2007

Figure 3. Survivors by sex, Italy, tables of mortality, 1902 and 2002



Source: Istat, *Annuario statistico*, various years

individuals of departure (100% of the generation) all the 1,000 reached the maximum age established in this case at the age of a hundred (100% of survivors at 100 years), the years lived would correspond to 100% of the possible years.

Indeed, calculating in terms of region, and considering that the years lived correspond to the area beneath the curve of survivors at different ages, the 1,000 survivors from 0 to 100 years would constitute an actual area (that is to say the area of the rectangle and thus the area of the years lived) equal to 100% of the possible area (that is to say the hypothetical area where all the 1,000 individuals of departure reach 100 years of age). Thus comparing in this logic of 'lived area' the curve of Italian survivors for the year 1902 and the year 2002, portrayed by the tables of mortality of ISTAT, one can easily observe how the area contained between the curve of 2002 and that of 1902 represents the 'regained' years of life of the survivors of 2002 compared to those of 1902. However, in their turn the 1,000 of 2002 'waste' in terms of lived years an area that corresponds to the surface between the higher boundary of the curve of survival at 2002 and the boundaries of the rectangle of 'maximum life'. The question spontaneously arises: will it be possible, and when will it be possible, to regain the current years that are still 'wasted'. In addition, what kind of years will be it be possible to regain taking into account the empirical evidence according to which the years 'that are still available' coincide with the age when in nearly all people a chronic illness is present? Furthermore, is the hypothesis and the prospect of 'shifting the wall of average life', reshaping the final axis of the rectangle beyond the age fixed here tentatively at 100 years, science fiction or a future possibility?

In the construction of variants for the projections of longevity it is thus of fundamental importance to consider carefully how possible positive discontinuities that break the barriers of the maximums reached today can combine with equally possible negative discontinuities that would exercise, in their turn, an opposing force in slowing down the prolongation of life (box 1). Thus diagnostic tools that are increasingly reliable and effective are constructed in synergy with *ad hoc* medicines calibrated for an elderly population, in the same way as the greater accessibility of futuristic therapeutic techniques would constitute positive elements for the reduction of certain causes of mortality in advanced age. The appearance of new epidemics, a weakening of physical strength due to phenomena accumulated during years of pollution, such as the spread of forms of behaviour that are extremely damaging to the health of the body (for example disordered eating habits, drug abuse, smoking, little physical exercise…) would render vain in part or completely the potential of certain positive discontinuities.

Box 1. The Prospects for the Average Longevity of Individuals

A. Possible positive discontinuities	B. Possible negative discontinuities
1. Substantial and recurrent successes in basic research (with particular reference to biogenetics and biotechnologies).	1. Negative effects of the accumulation of phenomena of pollution in the air, water, and food.
2. effective, simple, economic and easily accessible forms of treatment linked to stem cells, genetic engineering and nanotechnologies.	2. Iatrogenous effects of medicines taken over decades to combat chronic illnesses.
3. Medicines tested on and produced for elderly people.	3. The appearance of new, unexpected and unforeseen epidemics (as can happen or has happened with AIDS, the H591 virus, and new forms of tuberculosis).
4. Physical exercise throughout life and greater attention being paid to the body.	4. An excessive 'veneration' of the body.
6. More intense preventive activity linked to improvements in nutrition and lifestyles	5. An increased spread of drugs, doping, and obesity above all amongst the young generations.
	6. Large-scale climatic changes.
	7. The non-sustainability of welfare systems linked to the ageing of the population and/or economic crises.

To further confirm how these 'strategies of death' conserve a likeness even over great periods of time and how, therefore, some 'typologies of discontinuity' at the level of parameters of action can occur again albeit over centuries, it is interesting to observe how the scholar Toaldo, who is a point of reference, as has already been observed, for the construction of the pioneering 'life tables' of the eighteenth century, also concentrated on analysing how climatic, property and epidemiological factors influenced mortality. Indeed he observed how 'for example, from leafing through the registers of health care I have observed very often in the space of one or two weeks many deaths of people of the same age, not only at the level of years but also of months and days; this proves that a given severe, cold, humid season…has an impact on the individual data since the age itself is disposed to receive it and certain epidemics have a greater effect on one class of people than another… [In the same way as] who wants to invest capital in a life would be right to choose the life of a Jew (Toaldo, 1787, p. 51). One need only emphasise here that at the time of Toaldo if a mountain parishioner of the age of fifty was likely to live another sixteen years, a plain-dweller fourteen years and an urban dweller eighteen, at the same age a monk could expect to live for another twenty years, a nun for another twenty-three years, and a Jew for another twenty-five.

As was observed in the identification of principal demographic trends, one of the determinants of the ageing of a population – the contraction in the number of births largely due to decline in fertility – has constituted and could continue to constitute a primary element in the progressive and rapid thinning of the youngest classes of the pop-

ulation. The determination of accurate estimates of fertility is thus essential in the drawing up of an overall hypothesis on the future composition of populations in terms of classes of age.

Here the projections drawn up by the UN (table 7) show a pathway of alignment which should lead both as regards the macro-areas and the various individual countries in the world to an average level by 2045-50 of about 2.0 children for every woman. This is thus just below the level of replacement (2.06) that assures the zero growth of a population. One can, therefore, observe how a substantial and to be hoped for convergence in reproductive behaviour will be achieved thanks to a decrease in the world average of 0.6 children for every woman. Indeed, between 2000 and 2005 the projections for fertility for developed countries envisage a modest increase equal to +0.2 children for every woman, whereas even more significant, in terms of intensity and population involved, is the decline in the fertility of developing countries, which is equal to – 0.8 children for every woman.

Thus the policies in relation to fertility that countries will produce and implement will be decisive. These are policies which, even though extraordinarily complex, difficult and problematic whatever the context may be, will be indispensable in attenuating the demographic consequences of overly weak fertility (or in contrary fashion fertility that is overly strong) and in sustaining an otherwise unsustainable decline (growth) of populations and a population structure characterised by age bands that are increasingly made up of elderly people. With a world population which in 2050 is envisaged to be made up to the tune of 22% of people over the age of sixty, with a figure of 32% in developed countries, it is certain that in addition to careful policies for supporting and appreciating ageing, very difficult policies relating to fertility and births will be equally fundamental (tables 8-9).

It is certainly the case that the development of fertility will con-

Table 7. The average number of children for each woman in certain regions of the world, 2000-05 and envisaged for 20045-50

Region or country	2000-05	2045-50	*Increase*	*Increase %*
World	**2,6**	**2,0**	**-0,6**	**-23**
Developed countries	***1,6***	***1,8***	***+0,2***	***+13***
Europe	1,4	1,8	*+0,4*	*+29*
Japan	1,3	1,9	*+0,6*	*+46*
United States	2,0	1,9	*-0,1*	*-1*
Canada, Australia, New Zealand	1,6	1,9	*+0,3*	*+19*
Transition economies	***1,6***	***1,8***	***+0,2***	***+13***
Union of Independent States	1,6	1,8	*+0,2*	*+13*
South-East Europe	1,6	1,8	*+0,2*	*+13*
Developing countries	***2,9***	***2,1***	***-0,8***	***-28***
Latin America and the Caribbean	2,5	1,9	*-0,6*	*-24*
Eastern Asia and the Pacific	1,9	1,9	*0*	*0*
South Asia	3,2	1,9	*-1,3*	*-41*
West Asia	3,5	2,0	*-1,5*	*-43*
Africa	5,0	2,5	*-2,5*	*-50*
Max-min difference	*3,7*	*0,7*		

Source: my own calculation from data: DESA, 2007

Table 8. Some demographic consequences of alterative variants of future fertility in some countries (2005 – 2050)

				Annual average 2045-2050			2005-2050 population change		
	Fertility variant (on the left the 2005-05 values; on the right the 2045-50 values)			Births (000)	Deaths (000)	Ratio D/B	Less than 80	80 or over	Total
Italy		High	2,35	689	820	1,19	-4.481		+289
	1,28	Medium	1,85	429	818	1,91	-11.951	+4.770	-7.181
		Low	1,35	234	816	3,49	-18.518		-13.748
France		High	2,35	1.004	792	0,79	+8.289		+12.290
	1,87	Medium	1,85	647	789	1,22	-1.380	+4.001	+2.621
		Low	1,35	368	786	2,14	-10.154		-6.153
China		High	2,35	23.097	19.089	0,83	+245.560		+331.345
	1,70	Medium	1,85	14.279	18.883	1,32	-9.322	+85.785	+76.463
		Low	1,35	7.615	18.710	2,46	-230.370		-144.585
India		High	2,35	30.839	14.797	0,48	+741.748		+786.259
	3,07	Medium	1,85	19.581	14.347	0,73	+444.822	+44.511	+489.333
		Low	1,35	10.941	13.981	1,28	+184.645		+229.156

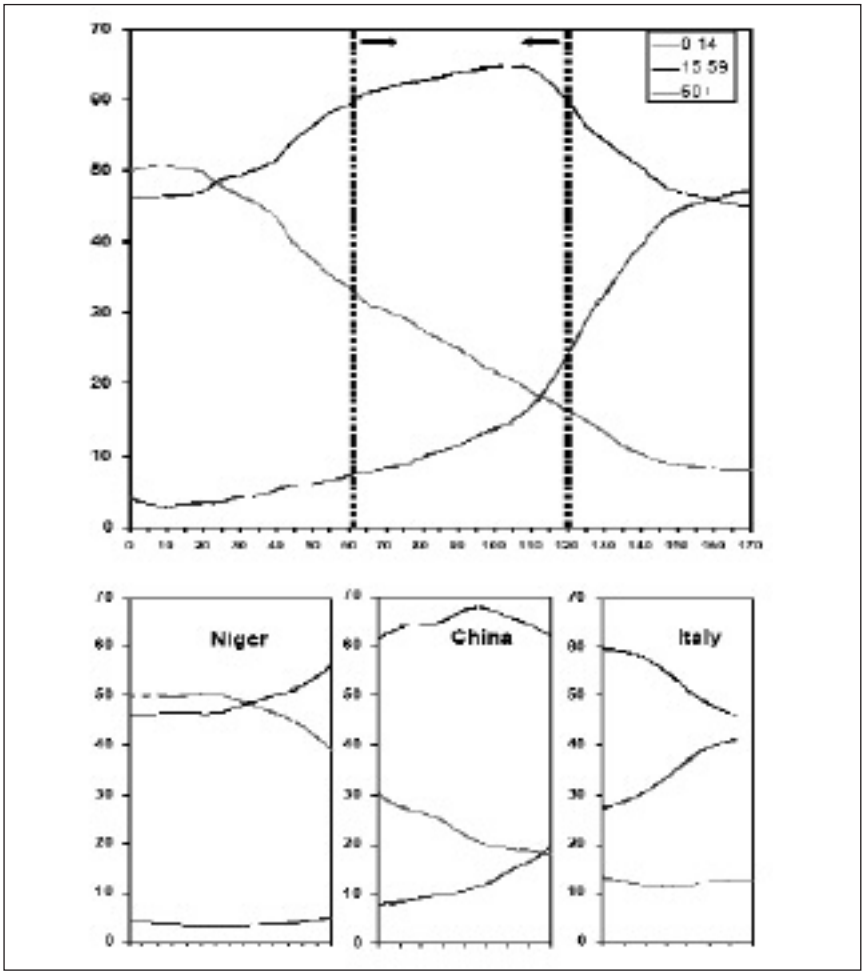
Source: UN, *World Population Prospects. The 2004 Revision (medium variant),* New York, 2005

Table 9. Total population, in thousands of inhabitants, of the ages 60+, 65+ and 80+ for the world and for groups of continents and percentage of the population, 2005 and projected for 2050

Region or country	2005	2050	*Increase*	*Increase %*	2005	2050	*Incremento*
World	**6.465**	**9.076**	***2.611***	***40***	**100,0**	**100,0**	
60+	672	1.968	*1.296*	*193*	10,4	21,7	*11,3*
65+	476	1.465	*989*	*208*	7,4	16,1	*8,7*
80+	87	394	*307*	*353*	1,3	4,3	*3,0*
Developed countries	***984***	***1.067***	***83***	***8***	**100,0**	**100,0**	
60+	203	345	*142*	*70*	20,6	32,3	*11,7*
65+	153	280	*127*	*83*	15,5	26,2	*10,7*
80+	39	105	*66*	*169*	4,0	9,8	*5,8*
Transition economies	***302***	***261***	***-41***	***-14***	**100,0**	**100,0**	
60+	47	76	*29*	*62*	15,7	29,3	*13,6*
65+	37	56	*19*	*51*	12,4	21,4	*9,0*
80+	6	14	*8*	*133*	1,9	5,4	*3,5*
Developing countries	***5.179***	***7.748***	***2.569***	***50,0***	**100,0**	**100,0**	
60+	422	1.547	*1.125*	*267*	8,1	20,0	*11,9*
65+	286	1.129	*843*	*295*	5,5	14,6	*9,1*
80+	41	275	*234*	*571*	0,8	3,5	*2,7*

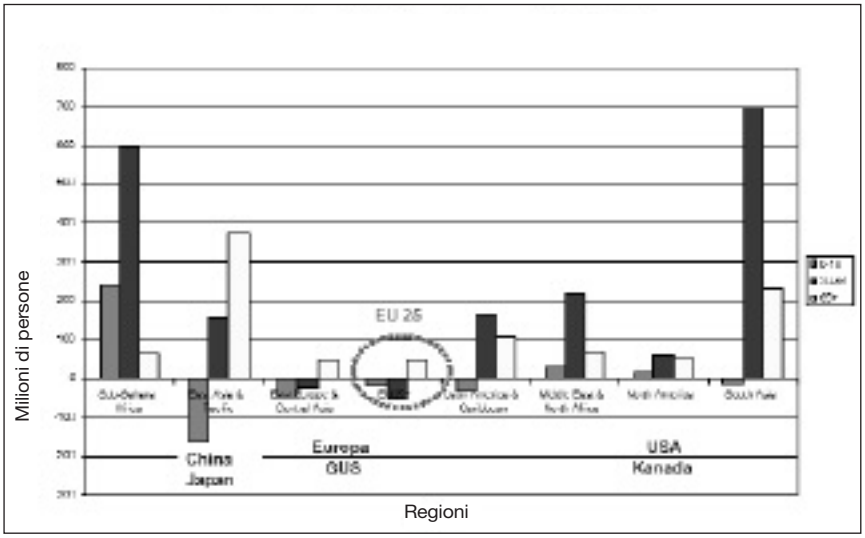
Source: my own calculation from data: DESA, 2007

Figure 4. A graph for the evolution of the structure by age of a hypothetical population in line with demographic transitions that have finished (from high fertility and mortality to low fertility and prolonged mortality) and with reference to three current populations that are undergoing different stages of demographic transition



Source: Golini, Marini, 2004

Figure 5. Variations of populations by age group and regions in millions (2000-20050)



Source: Eurostat, 2005

stitute a focal point in the move from six milliard and a half inhabitants to nine milliard in 2050 (table 9). The expected increase of 40% of the world population, together with the internal transformations of its structural composition, will also call into question the sustainability of the population of the earth in terms of food, energy and environmental resources, just as the albeit imperfect analyses of the MIT in the 1950s were a cause for concern in the famous projection of the Club of Rome. The worry about a further envisaged increase of 2.5 milliard in the population of developing countries is also incontestable if this demographic increase (+50% in fifty years) is not matched by an extraordinary and necessary economic restructuring. But, on the other hand, there is no less worry about a further increase in unsustainable consumption on the part of developed countries.

In considering the multidisciplinary intersections that are required to address present, imminent and future ageing of the population, which is inevitable at a global level, although differentiated at the level of rapidity and intensity in the various parts of the world, it is necessary, as has already been observed in this paper, to correctly indentify what, amongst other things, 'economic equilibrium' means. As is known, indeed, the virtuous circles of the economy always derive from a varyingly long-term rearranging of the productive system in a broad sense, in response to the demand, again in a broad sense, requested of it by a general 'consumer', whether an individual or society. The challenge to which, amongst other things, the economy will be called will involve, therefore, reorganising itself internally in order to assure a sustained and sustainable growth of GDP despite the structural changes in the population, and redirecting its supply in response to the changing needs of demand – interpretable as a dynamic demand for goods and services – of a structure which in terms of age is in constant and profound transformation. The ageing of the population, from the point of view of its economic consequences, will in fact affect both the

'population of producers' and the population of 'consumers'.

In constructing a general schema of the development of the structure by age of a hypothetical population subject to the first and second demographic transitions – a schema for that matter that refers to three current populations that are undergoing different stages of demographic transition, namely Niger, China and Italy – (figure 4), we can in fact observe how over a time frame of a century and a half the age band 0-14 has experienced a collapse in terms of percentages, falling from 50% of the population to less than 10%.

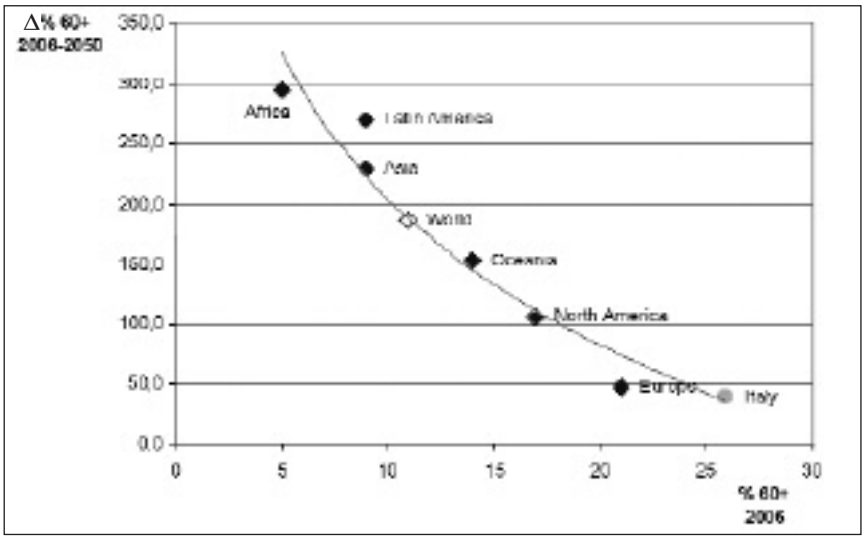
It is evident that the section of the population of less than fifteen years of age is the bearer of a special direct and indirect demand for goods and services which will gradually diminish compared to the demand of more elderly age bands (60+) which in 2050 could replace its role of being 'half the body' of the population, being near to the threshold of 50%. It is important to observe that the 15-59 age band, identifiable as working class, follows a bell pathway with a peak that can come to exceed 60% of the total population. This is what is happening in China where it will constitute 60% of the population, vigorously sustaining a strongly and rapidly growing economy. But forty years later, feeling the very intense fall in births of the past, it will be crushed under the unyielding increase in the elderly part of the population, slipping below the threshold of 45%. Each of these great age bands, as has already been pointed out, in their shifts, in percentage terms and in absolute terms, will force the restructuring of consolidated economic equilibriums in order to face up to new qualitative-quantitative typologies of demand for good and services and to take advantage of changed qualitative-quantitative human resources (figure 5).

Worthy of note, for that matter, as has already been pointed out in this paper, is the inverse relationship, well portrayed in figure 6, between the level of current ageing (on the horizontal axis) and expected ageing (on the vertical axis), in the sense that where the current ageing is already very intense (for example in Europe) the future increase in those over sixty will be less and vice versa (for example Africa). At different times and in different ways the ageing of populations will therefore be a strongly characterising element of all the countries on the planet.

4. Four Generations for a Revolution: a Century of Demography of the Elderly in the World

Four generations in about a hundred years: once again a different way of seeing the times and protagonists of an authentic demographic devolution that is transforming a population group, namely the elderly, into an authentic population within a population, because of an absolute, percentage and relative progressive proportion (table 10). Although, in fact, between 1950 and 2005, that is to say the first fifty-year period to witness the fulfilment of this centuries-old journey, the world and its various regions still had a greater increase of people with less than sixty years of age compared to those of sixty and over – a phenomenon especially accentuated in developing countries, be-

Figure 6. Ageing of the population: present and future. Percentage of 60+ in 2006 and expected increase between 2006 and 2050



Source: my own calculations from UN, 2006

Table 10. Expected variation between 1950 and 2050 of the population less than sixty years of age and over sixty years of age

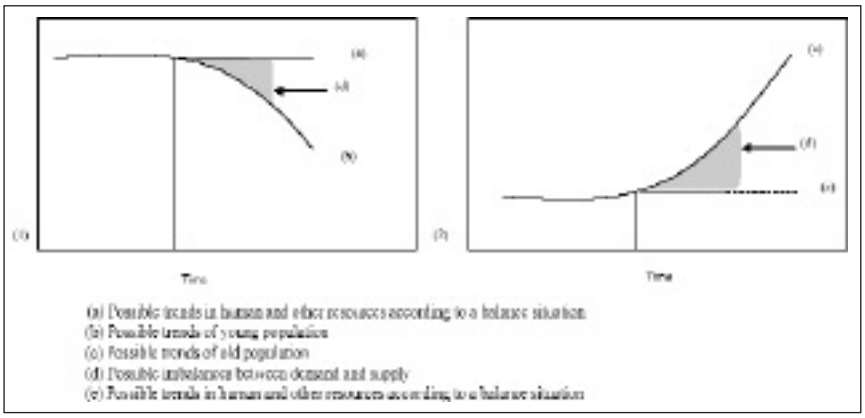
Region	Less than 60	60 or more		Less than 60	60 or more
	1950-2005			2005-2050	
World	+3.479	+467		+1.315	+1.296
Developed countries	+213	+124		-59	+142
Transition economies	+83	+28		-70	+29
Developing countries	+3.183	+315		+1.444	+1.125

Source: my own calculations from data: DESA, 2007

tween 2005 and 2050, or so the UN projections show, there will be an increase in the population with less than sixty years of age which will be limited to developing countries, and in any case halved compared to that of the first stage of the grey revolution. The expected near tripling of people over sixty is due, once again, to the populations of developing countries which, as has already been described, will experience an ageing that will be characterised by great speed, side by side with the very intense but not very accelerated ageing that is typical of the developed countries. The problem that arises, therefore, is that of facing up to an exceptional increase in the elderly population with a modest increase (or even a decrease) in the young and adult populations.

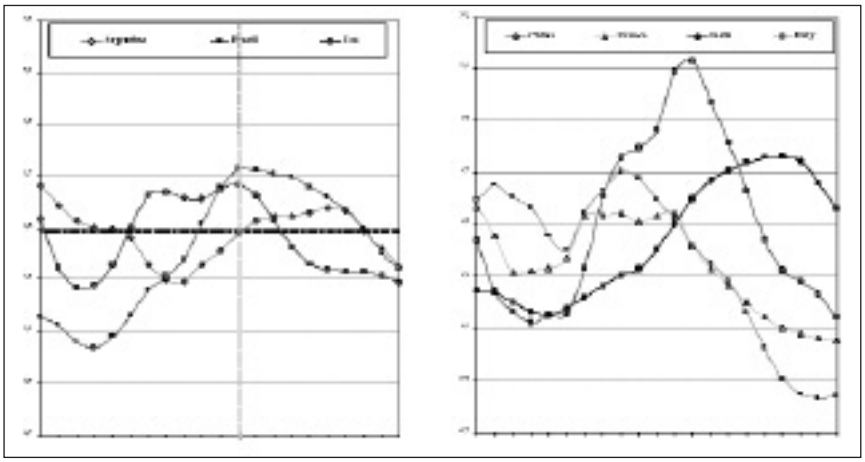
Some of the major difficulties linked to these extraordinary demographic transformations (figure 7) lie in their capacity to relocate human, in addition to physical and financial, resources *in itinere*. These are resources which, although they are inert in their supply (a) (for example the stationary character or even increase in teachers) would not match in a congruous way the structural change in the demand (b) (a contraction in school classes because of low fertility levels and a fall in births), thereby generating an area of varying degrees of breadth (d) of imbalance between the demand and supply of goods and services. A different analysis applies in the second case study where in the face of an increase in demand injected into the market of good and services by elderly people (c), the inertia of the supply (e) (for example of geriatricians, home carers) would create an area of insufficiency in the market of human, as well as physical and financial, resources in relation to the needs of a growing and thus unsatisfied new demand.

Figure 7. The dynamic adaptation of the economy and society. A graph that illustrates the imbalance between the population of specific age groups and human resources (for example teachers, paediatricians, geriatricians, nurses, etc.)



Source: Golini, 1993

Figure 8. Dealing with the impact of the demographic cycle domestically and internationally. The ration between the section of the population of working age (15-59) and the dependent population (0-14;60+) in seven countries at different stages of demographic population (1950-2000; average variant of projections until 2050)



Source: UN, *World Population Prospects. The 2004 Revision,* New York, 20

In a vision of a 'domestic' kind, of fundamental importance will be the *speed of change* in the population by age groups and the parallel capacity to have a similar rate of change in financial, physical and human resources allocated to the various age groups. The *political response* cannot, therefore, be limited exclusively to a demographic response but must, rather, be part of a global approach that internalises all social and economic aspects in the planning that takes place.

At an international level, in order to deal with the impact of the demographic cycle in the world arena and to govern the mechanisms of international competition and competitiveness that would otherwise lose from the outset, it will also be of fundamental importance to address the complex question of the contraction in the ratio between the section of the population of working age and the section of the population not of working age (figure 8), which over the next decades will be applied to all countries. All countries, inevitably, will have to review the threshold for the fixing of the age when people will have to see themselves as 'dependent on' and no longer the 'engine of' a productive system. A relocation of the thresholds for entrance into the labour market and retirement will be needed in order to find a response to a shortage that would otherwise be inevitable in the workforce and above all else to an

imbalance between pensioners and workers. Here we are dealing with the size of the working age population (WAP), expanding its boundaries both to keep those more advanced in age working and speedily to integrate young people who are by now mature enough for the system. These are measures that appear correct not only economically but also anthropologically , socially, culturally and politically now that life expectancy has been so expanded. It is not easy to understand, beyond the question of the sustainability of the economic system, the reason for an ejection from the labour market of people who are still helpfully and easily employable in the dynamic of production.

It is certainly the case, with the increase in productivity (employed/GDP) as well, that one can and one must identify a flying wheel to sustain a growth in GDP that would otherwise be condemned to a painful decline (box 2).

The strong deterioration in the ratio between people who are 'dependent because of old age' and people of working age is confirmed again by circumscribing the range of the analysis of the projections first to the European context (figure 9) and then to the development in absolute values of the population of Italy (figure 10) which is expected to have to prepare for a very strong contraction in the working age population in both absolute and percentage terms.

5. Facing up to the Ageing of Families

Of no less relevance in this context are the transformations at the level of units of micro-aggregation that create, through their further higher aggregations, those populations whose ageing is studied – families understood in a broad sense.

To address the ageing of a population means, indeed, also dealing with the ageing of families, which involves the co-existence (and not necessarily cohabitation) of three to four generations, not only in a

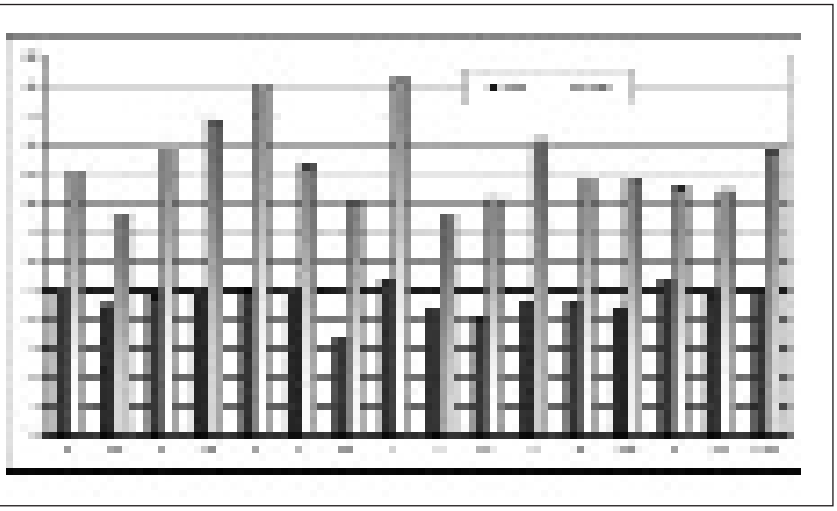
Box 2. Demography, Ageing and GDP

$$GDP = \frac{GDP}{Employed} * \frac{Employed}{Working\ Age\ Population} * \frac{WAP}{Population} * Population$$

|productivity|

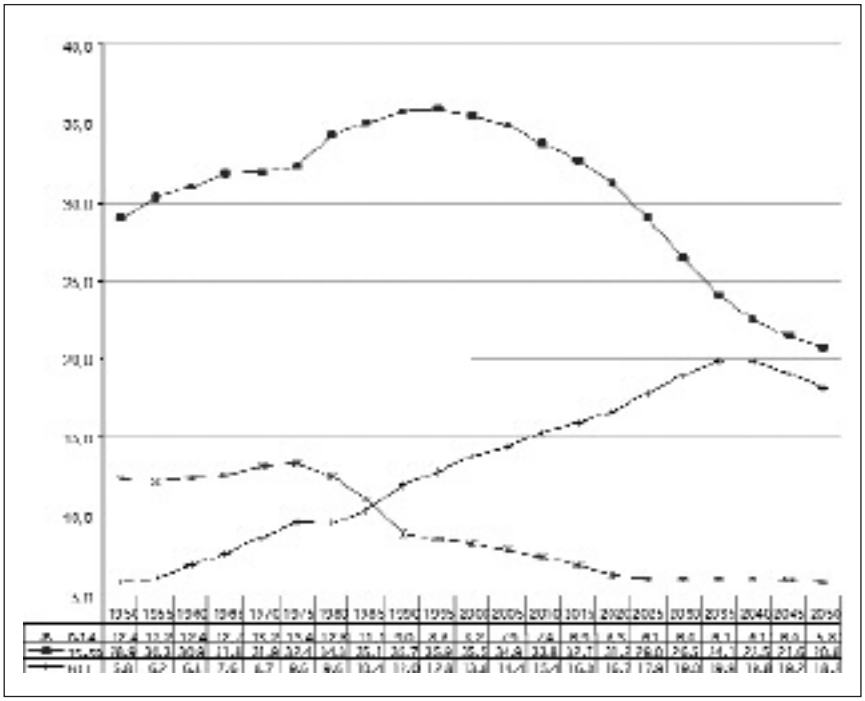
| economic components ||demographic components|

Figure 9. Number of people of the age of sixty five and over for every hundred people between the ages of twenty and sixty-four



Source: Eurostat projections (baseline)

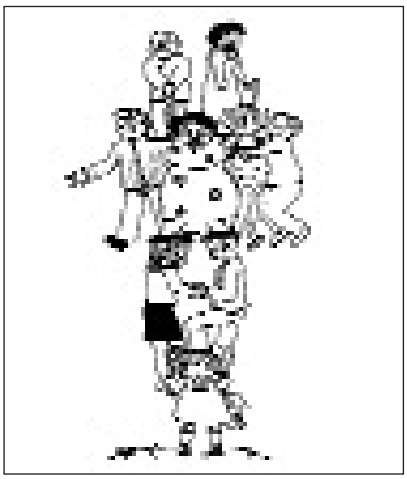
Figure 10 – Population by age groups: <15, 15-59, 60+. Italy 1950-2050 (medium variant, in millions)



Source*:* UN, *World Population Prospects. The 2002 Revision (medium variant),* New York, 2003

typical family unit (figure 11) but also, for example, in the contemporary Chinese population, with all the repercussions on terms of 'expectations' that the older generations have in relation to the members of the younger generations which often take the form of an only child 'crushed' by the concentration of his identity by all the projections of the numerous adult and elderly members of the family and thus in a precarious psychological state of balance.

Figure 11. The co-existence of different generations in a family unit of a Western (but not only) country

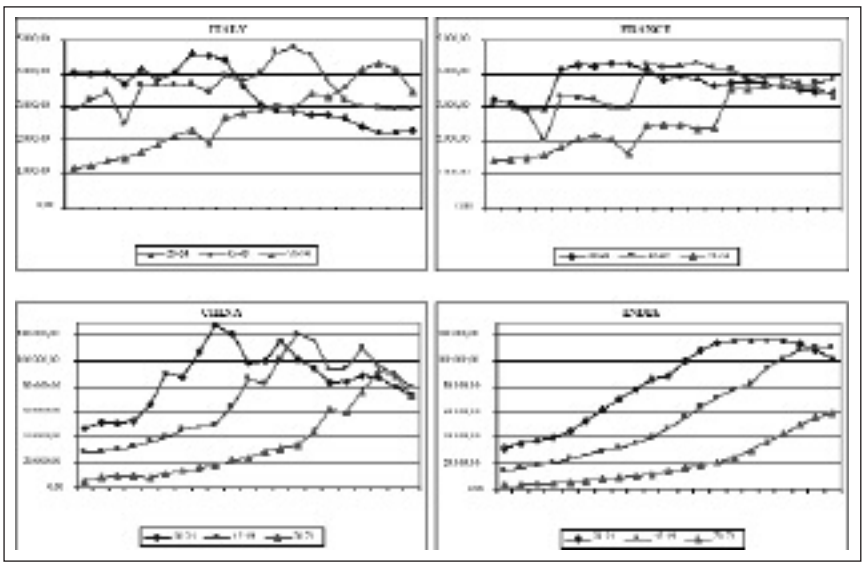


Source: Golini 2003

For that matter the increase in the number of families with a single child or even without children ('child-free' families according to some contestable feminist negative tendencies which commit the sin of 'social short sightedness') requires an increasingly accentuated growth in inter-generational solidarity between elderly people, to be flanked and implemented in parallel with traditional inter-generational solidarity which will necessarily decrease both for demographic reasons and for social reasons (the very strong increase in separations and divorces which disrupt the families that people come from) (figures 12-13).

Figure 12. The increase within families of the co-existence of different generations

Figure 13. An assessment of co-existence between three generations (between 20-24, 45-49, and 70-74 years of age, in thousands), 1950-2050, Italy, France, China, India



Source: UN, World Population Prospects. The 2004 Revision (medium variant), New York, 2006

5. Conclusions

To end this paper, I may state that the challenges raised by demographic ageing are immense and require both developed countries and developing countries to have important and diversified capacities.

In particular, economically developed countries will have to find, develop and combine a capacity to: make the productive system survive by dealing with the impact of their demographic cycle combined with that of developing countries; make their system of social security survive by dealing with the impact of demographic cycle; find a different system of assistance and care for disabled elderly people given that what in many countries is based upon families seems to be no longer sustainable because of the alteration in the ratio between the generations, modifications in the nosological framework, the length of periods of care, the increasing fracture and reforming of families , and the frequent inadequacy of home habitations; try to increase the fertility rate, in order to thereby ward off an increasingly intense process of ageing as well; and manage immigration which is necessary but which indicates that it will be on an increasingly mass scale.

Developing countries, in their turn, will have to find, develop and combine a capacity to: maintain and improve their productive systems by managing to create over a few decades over a *thousand million decent* jobs (that is to say with remunerations that go beyond two dollars a day), managing, therefore, to deal with the demographic impact of developing countries and the problems of competitiveness that are created between them; create everywhere efficient and universal national health services, and create everywhere a general system of social security, dealing with the extraordinary speed of their ageing and the difficulties of economic growth.

These are certainly complex challenges, but responding to them and addressing them would certainly allow developed countries and not yet developed countries to experience the 'intervals of death' not only without excessive worry but even with relative tranquillity.

Is it perhaps a necessarily less wise and detailed approach to the initial 'gains in life' to suggest to the fathers of mortality studies that they should define the first tables to analyse human survival as 'life tables' rather than 'death tables'? Is it because they were still surrounded by a very frequent early death that a life expectancy of sixty years already constituted a sufficient achievement to define a table a 'life' table' and not a 'death' table? And is it because death was seen as being an integral part of the human journey that it was necessary to define the sequences of numbers that testified to a capacity to be living as 'life' tables'?

A commitment of the future, therefore, will also be a return to the serenity of Don Toaldo in defining his tables as 'life' tables in which the just hope of prolonging life is accompanied by respect for the human pathway of the mortal creature who only in the acceptance of this eschatological tie can really enjoy the profound significance of being able to pass with awareness through the various stages of life.

Prof. ANTONIO GOLINI
Lecturer in Demography,
'La Sapienza' University,
Rome, Italy.

I would like to thank Dr. Daria Squillante for her important contribution to the writing of this paper.

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Notes

[1] Emphasis should be laid on the subsequent obsolete charts or hypotheses about maximum life span (for example Bourgeois Pichat) which, whatever the case, indicated a progressive ageing of the population to the statistical benefit of the most advanced ages (Golini, 2003).

[2] This very important conceptual shading can be better understood by observing how the maximum individual age at death became established, for example during the Italian period of 1973-2003, on a threshold of low oscillation:110 years in 1973 (the first over hundred woman from Lazio);111 years in 1991 (a man from Calabria); 112 years in 2002 (a man from Sardinia); 113 years in 2003 (a man from Puglia).

ROBERTO BERNABEI

3. Spiritual Care for the Sick Elderly

In the last thirty years there has been a change in lifestyles and in the cultural and social conditions of the general population. Programmes involving prevention and screening for cancer, and campaigns for the promotion of, and education in, prevention of cardiovascular risk, have changed the causes of illness and death in the elderly part of the population. This phenomenon has led to a reduction in mortality rates caused by cardiovascular pathologies, stroke, domestic accidents, and an increase in mortality rates for lung pathologies and diabetes. Taking into consideration, in addition, the constant increase in the average life span of the population both in industrialised countries and in developing countries, with an increase in the percentage of individuals within society over the age of eighty, we may state that health care and social assistance have experienced the impact of this typology of patient.

Advanced age, having a number of pathologies at the same time, the risk of the compromising of physical capacity, sarcopenia, disability, handicaps or a compromising of 'social' functions, all constitute the elements that characterise the so-called 'frailty' of elderly people. Physical disability and social disability have a close relationship with dependence.

On the basis of these observations, there has emerged in outline the specificity of the geriatric patient and thus of an individual of an advanced age, affected by various concomitant pathologies, where his functional status, quality of life and prognosis also depend on non-physical factors such as his cognitive-neuropsychological condition and economic, social and environmental situation, which, indeed, make it difficult to draw near to him and provide assistance to him.

An increase in disability also implies an increase in the demand for services involving assistance and help for elderly people, as well as a necessary planning of the action to be taken through a correct utilisation of the resources that are available. From a clinical point of view, an frail elderly person needs the integration of health-care and social services which should achieve, through various professional figures, a plan of individualised intervention through a suitable assessment of the problematic areas of the patient himself.

The international literature in the field has for some time clarified that the multidisciplinary and interdisciplinary character of the action taken constitutes the specificity of the role of geriatrics. It is thus indispensable to acquire instruments for assessment that cover these various dimensions and assure overall and individualised professional intervention which is at one and the same time preventive, curative and rehabilitative.

The figure of the geriatrician has for some time been acquiring an outline, above all in the light of certain studies which have demonstrated how the presence of a geriatrician and a geriatric assessment unit within hospital departments allows a reduction in the re-admission rates of patients to hospitals, a reduction in mortality, and a reduction in costs.

The study by Rubenstein is by now a landmark. In this study two groups of elderly people chosen at random were compared in which the 'treated' group was made up of elderly people who were assessed with multi-dimensional assessment instruments and followed by a geriatric assessment unit and the 'control' group was made up of elderly people who received conventional treatment without multi-dimensional assessment instruments or a geriatric assessment unit.

The results obtained were as follows: a survival to one year of 70% of the group that was followed by a geriatric assessment unit as against a rate of 50% in the case of the control group; a significant reduction in mortality at two months (-41%) and at six months (-36%) in the group followed by the geriatric assessment unit as compared to the control group; 73% discharged and sent home in the first group as opposed to 53% in the second; 12.7% transferred in the first group as opposed to 30% in the second; and a decrease in overall annual expenditure on health care (a saving of 5,229 dollars for each patient).

In the light of these facts the concept of team work has become increasingly established. This takes place through an assessment unit in which there is the figure of the geriatrician who, through a system of 'case management' and through suitable instruments of multi-dimensional assessment, draws up a plan of action directed towards an improvement in the quality of life of the patient and an optimisation of the resources that are available; through initiatives directed towards the prevention of all factors than can affect the patient's level of self-sufficiency; through the treatment of illnesses; and through rehabilitation.

For multi-dimensional assessment, a methodology of inquiry has been established which, through a broad gamut of tests, measurements and scales of assessment, which are able to identify the problem or the problematic area that are to be assessed, flanks the normal nosological assessment of the pathologies of the patient, allowing a more overall and deeper knowledge of them, in particular at a functional, cognitive and social level.

In a standardised and interdisciplinary way, it assesses the various problematic areas of the 'frail' elderly person in order to identify with precision the problems that are present and to draw up a plan for

assistance that will solve these problems. Multi-dimensional assessment as such should assure: an identification of the needs and the problems at the level of assistance of the individual patient; problem solving; the planning of action at the level of assistance (prevention, treatment, rehabilitation); and follow-up.

The meta-analysis of Stuck *et al.* demonstrated a reduction of 28% in the mortality of patients who were followed with multi-dimensional assessment, a reduction in level of admission and re-admission to hospital, an improvement in the physical and cognitive condition of patients, and a decrease in the levels of institutionalisation.

On the basis of these premises, there emerges the need for a methodological approach directed towards the problems as a whole that an elderly person who runs the risk of non-self-sufficiency experiences, and the employment of multi-dimensional instruments of assessment that ensure that the action that is taken is of a high professional standard.

An analysis of the literature in the field of geriatric assessment and other fields as well offers a very broad gamut of instruments that are certainly suitable but which are at the same time sectorial and specific. Traditional instruments of assessment engage in a descriptive assessment of the individual problematic areas of the elderly and their principal limitation is that they do not lead in a directed way to a plan for action, they describe an individual problematic area, and they do not assure a rapid comparison between the various experiences at the level of assistance and the various settings at the level of assessment.

The second-generation multi-dimensional assessment instruments are all inclusive instruments that move towards a correct aetiological diagnosis of the problems that have been identified; lead to a better individualised plan of assistance; assure a monitoring of the patient's state of health; and allow the creation of a database (which in turn means a comparison, the control of the quality, and the transferability, of the data that has been collected).

The need for an all inclusive instrument that assesses all the problematic areas of a resident elderly person and also includes all his residual capacities and preferences for, and ability to engage in, various activities, was met by the drawing up of the resident assessment instrument (RAI).

The RAI (or VAOR in Italy) is a multi-dimensional assessment instrument that was created by more than eighty experts in response to a mandate given to them by the Congress of the United States of America following the OBRA law of 1987.

The aim of the RAI is to create, through an overall assessment of the resident guided by questions contained in the minimum data set (MDS) and summarised in the answers given to the items proposed – these are the bases for the drawing up of a plan of individual assistance that allows the achievement and/or maintenance of the highest possible level of physical, mental and psycho-social functioning.

The assessment form for home assistance, validated in the version translated into Italian as well, namely the VAOR-ADI, allows an overall assessment of an elderly person and, supplemented with client assessment protocols, identifies all the various health-care and non-health-care problems of the patient.

The compilation of this assessment from for home assistance, with its three hundred items, is not in itself conclusive. It is only 'descriptive' of the elderly person and achieves this through positive or negative answers to the assessments that are contained in it. The answers are 'weighed' by the various PVCs (automatically through the software that is used) in order to become automatic or potential indicators of a problem and/or need at the level of assistance.

Obviously, this system, in addition to being useful for the planning of action taken at the level of assistance in the case of individual patients, also constitutes a basis for a possible cataloguing and storage of all the data involved.

The VAOR system, indeed, functions both as a facilitator in decisions of a clinical/care character at the level of the patient and as a standardised and validated instrument for the collection of data and thus for the creation of a database for population studies.

The creation of data banks which bring together information of a demographic, clinical, and social/health-care character, is absolutely indispensable if we want to improve the planning of care services for elderly people, to improve their quality, and to allow debates not only within individual nations but also between nations.

Hitherto the implementation of the family of RAI instruments has allowed the creation of an international database which at the present time is used for the purposes of scientific research and the monitoring of the quality of care. The group of fifty-eight researchers that represent twenty-five nations which is used to study multi-dimensional assessment instruments bears the name interRAI.

In addition to the possibility of defining factors of prognosis and assessments of specific outcomes, the use of a database also allows the control of indicators of quality of the care that is provided which show changes over time ('incidence measurements') or the situation at a given time ('prevalence measurements'). Some indicators of quality offer correct measurements as regards the basic risks of the patient and in addition have the advantage of allowing comparative analyses between patients within the same care setting in the same region or between different geographical regions.

Studies carried out with the RAI database have allowed the establishment of forecasting factors as regards the non-use of painkillers in cancer patients, the risk of mortality linked to an absence of vaccination, and the disability linked to physical activity, etc.

The use of a minimum common denominator created through the employment of equal instruments of assessment/data gathering was the point of departure for the creation of the AD HOC (Aged in Home Care) Project, which was directed towards ascertaining the best strategy available for home care for elderly people through the establishment of a reference model for home care that could best meet the needs of elderly people in Europe.

Through a comparison of the data from eleven European countries it emerged that in Italy home care patients are extremely compromised from a functional and cognitive point of view. In addition, the formal support, calculated in terms of weekly hours of care, is minimal compared to the needs and requirements of the part of the population receiving home care. In this area, home care services are used by only 3% of elderly population, the 'heaviest' percentage in terms of care. This fact indirectly reflects the lack of availability of alterative care structures and the difficulties that home care services encounter in dealing with such patients in an adequate way.

The use of multi-dimensional assessment instruments is envisaged within a geriatric assessment unit, whose fundamental core is made up of a geriatrician, a professional nurse, a social worker, a rehabilitation therapist, an oculist, a psychogeriatrician, and, according to need, an occupational therapist, a lalophomiatrist, a hearing specialist, a dietician, a foot specialist, and so forth.

The work of a geriatric assessment unit takes place within an integrated network of social/health-care services for elderly people that includes – before anything else – integrated home care and health-care homes. Within the geriatric assessment unit there can be the figure of the case-manager or the case co-ordinator who is able, by using suitable instruments, to carry out a multi-dimensional assessment and to establish with the general practitioner and with all the other member of the geriatric assessment unit the suitability or otherwise of one or more ongoing care services. The case co-ordinator has a double task – on the one hand that of being a counter to which the elderly person can turn for an assessment of his needs and a consequent referral to the service that he requires, and on the other that of being a co-ordination centre. The case co-ordinator has to be able to engage in a multi-dimensional assessment of the elderly person and to plan specific initiatives through the drawing up of individualised care plans.

This model of care has been applied in Italy in the NHS area of Rovereto (TN) where, through a controlled clinical trial, the impact has been observed of an integrated programme of home (social and health-care) services on the phenomenon of institutionalisation, on the use of services, on the consumption of resources, and on the functional decline of 'frail' elderly people who live in their own homes.

At the beginning of the experiment, the individuals of the active group as opposed to the members of the control group did not display any significant differences as regards functional and clinical variables. However, after a year it was shown that integrated measures of home (health-care and social) care, implemented through an interdisciplinary team that included amongst other figures a general medical practitioner and a non-medical professional worker with the duties of a 'care manager', were able to reduce the risks of admission to hospital and the length of stays in hospital or a nursing home.

In addition, using the same home care resources, the individuals of the active group showed a significant reduction in their functional and cognitive decline. Lastly, the overall cost for the care provided to each individual in the active group was significantly lower than was the case with the members of the control group.

Similarly, the implementation of home care services based upon the organisation of services through a geriatric assessment unit demonstrated at a national level a reduction in the level of hospitalisation and the length of admission to hospital, as well as a diminution of hospital costs through a reduction in incongruous unplanned admissions and re-admissions, which, indeed, are what most bear on health-care expenditure.

The efficacy of the multi-dimensional assessment instrument as opposed to the conventional assessment instruments applied to individual problematic areas emerged even more after the Bergamo experience where two methodologies for multi-dimensional assessment were compared. The patients involved in the study, who were the same at the level of general characteristics, were chosen by random from two districts of the Italian NHS of Bergamo. District 1 used as an instrument of multi-dimensional assessment the VAOR-RAI (the intervention group) whereas District 2 used conventional instruments for geriatric assessment for the functional state of patients (the ADL and IADL index) and for the cognitive state of patients (MMSE). Irrespective of the group to which they belonged, all the patients considered suitable for the home care programme received case management attention and a planning of what was to be done for them by the local geriatric assessment unit and general medical practitioners.

The differences between the intervention group and the control group were statistically significant as regards functional and cognitive performances, which were improved in the intervention group where there was, in addition, an increase in the use of social services and a reduction in the levels of hospitalisation and days spent in hospital.

It is thus evident that in the approach to patients over the age of seventy-five, in addition to anamnesis and a careful objective examination, it is also indispensable to engage in a multi-dimensional assessment directed towards identifying problems of a clinical, laboratorial and functional character and which analyses in a more complete way the various problematic areas of elderly people.

Prof. ROBERTO BERNABEI
Director of the Department of Gerontology and Geriatrics, The Catholic University of the Sacred Heart, Rome.
President of the Italian Society for Gerontology and Geriatrics.

4. The Origins of Illnesses that Influence Old Age Today

JOSÉ MANUEL RIBERA CASADO

4.1 Behaviour, Lifestyles, Diet, Greater Life Expectancy

I will try to analyse in a positive way the title that was assigned to me for this paper. For this reason, rather than referring directly to the generic heading of the symposium, namely 'the origins of illnesses that influence the elderly', and to the part that was assigned to me, namely 'behaviour, lifestyles or diet', I will centre my paper around these points but by starting with a more positive observation that takes as its basis the questions that refer to prevention. I believe that in this way I will meet the spirit of the symposium and of the conference in a better way. To this end I will organise my paper into two parts. In the first part I will develop certain ideas connected with what we could see as 'healthy ageing', meaning by this a kind of mirror image of the 'illnesses that influence the elderly'. In the second part of the paper I will address 'behaviour' (the 'human behaviour' of the title of the paper) which must have as its foundation approaches based on prevention. In this context I will place greater emphasis on those aspects connected with lifestyles and diet, as indeed is incumbent upon me.

1. Healthy Ageing: Some Concepts

One can make many observations about ageing. In the field of the *evidence* that has been produced there are some kinds of evidence which are not very contestable. They are fundamentally three in number. The first is that one is dealing with something to which we all aspire. However negative the vision that each person may have of old age, evidence demonstrates that we all want to reach it. Nobody wants to die young. Even those who reject old age and announce that they do not want to become elderly find a suitable moment to make the jump as the years go by. It appears clear that those people who do not want to reach old age are a not very significant minority: perhaps some people who commit suicide and in almost all cases people who have motivations that are exceptional in character.

The second form of evidence is of a demographic character and is a novelty as regards the whole of the previous history of mankind. Until the twentieth century a certain advanced age was a very rare phenomenon within the reach of very few people. It was experienced as something very singular and was in now way a significant phenomenon within the general context of society. The demographic transition of the last hundred years have led us towards a society that is increasingly aged where a very important proportion of the population reaches an age that was unthinkable a few decades ago. Here it is worthwhile to recall certain data. Average age expectancy in the countries of Western Europe at the beginning of the twentieth century was between thirty-five and forty years of age, with a few years more in the case of women. A hundred years later in this same geographical area these levels are above eighty for women and area near to this age in men. If we add to this that the number of births has decreased dramatically, we can understand that the level of people over the age of sixty-five – the retirement age – has increased in a spectacular way, constituting, according to the country involved, between 15% and 18% of the total of the population. Today in developed Europe for the first time in history the number of people who are over the age of sixty-five is greater than those who are under the age of fifteen! There are more elderly people than there are children!

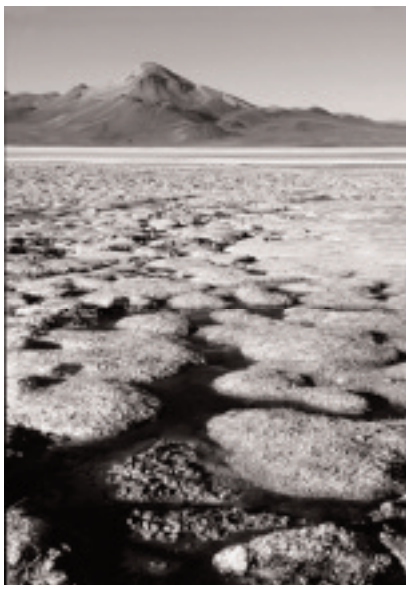
Various factors have contributed to bringing about this situation and some of them are directly connected to the health-care world. First of all there are measures of public health, amongst which is included something that is very elementary, namely as drinkable water, a provision that was not widespread at the beginning of the twentieth century. There are the epidemiological advances and in a specific way gradual increased knowledge about various risk factors in relation to all kinds of illness and the possibility of dealing with them. This subject, the entering onto the stage of the so-called 'risk factors', is equally a recent phenomenon. Only beginning with the publication of the first data of the study by the Framingham study during the 1950s did people begin to speak about this question. To a lesser extent, other advances more directly linked to

individual health, such as those achieved in the field of pharmacology, anaesthetics and surgical techniques, have also had an impact. It is important to bear in mind that in order to understand the ageing of the population, in addition to advances in that world that is most directly connected with health, many other factors that are directly derived from what we could call social progress and economic development have also played an essential role.

The third area of evidence connected with ageing is the observation that with the passing of the years changes take place in our bodies. These are very important changes which, if described in a simple way, are habitually expressed in losses. To grow old means to lose as one goes through life by very different pathways a good part of the enormous margin of functional reserves with which we come into the world. These are losses that have in common the fact of becoming increasingly vulnerable to any kind of aggression, thereby facilitating the weakening of the body, the appearance of illness, and in the final analysis death itself.

Before going on it is worthwhile recalling certain concepts of a demographic character. I am referring here to what we call *life span* or *life expectancy*. This is a multifaceted phrase that should be stressed. First of all should speak about what the literature in English in this field terms 'life span', which could be translated into Italian as '*estensione di vita*' or '*speranza o aspettativa di vita massima***'**. One is referring here to the maximum period of time which in the best possible situation the life of an individual or a specific animal could achieve. This is a specific limit for every animal species but one shared by all its members and it has undergone only a small number of changes over time. In all periods of history and in all animal species exceptional individuals have existed which in a very small proportion have managed to reach this limit point. In order to be able to know the maximum life span to which a man can aspire it is necessary to have available without any margin of error the dates of his birth and death, something that has only been possible since the widespread creation of the 'civil register', something that took place in European countries at the beginning of the nineteenth century because of the Napoleonic revolution. This took place somewhat later in other parts of the world.

The absence of reference data that are reliable as regards birth dates on many of those purported extreme life spans that have been described in remote areas of the planet which are nearly always at a high altitude in mountain chains such as the Andes, the Caucuses or the Himalayas means that these extreme life spans cannot be taken into account. With civil registers as one point of reference one can state that the greatest life span for man is roundabout the age of 120 and it is not likely that this limit will change significantly in the short term. To achieve the age of 120 is the most important goal for which biogerontologists are fighting. The longest living person about whom we have firm evidence is Jeanne Calment who died in France in 1997 at the age of 122.



A second concept is that of 'average life span or life expectancy'. This refers to the period of time which, according to statistical criteria, an individual can probably live starting from a specific moment, which can be the birth of that individual or any other age. This also requires a physical location. In order to establish this figure the whole of the population of reference is taken into consideration and the predictable average length of age is established. This concept is variable and it has undergone very important changes down history and according to the geographical area of reference.

The other two important concepts linked to life expectancy are 'independent life expectancy' and its opposite – 'dependent life expectancy'. Here the limit is determined by the fact that the subject in question is or is not able to rely upon himself or herself to carry out the basic activities of daily life and does or does not require the help of third parties. In this context what we know as 'dependence' has changed into a fundamental referent for our society to the point of giving rise in our country and in other countries as well to a specific law which some people have defined as the basis for the establishment of the fourth pillar of the welfare state in an advanced society. The result of a good 'functional capacity' – the antithesis of what dependence is – constitutes the fundamental objective of the specialisation of geriatrics and is a more specific challenge as a medical specialisation.

Old age is not something that is reached in a brusque way. One does not become old at a specific moment, nor is there an age that can be used as a perfectly definable limit. The establishment of a top point, an age, has sense in only two situations. For administrations when a person retires and becomes a pensioner or for demographers or specialists in epidemiology when, for whatever reason, they need to carry out studies on a population. Ageing is produced in a dynamic way and is modulated by three complementary pathways that are very differentiated at a conceptual level but which interweave and overlap with the passing of the years to the point of giving rise to the contemporary resulting situation of every person whatever his or her age may be. These three pathways are as follows:

First of all, one's own physiology. I am referring here to the modifications caused by the continuous use of our organism during the course of our lives. These are changes that are connected with the simple passing of time. Their fundamental characteristic is that of

being universals in the dual sense of influencing all individuals and doing this to each of the organic components of an individual, although the cadence of modifications that they can bring out can vary from person to person. The same may be said of the components of an individual's organism. We are referring here to certain changes that are placed in gerontology under the heading of 'physiological ageing'.

The losses caused by physiological ageing, although they are universal, influence in particular the skeleton and the renal, endocrinal, gastro-intestinal and neuromuscular systems of the body, as well as the various regulatory systems employed in the control of homeostasis. The most significant of these modifications are bone and muscular losses, losses connected with skin, the loss of intra- and extracellular water content, a relative increase in the proportion of fats compared to other immediate principles and also the redistribution of fats.

At a second level are located the changes brought about by the effects of illnesses, accidents or surgical mutilations which every individual has accumulated during the course of his or her life. These are processes that where they do not produce death have large and small functional consequences that force people to accept certain limitations and physical adaptations to help functions that have deteriorated because of pathological events. In this case we refer to changes that can be attributed to 'pathological ageing'.

Lastly, there is a third group of factors that generate changes that are correlated with the kind of life that an individual has led. This is a matter of the consequences of exposure over many years to agents like contamination, suitable or unsuitable diet, the regular consumption of toxic agents such as tobacco or alcohol, stress, the lack of physical exercise or exposure to specific risk factors. These are changes that go under the heading 'environmental'.

The changes that I have defined as physiological constitute what in a strict sense is known as 'primary ageing', whereas those derived from pathologies or environmental factors are usually defined as forms of 'secondary ageing' and in practice offer, as we will see, very broad margins for intervention. Primary ageing is very much linked to genetic factors and it is calculated that it contributes to the extent of 25% to the inter-individual variations as regards what is known as maximum life expectancy. Genetic factors play an important role in the development of cardio-vascular illnesses, of many tumours, of specific endocrinal-metabolic processes or of some neurological processes.

According to the various situations that in each specific case accompany the ageing of an individual, we can establish different appellations which anyway appear excessively schematic. Thus we can speak about 'eugenic ageing' or 'successful' ageing when during the course of the process of ageing what I have defined as 'physiological changes' have dominated, with a low level of incidence on those changes derived from pathology or adverse environmental factors. These are individuals who have had few illnesses and who in basic terms have led what in everyday language is known as a healthy life, with a low level of aggression received from environmental factors.

In contrary fashion there also exists 'pathogenic ageing' or accelerated ageing when an excess of illnesses or accidents, and/or an excessive level of submission to injurious environmental factors, have influenced the existence of excessive changes that took place earlier than they would have otherwise done in life. These are individuals who, as everyday language puts it, 'look older than they really are'.

Geriatric literature uses another two terms which after a certain fashion equally express ways of ageing. Thus it speaks about 'usual ageing' to refer to what statistical normality assumes to be the norm and to 'successful ageing' when the intention is to refer to that group of individuals who have tried to reach an advanced age in an enviable state of health, or put in other terms, who have been able to achieve 'successful ageing'.

It is worthwhile to comment on another two concepts that are very interconnected with what has been observed in this paper and which are concepts for which we who work in the world of ageing fight for from a medical perspective or otherwise. One of these relates to population and it refers to the 'curve diagram'. By this the wish is expressed that although we are not able to extend our maximum life expectancy we at the least manage to increase average life expectancy to the point of drawing it near to the limits of the maximum life span so that the mortality curve in both cases is kept horizontal, practically, to ages that are very near to the maximum limits.

The second of these concepts is the concept of 'morbidity compression' and has a very personal and individualised character. Given that we all die and this fact is always influenced by an illness or an accident of a negative character that acts as a trigger element, we strive to ensure that all those processes that limit our vitality and in essential terms determine our death accumulate during a short and final stage of life. This is a period of hours, days or weeks, so that up to that point we are able to enjoy certain optimal conditions of health.

In a broader context it is necessary to remember that in the year 2001 the World Health Organisation coined the phrase 'active ageing', and held this up as a challenge for future years. This slogan – more than a slogan I would speak here about a specific programme – was intended to replace the slogan which the World Health Organisation in the 1990s defined as healthy ageing. The World Health Organi-

sation defines active ageing as 'the process of the optimisation of the possibilities of health, of participation and of safety in order the improve quality of life as people gradually age'. This concept was ratified and gave rise to a specific document at the Second World Assembly on Ageing which was held in Madrid in the year 2002.

2. Satisfying Ageing: Orientations

The next question will be to see how we can compress our morbidity and, in connection with this, how we can obtain that successful ageing to which we all aspire. The answer is a complex one but it deserves certain reflections on the basic points that can direct us towards this end.

The point of departure to obtain this objective relates to *prevention*. As regards geriatrics, prevention usually means the ability to identify patients who are at a greater risk of having certain illnesses or clinical problems and to apply suitable policies to minimise this risk. This includes, among other things, the identification of every type of risk factor and their behaviour, the advisability or otherwise of establishing measures of periodic control for processes with a high prevalence (table 1), and the suggestion of certain courses of action to change lifestyles or the preventive employment of specific pharmaceuticals or vaccines.

Two basic principles: the first is that these preventive measures must be applied very early on in a person's life; if possible, during childhood; the second lays down that no age is a bad age to begin preventive measures because it is never too late to begin. The general objectives of prevention in geriatrics are: a) to reduce premature deaths caused by acute and chronic illnesses; b) to maintain the functional independence of a person as far as this is possible; c) to increase active life expectancy (independent) and d) to improve quality of life.

I have commented on the pathways by which changes associated with the process of ageing are conditioned. Is there an opportunity to act on some of these so that the positive aspects are strengthened and the deleterious aspects are limited?

As regards primary ageing, what is called *physiological ageing*, our possibilities of intervening today are minimal. We are born with a specific genetic endowment which at the present time does not give us a margin of implementation. Not even in human beings have great advances been made through the various attempts to block mechanisms that are inserted into the process of ageing. This is a field that is a permanent subject of study by basic researchers who have the dual aim of lengthening maximum life expectancy and minimising or suppressing some of the deleterious consequences of this process, achieving thereby more successful ageing. Their attempts at the present time are concentrated above all on the most elementary animal models.

We have greater possibilities of achieving a healthy old age when our attempts are directed towards forms of behaviour related to secondary ageing. The first goal here is to minimise the consequences of so-called 'pathological ageing'. Here, to an even greater extent, prevention is a key word: primary prevention and secondary prevention in relation to many of the illnesses or accidents that can arise during the course of a person's life and whose consequences can limit with varying levels of seriousness the future quality of life. Preventive measures that try to avoid the appearance of illness or their short or long term consequences can be of various kinds. Many of these are of a pharmacological kind but there are also ones of a social character and some of them are related to environmental factors. By way of example as regards some of the measures that are connected most directly with decisions of a social character that influence the whole of the population, I will cite measures directed towards preventing events such as road accidents, fires or environmental contamination.

Amongst the *pharmacological measures* of an individual character which can be adopted, there are an infinity of examples. Perhaps the most simple in the field of primary prevention is that connected with the use of vaccines. A correct fol-

Table 1. The Principal Periodic Tests Recommended in Geriatrics

Kind of Test	Recommendation	Level of Effectiveness	Level of Evidence
Arterial pressure	One visit at least once a year	I	A
Breasts	Annual physical test >40 years	I	A
Breast scan	Every 1-2 yrs. from 50 to 69 and from 1-3 years from 70 to 85		
Cholesterol	Every 5 years. Contestable in many elderly people	I-III	C
Sigmoidoscopy	Every 3-5 yrs. >50	II	B
Rectal tract	Annual >40.	II	C
Sight and hearing	Annual test >65	III	B
Mouth	Annual test >65	III	C
Testicles, skin	Annual test	III	C
Heart and lungs			
Basic glycaemia	Periodically in groups at risk	III	C
Thyroid function	Occasionally in >65	III	C
Glaucoma	When needed, periodic in >65 by a specialist	III	C
Densitometry	In the population at risk	III	C
Prostate	Annual PSA/physical test >50	III	C-D

Supplemented by: Bloon

lowing of the calendar of vaccinations during childhood was shown during the twentieth century to be a fundamental measure in avoiding developments that have major negative effects on the future quality of life of an individual. We may think of what anti-polio and anti-smallpox vaccinations achieved. For old age as well there is a well established calendar of vaccinations the implementation of which can produce more successful ageing for individuals. Annual anti-influenza vaccinations and to a lesser extent anti-pneumococcica vaccinations are a good example of this.

In secondary prevention the possibilities offered by contemporary pharmacology are enormous. In the field of cardio-vascular pathology alone I may point to the role played by pharmaceuticals such as astatine, the inhibitors of the angiotensine enzyme converter or the beta-adrenergic receptor blockers or beta blockers, when one has to limit the growing worse of an illness or when one has to reduce the number and the gravity of complications in individuals with lipid alterations with coronary diseases or who have been the victims of cardiac insufficiency. Similar observations can be made about the employment of anti-coagulant therapies in patients with atrial fibrillation or those who are the carriers of specific arterial or vein diseases.

In engaging in prevention and in the achievement of successful ageing it is necessary to carry out suitable controls of the chronic processes generated by serious complications that can give rise to developments such as mellitic diabetes type 2, arterial hypertension and osteoporosis. These are pathological disturbances which at one time could not be controlled and whose control is today within our reach so that their long-term evolution depends on a diligent application of the therapeutic protocol that is required.

Examples that refer to causes that cannot be placed under the heading of secondary prevention can be given *ad infinitum*. They go beyond the cardio-vascular apparatus and also include what we know as campaigns for the early detection of specific illnesses where it is possible to intervene during their early stages, whereas there are high risks of death or the ailment becoming chronic with an 'unsuccessful' prognosis as regards quality of life when the diagnosis is made at an advanced age. The need to establish an accurate control is applicable to many forms of cancer but also to other illnesses such as arterial hypertension, mellitic diabetes type 2, osteoporosis, endocrinal illnesses with functional disturbances of the thyroid, etc.

Where our ability to act is greater in preparing someone for successful ageing in the field of secondary ageing is in the context of everything connected with what has been called 'environmental factors'. Above this should be located the education of children in what is known as 'healthy lifestyles'. There are three elements that predominate in this concept – physical exercise, suitable diet, and the avoidance of toxic habits such as excessive alcohol consumption and smoking.

The advantages of physical exercise carried out constantly during a lifetime of an individual, but especially engaged in during old age, have been clearly demonstrated in medical literature. A person who is physically active lives longer and in better conditions of health. This was demonstrated in the 1950s by a study on London bus drivers and ticket collectors. But the advantages of physical exercise are also to be seen in other sectors (table 2). It keeps bones and muscles in better condition and limits their physiological losses, it improves heart performance and breathing, it helps to control very common developments such as diabetes, arterial hypertension, and alterations in cholesterol levels or smoking, it improves mental performance by cooperating in the fight against depression and anxiety disturbances, it limits losses and in general helps in a decisive way to achieve successful ageing and helps an individual to maintain his or her autonomy into advanced old age.

Age is never a counter-indication for physical exercise or sport if practiced in a way that is suitable to the person involved. This includes simple walking or dancing up to the non-competitive practice of sports such as swimming, walking, cycling, gymnastics or golf. Except when there exist evident counter-indications that are linked to well known specific pathologies, the recommendation must always be positive when one takes into consideration aspects such as the type of sport that one wants to engage in and previous experiences in relation to that sport. There should also be an assessment of the intensity of the exercise that is envisaged, the environmental circumstances of the place where it is to be engaged in (time of year, physical area, time of day, length, equipment, etc.), the warming-up period and the rest period, something, indeed, required of any other individual circumstance (concomitant chronic illnesses, the pharmaceuticals that are being taken, etc.) that can involve a risk.

One can make similar observations about nutrition. A suitable diet is another 'healthy habit' that represents one of the basic principles of prevention in geriatrics. The evidence on the importance of having a good diet which is usually associated with other healthy practices in the lifestyle of an individual has been amply demonstrated by many studies in the field. The recommendations here as well take as their point of reference common sense and should begin with good knowledge of the nutritional problems that are most frequently encountered in elderly people, not to speak of their energy requirements and their needs and shortages at the level of vitamins and minerals.

A varied diet is recommended according to the previous habits of the individual involved. It should

contain a sufficient energy input and be rich in fresh foods, milk products, vitamins and minerals (table 3). The levels of calcium, of vitamin D and of folic acid are usually low to a high degree in elderly people. In some situations the administration of food supplements can be recommended or diets enriched with vitamins or minerals can be proposed. The advantages of a systematic and universal administration for preventive purposes of these products or large doses of certain vitamins or minerals is a very debatable question.

It is of fundamental importance that every day an elderly person drinks a sufficient quantity of liquids which should never be less than two litres – with age there is a reduction in the quantity of both intra- and extra-cellular liquid as well as there being a reduction in feeling thirsty. This means that with situations involving increased losses, such as high temperatures, the presence of vomiting and diarrhoea, fever and sores, the risk of dehydration increases and with this also the possibility of a decrease in kidney function or of the central nervous system.

Another recommendation is to promote the consumption of fibres through foods that are rich in fibres or, when this is necessary, through specific items. By doing this we engage in primary prevention, as well as secondary prevention, as regards processes of constipation and diverticolisis which are highly present among elderly people, and we can also control more effectively illnesses such as melytic diabetes type 2.

The consumption of alcohol must not be prohibited in too severe a fashion except in situations that are very specific. Such consumption should be limited to one or two glasses of wine every day or the equivalent if we are dealing with other kinds of alcoholic drinks. Instead, because tobacco is a risk factor for very many cardiovascular, respiratory and tumour processes at any age, the recommendation should always be to eliminate it.

The next point is connected with the possibility of knowing about and acting upon the so-termed *risk factors* (RF), both those of a general character and those that are specific to specific pathologies. Although the concept of a risk factor was initially linked to the cardiovascular apparatus, at the present time it is applicable to any type of process and at least in the concrete case of elderly people it goes beyond what is merely medical and enters the sphere of social prob-

Table 2. The Principal Advantages of Physical Exercise in Advanced Age

– It helps to maintain a good muscular mass
– It improves aerobic capacities
– It reduces the risk of cardiovascular illness
– It stabilises the bone mineral density and prevents osteoporosis
– It modifies in a favourable way the hydrocarbon homeostasis
– It helps in the control of the very common chronic processes of old age (ischemic cardiopathy, arterial hypertension, mellitic diabetes, obesity, depression, osteoporosis, etc.)
– It helps in the fight against other cardiovascular risk factors such as smoking or hyper-cholesterol levels
– It reduces anxiety levels
– It helps to maintain better mental activity
– It fosters joint, respiratory, trauma, vascular, post-operation, etc. rehabilitation.
– It improves quality of life

Table 3. Principal Recommendations as Regards Alimentation for People of an Advanced Age

• **Total calorie in-take (daily Kcal/):***

	Men	Women
60-69	2,400	2,200
70-79	2,200	1,900
>80	2,000	1,700

If >1,500 Kcal/a day there is a high risk of a deficit as regards micronutrients

• **Protein in-take**
  – 1.1 gr./Kg weight/daily
  – Increase in acute medical or surgical situations
  – Reduce if there is a kidney insufficiency

• **Ingestion of carbohydrates:**
  – 50-60% of the VCT**
  – Minimum 150 gr/daily

• **Fat in-take:**
  – 30-40% of the TCV**
  – Monosaturate fats: 10-15%
  – Saturate fats: up to 10%
  – Polysaturate fats: 7-8%
  – Cholesterol: <100 mg/daily

• **Liquids** (essentially water): minimum of
  – 1.5-21./daily

• **Fibre:**
  – 10-13 gr. For every 1,000 Kcal consumed
  – Proportion of soluble to insoluble fibre 1:3

• **Calcium:**
  – 1200 – 1500 mg/daily (above all women)

• **Alcohol**
  – Not more than one glass of wine every day or its equivalent

* The total calorie in-take is very conditioned by the individual characteristics of the patient (weight, height, sex), by the presence or otherwise of associated illnesses and above all by his or her level of physical exercise.
**TCV: Total Calorie Volume

lems. The positive effects of the fight against risk factors in the elderly part of the population have been studied rather late as regards the elderly and the young but they have also been demonstrated to be effective as regards the elderly. It should be emphasised that those risk factors that influence the elderly and the less elderly are not always the same and when they are the same they do not always act with the same intensity in the various groups that make up the population.

To speak about risk factors with reference to that part of the population which is of a very advanced age is to encounter a whole variety of medical processes and social situations and problems which are often closely bound up with each other. It is important to have good knowledge about them so as to be able to address them with guarantees from the point of view of prevention. Today, fortunately enough, we have available sufficient information to be able to be effective in the majority of cases that present themselves.

The basic principle of all possible measures by which to intervene in this field, as in other fields, is based upon good health-care education for elderly people, their environment and society in general. In this sense, of fundamental importance is the role of health-care professionals, of educator at all levels, and of those who are in charge of the mass media.

Care for the *sense organs and the mouth* is another key point in achieving successful ageing. Alterations in them are very common, they increase the disease rate of those who suffer from them, they give rise to important functional limitations and they have a very negative effect on the quality of life of an individual. Losses in the sense organs, the eyes and hearing are usually a part of the major geriatric syndromes.

Specific prevention in relation to sensorial pathology passes by way of becoming aware that its loss, although inherent to major extent in the changes influenced by age, should never constitute a sort of fatalism to which one must necessarily resign oneself. These are losses which in many cases can be prevented through early periodic tests that discover and then correct them, as well as the possible losses that they can produce according to their aetiology. Whatever the case there is always the possibility of secondary and tertiary prevention without age in any way constituting a counter-indication.

Deterioration in the skin and the mouths of elderly people has been subjected, as in the cases, to a lesser extent, of sight and hearing, to lack of historical interest. A lack of interest I would emphasise that was full of appeals to resignation. Taking as an example to which to refer

the case of teeth, it is necessary to remember that the proportion of elderly people who are totally or partly without teeth is extremely high. Lack of teeth, in addition to having a very negative effect on the quality of life of an elderly person, is transformed into a risk factor for many other disturbances connected with nutrition or local pathologies of an infectious character or involving cancer. Thus in this field as well it is vital to apply preventive measures in the form of suggestions at the level of hygiene and periodic tests.

Elderly people are great consumers of pharmaceuticals which furthermore, very frequently, are self-prescribed. This means that the risk of having negative reactions to such pharmaceuticals (iatrogeny) is very high. There must be a periodic re-examination both of the level of therapeutic compliance and of the efficacy of the response to those pharmaceuticals that are considered necessary so that there can be an elimination at any time of those pharmaceuticals that are not considered necessary. It is known that the appearance of negative reactions is influenced by the pharmaceuticals that are consumed much more than by age.

Another recommendation is that connected with *control measures* in the face of specific processes which because of their gravity, because they can make people invalids or because of their high prevalence in this section of the population, constitute a problem of the first order. If the question is approached from the point of view of cancer it advisable to remember that we are speaking here of the second highest cause of death amongst elderly people, a cause that is second only to cardiovascular diseases, with the special feature that just as the fight against these latter has been demonstrated to be effective over the last ten years there is no evidence of a decrease in the incidence of cancer pathologies over the same period of time.

From a theoretical point of view, the ideal form of prevention against cancer is primary prevention through action against cancer-inducing agents. This is something that is not very practical in the short term given that our knowledge in the field is still at a low level and in addition this would an application of such measures at a very early age. Whatever the case we know that certain measures such as avoiding tobacco, changing certain forms of diet or avoiding excessive exposure to the sun are very effective in this field.

The only malign physical tumours for which there exists a high level of evidence as regards the effectiveness of periodic tests in this age band are breast cancer (self-examination and periodic breast scans), prostrate cancer (the rectal

tract and PSA), and cancer of the large intestine (periodic rectal-sigmoidoscopy of subjects at risk, especially those who have family or personal precedents on this field). Mention should also be made of skin cancer. Other cancers such as cancer of the cervix require an intensification of efforts made in the first stages of life, whereas in cases such as lung cancer, stomach cancer or other forms of cancer we do not have sufficient evidence available to us.

In the category of prevention should also be included those measures intended to improve the *social environment*. Problems such as loneliness, a poor economic situation or the lack of family support have an effect upon quality of life and make difficult the achievement of successful ageing. The list of possible actions in this field is broad in character and calls upon the responsibilities of government bodies. It includes measures directed towards improving the environment and fighting against contamination, on to other more specific measures to do with very concrete problems.

It is worthwhile placing emphasis on the non-acceptance of any form of *discrimination* based upon age. This is a bad habit that has been very much introduced into society in general and into daily clinical practice. This is a bad habit in which families also take part but in which medical doctors and health-care structures also participate. Age in itself should never figure in the list of counter-indications although an elderly person necessarily is frequently the subject of these counter-indications. It is simply that the general criteria established for most people should also be applied to elderly people.

We can see that many of the measures that are required for successful ageing are of a social and educational character. They imply a change in mentality that influences lifestyles and this should take place to begin with at a very early age. If at all times and at all stages in the life of an individual man has always seen health as his most valuable gift, he should give priority to this subject and employ the necessary instruments so that this result which nowadays has ceased to be utopian can be transformed into a real possibility and should be consolidated in the habitual way of growing old.

There should be no absence of an appeal for attention to be paid to something in our society which I referred to above in this paper. I am referring here to *abuses, neglect and maltreatment* in relation to the elderly. Ever since the 1980s medical literature and to a lesser extent also juridical literature has offered increasing evidence to demonstrate at what stage we are in relation to a real problem that can affect, according to the criteria that are used to assess it and the context in which studies are carried out, between 5% and 20% of the elderly part of the population. However in practice this is rather ignored and to such an extent as to give the impression that our society is extraneous to this concern.

Today we know the principal risk factors that can transform a person into a victim of this scourge. Today we have available to us studies that describe to us both the profile of the aggressor and the profiles of the victims of this phenomenon. We know the reason for the silence that exists in relation to it and we use important information of the greatest interest. We also know, and this is my second observation, the possibilities as regards prevention in this field. Everyone declares that they are not indifferent to this problem, that they know it exists, that they want to be sensitised to it, and that they will intervene when this is necessary, even though with the greatest discretion possible, when confronted with the least suspicion that this phenomenon is present.

Everything that has been said hitherto on this paper leads us to an unequivocal *conclusion*. The best way of achieving healthy ageing passes by way of *prevention*. A prevention that begins in the earliest stages of life, is maintained in an uninterrupted way throughout life and which maintains its value at the most advanced age. A prevention whose central axis must be based on what we call life habits and which at a collective level requires, in fundamental terms, attempts to achieve the good health-care education of society as a whole. This is an objective that embraces a very broad horizon and in which is included, together with measures which are of a strictly health-care character, also others of an environmental, economic and social character.

Prof. JOSÉ MANUEL
RIBERA CASADO
Director of the Geriatric Service,
The San Carlos Hospital,
Madrid, Spain.

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JOHN J. TURNER

4.2 Scientific Technological and Industrial Change in Medical Care of the Elderly

Introduction

My thanks for this invitation to Bishop Thomas Williams Auxiliary Bishop of Liverpool and Chair of the Hospital Chaplaincy Association and the Healthcare Reference Group of the Catholic Bishops' Conference for England and Wales.

Technological and pastoral health care should always go hand in hand but we need to protect and cherish pastoral care as the accelerating pace of medical science sometimes threatens to overwhelm it.

In 1999 His Holiness Pope John Paul 11 wrote a letter to the elderly of the whole world: 'To my elderly brothers and sisters. Nowadays thanks to medical progress and improved social and economic conditions, life expectancy has increased significantly in many parts of the world. The gift of life is too beautiful and precious for us ever to grow tired of it'. We are reminded of increased longevity and the value of the gift of life.

The phenomenon of scientific and technological progress has been accompanied by increasing dilemmas. There are many wonderful and beneficial developments but increased choices are testing our ethics and philosophies of care. The pace of scientific change has accelerated remarkably in the last fifty years but we must remember and appreciate all that has gone before. Sometimes we need to learn again the lessons of history. As a Senior Registrar in Medicine I trained with Sir David Weatherall Nuffield Professor of Medicine at the University of Oxford. The Weatherall Institute of Molecular Medicine is symbolic of the leading edge of twenty-first century medical research into the genetics of disease and has helped in the understanding of Haemoglobinopathies such as Thalassaemia prevalent in the Eastern Mediterranean.[1] The institute is close to the famous Bodleian Library and provides a striking contrast to the collection of historic medieval manuscripts representing mankind's slow accumulation of knowledge and scholarship over the centuries.

Industrial Diseases

The health legacy of industrial lung diseases remains long after old heavy industries have been swept away. Stone dust inhalation was a side effect of the cutlery industry and as a boy I saw many men sitting on stools outside their small terraced houses breathless and coughing. Chest X-rays reveal the widespread changes of pulmonary silicosis and lung function tests measure the associated decline of alveolar oxygen exchange. The industrial revolution was powered by coal and the miners were exposed to the accumulative effects of coal dust inhalation resulting in pneumoconiosis which is demonstrated well on high resolution CT scans of the thorax. The most serious complication of asbestos exposure is Mesothelioma which has a poor prognosis and there is often after a long duration from exposure to clinical presentation. Families are also at risk from secondary exposure when washing clothes contaminated with asbestos fibres. Asbestos was widely used in industrial pipe lagging for insulation and in the shipbuilding industry. Mesothelioma is well shown on CT and MRI diagnostic imaging but remains notoriously resistant to treatment.

Life Saving and Life Enhancing Technology

Michelangelo's masterpiece of the creation of Adam in the Sistine Chapel here in the Vatican depicts the miraculous spark of life. Implantable cardiac defibrillators are a remarkable example of modern medical technology and transmit quite literally a 'spark of life'. A priest of the Liverpool Archdiocese whom I recently saw professionally told me his dramatic medical history. He had collapsed while conducting a funeral and was resuscitated by a medically qualified parishioner. After admission to hospital he had several further episodes of ventricular fibrillation and cardiac arrest and each time was successfully resuscitated. A miniaturised cardiac defibrillator was implanted with great success.

Many medical advances have not only extended the length of life but have immeasurably improved its quality. This is well illustrated by the developments in prosthetic joint surgery. Surgical technique and the design technology of the prostheses continue to evolve and improve. We now have minimal invasive hip replacement and unicompartmental knee replacements. These are associated with fewer days in hospital, lower complication rates and faster rehabilitation times. It is not only the recipient who benefits but the whole family as well as the wider society.

There has been a transformation in stroke services. Stroke is age related with a rising incidence and was formerly too often either a sentence of death or of high disability.

Outcomes are now improving with the rise of specialist stroke units, risk factor identification, control and the increased emphasis on prevention. The use of thrombolysis in ischaemic stroke is growing but requires rapid early diagnosis with fast access to scanning and highly organised facilities.

Surgical improvement of arterial blood flow through the carotid arteries has resulted in a sharp rise in the numbers of successful carotid endarterectemies and the development of sophisticated surgical techniques including stenting and the protection of brain tissue from embolisation during surgery. Good outcomes also depend on the careful selection of suitable patients using Doppler ultrasound and magnetic resonance angiography to map out the areas of stenosis.

The rising numbers of dementia may be considered as part of the price of medical successes in improving mid life survival from infectious diseases, cardiovascular disease and Cancer. The numbers of dementia are predicted to double in the UK to over 1 million by 2025. In addition to the direct burden of dementia itself it is a major complicating factor in the treatment and outcomes of other conditions. It threatens to become one of the biggest challenges for health and social care in technologically advanced societies.

Contagion. Ancient and Modern

In 1347 Michele Di Piazza, a Franciscan monk, observed the arrival of the Plague in Sicily on galleys trading from Venice.[2] He accurately described the respiratory transmission of pneumonic plague and the devastating speed of progression from onset to death. The consequences were to plunge Europe into a major social and institutional crisis. *The Plague of Ashdod. Nicholas Poussin* – painted in Rome and displayed in The Louvre Paris superbly captures the tragedy.[3] The oriental rat flea feeding on human blood arriving from China was the mode of transmission and rapidly disseminated the causative bacterium *Pasteurella Pestis.* Plague has not entirely disappeared. Approximately 3,000 cases of plague are reported annually worldwide. It is a chilling sign of the times that modern bioterrorists have considered using plague as a biological weapon.

The rise of MRSA and Clostridium Difficile are threats to the New Age of Medicine and attract much media interest. We regularly see headlines like this. 'Fears over deadly Hospital bugs' - BBC News.[4] The combination of complex surgery, multiple episodes of hospital admission, intensive care and our enormous use of venous and arterial access lines provide fertile conditions. We need to be very disciplined in our use of antibiotics and to achieve the highest standards of clinical hygiene and hospital cleanliness.

End of Life Decisions

The engraving deathbed scene of George Washington with his physicians, circa *180,*[5] reflects the grave responsibilities of physicians dealing with the end of life. The rise of consumerism in combination with new forms of aggressive secularism [*Richard Dawkins. The God Delusion*] is a political and social force that has increased the difficulties in decision-making for modern physicians. The use of advance directives and living wills is increasing and in many countries carry legal force, creating many ethical dilemmas between doctors patients and their relatives. .Cardiopulmonary resuscitation (CPR) is effective and often life-saving in situations such as the acute coronary syndrome. In advanced progressive irreversible diseases such as late stage metastatic cancers, advanced respiratory failure and cardiac failure or severe dementia the clinical outcomes from CPR are very poor. In these circumstances an inappropriate emphasis on CPR may conflict with the philosophy of care required to provide a focus on human dignity and a process of natural death with all the necessary nursing, medical and pastoral support.[6]

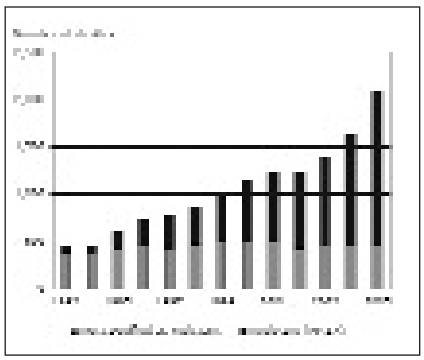
Primum Non Nocere

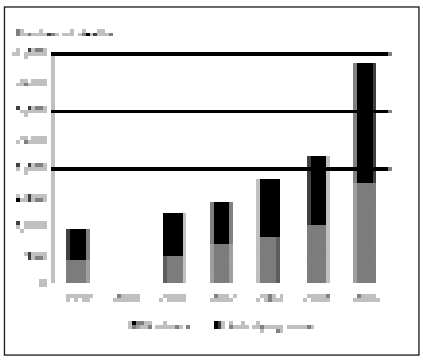
As therapeutic choices increase we need to frequently remind ourselves of 'first do no harm'. Food and fluids are the very fundamentals for sustaining life. In frail older patients with severe illness some impairment of swallowing is common with some risk of aspiration and pneumonia. In the UK this increasingly results in a 'Nil *by Mouth'* sign above a hospital bed. What are the consequences and what choices have to be made next?

Intravenous Fluids
Subcutaneous Fluids
Naso-gastric Tube feeding
Per Endoscopic Gastrostomy Feeding
Per Endoscopic Jejunostomy
Parenteral Feeding

These techniques are important but all have limitations and complications. The oral route is preferred wherever possible but in frail ill older patients it demands skilled nursing offering frequent small amounts of fluids, semi

Graph 1) Trends in MRSA for England and Wales
UK Government Office of National Statistics.
Graph 2) Trends in Clostridium Difficile
UK Government Office of National Statistics





solids or liquid nutrition. This is time consuming and the pressure on ward nurses may lead to the premature use of a technological delivery of fluids and nutrition. We are seeing an increased proportion of nursing time taken up by documentation and computer data entry at the expense of direct patient care - not only physical but emotional and pastoral.

We need always to remember to try to use our technology in the best interest of the individual patient, taking care to avoid inflicting unnecessary procedures. Mayor looked at a group of patients who died within 30 days of endoscopy.[7] The cause of death was not the endoscopy itself but the severity of the associated illnesses and asks the question: was this intervention justified?

As the use of modern technological medicine becomes ever more complex we must continue to remind ourselves that science must be accompanied by the art of medicine and should be tempered by care and concern for the individual patient. The qualities of the compassionate doctor are depicted well by Sir Luke Fildes in *The Doctor.*[8]

Conclusion

His Holiness Pope John Paul II addressed this conference ten years ago. 'The conference papers emphasised the complexity of health problems in today's world'. The complications involved in healthcare have become greater. Decision-making for physicians has become more taxing. The need for a strong ethical base is greater than ever.

Dr JOHN J TURNER FRCP,
Consultant Physician,
University Hospital Aintree,
Liverpool, England.
Great Britain.

Notes

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FRANÇOISE FORETTE

4.3 Therapeutic Prospects in Gerontology

First of all, certain principles must be listed. No pharmaceutical is specific to old age; before being put on the market all pharmaceuticals which are used in relation to illnesses that become more frequent with old age should be studied on people over the age of eighty. Such, however, is not the case. Most tests used to involve a limit of the age of sixty. More recent tests have raised the age threshold but it is rare for the barrier of the age of eighty to be broken. And yet people over the age of eighty often have more than one kind of pathology and are great consumers of drugs and medicines. There is a bad use of drugs and medicines (disuse): on the one hand, the number of drugs or medicines that are prescribed are too high in number (overuse) and involve a iatrogenic risk – over 20% of admissions to hospital are connected with inappropriate forms of treatment; and, on the other hand, the drugs and medicines that are recommended are under-used by very elderly people (underuse).

Let us consider the set of illnesses that are linked to ageing: cardiovascular illness, cerebral vascular accidents, Alzheimer's disease and connected diseases, osteoporosis and fractures, depression, cancers, and sensorial disturbances. It has been demonstrated that most of these maladies are not treated according to the recommendations of medicine based on evidence (evidence-based medicine).

Let us now take three examples of bad use and underuse: heart failure, osteoporosis and Alzheimer's diseases.

Heart failure

All epidemiological studies have shown a drastic increase with age of heart failure (Kannel W., 2000). A recent study (Euro Heart Failure Survey, 2005) indicated that the forms of treatment that are recommended are not applied: the inhibitors of the conversion enzyme and the beta blockers which are recommended at the present time are in a significant way not prescribed for patients over the age of seventy-five, whereas dioxin is more used. But the situation has significantly improved for patients over the age of eighty-five where inhibitors of the conversion enzyme are used (Gambassi, 2000).

Osteoporosis and fractures

Fractures of the hip and the vertebra are a cause of death and of falling into dependency, as has been demonstrated by numerous studies. The projections suggest that in the world the number of fractures is increasing, rising from 1.66 million in 1990 to 6.26 million in 2050 (Cooper, 1992). Strategies for prevention which involve, amongst other things, the treatment of osteoporosis, are available but they are insufficiently used (Gehlbach, 2007). Less than 50% of women who run a high risk of fractures receive suitable treatment which involves calcium and vitamin D, biphosophonates, teriparitide or ranelates of strontium. Only 17% of women afflicted by fractures receive appropriate treatment. Here we encounter a second example of under-treatment. Comparable data can be observed for tumours or depression.

Alzheimer's disease

This disease raises special question given the dramatic increase in its incidence and prevalence with age: (Ferri, 2005): the number of patients suffering from this disease will rise from 20 million in 2001 to 80 million in 2040 if no preventive or curative treatment is discovered. There are about 4.6 million new cases ever year and one every seven seconds. What is at stake here for public health is something on a major scale. The pharmaceuticals for the symptoms of this disease are underused. The research into preventive methods or drugs and medicines that act on the process involved must be encouraged as a priority. In France these methods relate to about 850,000 people, that is to say 25% of the population over the age of eighty-five, with 225,000 new cases every year. One person in every two suffering from this disease is not diagnosed and only 17% of patients with this malady are treated with the drugs and medicines that are available.

At the present time, forms of substitutive treatment of symptoms exist. These include cholinergic forms of treatment which replace the most defective neurotransmitter, the acetylcolin. Here we are dealing with three inhibitors of acetylcholinesterase – donepezil, rivastigmin and galantamin (Birks J., 2006). A fourth non-cholinergic agent, memantine, is an inhibitor of the NMDA receptors (Aerosa, 2005). The results of these forms of treatment demonstrate a moderate but significant improvement of the cognitive functions in the activities of daily life and of the overall judgement of patients. There is certainly a dose effect and some cholinergic secondary effects. The period of effect is limited in time but the benefit is persistent when compared to placebo.

The treatment of the symptoms of Alzheimer's disease has opened up a new era of research. It has shown researchers and industrial investors that the myth of the absolute incurability of this disease has been seriously undermined and that a step by step advance, to be com-

pared with that used by AIDS specialists, is promising. It has shown that an improvement in symptoms produced by substitutive forms of treatment, which are certainly moderate but which are perceived by the medical doctor and the patient, would allow patients to lead a longer life, and a life which deserves to be lived, surrounded by family relatives. One should not underestimate this success and it is not a good thing that such a dramatically low number of patients benefit from such treatment.

The notable advances that have been made at the level of our knowledge about this disease now allow us to see approaches that will act upon the chain of lesions of the brain and will allow us to delay, that is to say block, the pathological process involved (cf. Blennov, 2006 and Klafki, 2006). But we must be clear: these new approaches are not based on any hypothesis which hitherto has received definitive confirmation. The most commonly proposed hypothesis is the amyloid hypothesis.

The amyloid hypothesis

Of the two objectives that are possible, namely extra-cellular amyloid plaque and intra-neuronal neurofibre degeneration, the choice has fallen on the first as a priority. The objective is to attempt to influence the production, aggregation, deposit and/or clearance of the A beta amyloid protein. According to this hypothesis, the element that begins the chain of lesions is an imbalance between the production of Aβ and its physiological clearance. In family diseases, the imbalance is said to be principally due to the over production of Aβ linked to the mutations of the genes of the APP and the presenilins, whereas sporadic diseases are said to suffer above all from a reduction in the protein clearance under the influence of general risk factors such as APOE 4 and environmental factors.

The accumulation of abnormally high quantities of soluble or insoluble A beta 42 is said to involve synaptic anomalies, the progressive formation of plaques, the activation of micrology and astrocytes with subsequent inflammation, oxidative reactions and intra-neuronal ionic alterations, and neural dysfunctions with neurotransmission deficits. Lastly, and possibly, the alteration of the kinase systems and phosphatase systems is thought to lead to hyperphosphorylation of the tau proteins that make up the microtubuls and lead to the formation of neurofibrillary degenerations, acting thereby between the two lesions and leading to neuronal death and cognitive deficits.

The anti-amyloid approaches

Three kinds of treatment based upon the amyloid hypothesis are being developed: secratase modulators; active (vaccine) or passive immunotherapy; and inhibitors of the fibrillary aggregation of the amyloid.

Secratase modulators

The amyloid protein of forty to forty-two aminate acids comes from a dual selection of a normal protein of the organism, the APP of 650 to 770 aminate acids. The metabolism of APP takes place as a result of the action of three secretases, the alpha, beta and gamma secretases, by two pathways. 1. A physiologicalnon-amyloidogenous pathway takes place a as a result of action of the alpha-secratese which cuts in two the sequence of the A beta, liberating a large fragment of soluble APP, and then as a result of the action of the gamma-secratese which breaks up the terminal C fragment. 2. The myloidogenous pathway takes place as a result of the action of the beta-secretese which breaks up the APP at the beginning of the sequence of the A beta and then as a result of the action of the gamma-secretase which frees the free fragment which constitutes the amyloid peptide A beta 42 or A beta 40. To inhibit the amyloidogenous pathway, the aim is to stimulate the alpha-secretase and to inhibit the beta or gamma-secretases.

Bace 1 inhibitors or beta-secratase inhibitors. Animal experiments have amply demonstrated that 'Bace knockout' mice conserve a normal phenotype despite the absence of beta-secratese activity (Luo Y, 2001). Other research has stressed that the oral administration of a selective non-peptidic Bace-1 inhibitor reduces the beta cleavage of the APP and involves a significant reduction of A beta 40 and A beta 42 in the brains of APP transgenic mice (Hussain, 2007). Other experiments have been underway that demonstrate that the development of this therapeutic approach is possible. A very large number of groups have synthesised these inhibitors. Few of them meet all the pre-conditions that are needed for development (Hill, 2007).

The inhibitors of the gamma secretase. The development of these substances raise at a theoretical level a greater number of questions about possible secondary effects because the cleavage of this site runs the risk of altering other vital functions such as those of the Notch which could interdict a blockage in the long term (Hull, 2006). The objective is to discover selective products for the cleavage of the APP and which in particular inhibit the formation of Aβ42 which aggregates more (Evin, 2006). Some products have been developed that do not relate to the Notch signal (Petit, 2001) and appear to be well tolerated in the phase 1 studies (Siemers, 114).

The alpa secretase activators. The stimulators of apha secretase have the purpose of directing the metabolism of the APP towards the non-amyloidogenous physiological pathway. An activator of the kinase

C protein, tested in cancer, appears to increase to a significant extent the activity of the β secretase and reduce the concentration of Aβ42 in the brains of Alzheimer transgenic mice. Given that briostatin 1 has already been amply tested in cancer treatment, tests could be rapidly implemented with Alzheimer patients (Etcheberrygaray, 2004).

Immunotherapy

Active immunotherapy. Active or 'vaccine' therapy was developed after the publication of the works by Schenk on PDAPP transgenic mice. Thanks to their transgenes, such mice over-express the human amyloid protein, they deposit them in specific regions, and progressively develop a neurodegenerative pathology. In 7-8 months the amyloid protein is deposited in plaques, in 8-9 months neuritic dystrophy and glyosis have developed, and in 10-12 months there is synaptic loss.

The hypothesis developed by Schenk (1999) is that the immunisation of the amyloid protein is able to stimulate the immunity system and prevent the deposit of the amyloid, that is to say to increase its clearance. The results are clear: immunised before the formation of lesions, one observes an almost complete prevention of the formation of amyloid plaque, neuritic dystrophy and the block of glyosis. When the female mouse is immunised at eleven months, that is to say when the lesions are already formed, one can observe the reduction of an amyloid burden, of dystrophy and of astrocytosis, as compared to non-vaccinated non-transgenic mice. Subsequent research showed that Aβ immunisation reduced not only the plaques but also some behavioural disturbances of the animal model (Janus, 2000) and memory loss (Morgan).

Interest in this research stimulated very rapid experimentation on humans. After a phase I study, Elan and Wyeth engaged in a phase II study in which 298 Alzheimer patients were vaccinated with the Aβ peptide and 72 received a placebo (Gilman, 2005). The test was brutally interrupted because of the appearance of meningoencephalitis. In total, eighteen patients were affected, that is to say 65 of the population subjected to active treatment (Orgogozo). This grave secondary effect was attributed to a cell T response against the terminal C fragment. The expected anti-Aβ antibodies were developed by 205 of the respondents of the total population. In this test which was prematurely interrupted, the vaccination did not demonstrate any significant benefit as regards the pre-established cognitive criteria but a post-hoc analysis brought out a significant benefit as regards a composite criterion. The total cerebral volume diminished and the hypothesis here was a clearance of the cerebral burden in amyloid peptide (Fox 2005) .

An autopsy case revealed an extended disappearance of amyloid plaques in numerous zones of the cortex, the persistence of a couple of helix filaments in the neo-cortex zones without plaques, signs of meningoencephalitis of the T-lymphocytes, infiltrations of macrophages in the white substance, and a persistence of amyloid angiopathy (Nicoll, 2003). The disappearance of the amyloid plaques of the A beta immunisation was able to lead to a clearance of the beta-amyloid. An examination of the brain of a vaccinated patient without meningoencephalitis confirmed this hypothesis (Masliah, 2005).

For that matter, a sub-sample of the study demonstrated that 19 patients that developed anti-bodies against the amyloid plaque demonstrated over the period of a year a cognitive decline and a deterioration in daily-life activities that were lower than in a the case of the nine patients that did not develop anti-bodies. Despite the small size of the sample, these data suggest that the anti-bodies directed against the amyloid plaque can slow down the cognitive decline connected with Alzheimer's disease (Hock, 2003).

Despite the grave secondary effect, the data as a whole clearly encourage us to proceed with research in this direction. The objective is to conserve the production of anti-bodies by avoiding a deleterious T cell response. The employment of different helpers and above all fragments Abeta that will not lead to the lymphocyte T response is now underway in experiments (Agadjanian, 2005).

Passive immunotherapy. Passive immunisation through anti-A beta anti-bodies in order to treat, that is to say to prevent illness, is another promising method. Potential candidates here are humanised monoclinal anti-bodies. Molecules that are able to 'siphon' the amyloid towards the blood through the haematic-enchephalic barrier could be 'therapeutic' anti-bodies (Fillit, 2004). The injection of intravenous immunoglobins in 5 patients permitted a decrease in the total Abeta level in the cephalorachidian liquid, an increase in this level of 233% in the serum, and the ADAS-cog cognitive test is said to increase by 3.7 points in six months (Dodel, 2004). A large number of companies are at the present time experimenting with anti-bodies.

The inhibitors of the fibrillary aggregation of the amyloid

Another therapeutic approach is that of preventing the formation of presumably toxic holigomeric aggregates of the Aβ. Weknow that the GAG are connected with the Aβ and cause their aggregation (van Horssen, 2003). The pharmaceutical candidate (Alzhemed) is a mimetic-gag intended to interfere between the GAG and the Aβ. In the United States of America and Europe two experiments are currently underway but one of these has already been broken off. This generates a certain pessimism as regards the efficacy of this product.

Metals such as zinc and copper can accelerate aggregation of the Aβ. Clyochinol chelate (PBT-1) reduces deposits of Aβ in transgenic mice. The phase II experiment demonstrated a marginal cognitive improvement but was interrupted because of an iodide impurity. Other experiments with a pharmaceutical that does not contain iodide (PBT-2) are now underway (Ritchie, 2003).

Therapies that aim at the tau protein

Neurofibrillary degenerations (DNF) correspond to intra-neuronal aggregation of abnormally phosphorilated tau proteins. They

constitute the second neuropahological lesion of Alzheimer's disease and soon arrive with the development of the malady (cf. Buée, 2006). One can observe tau hyperphosphorylation in a large number of neurodegenerative diseases and this is seen as being secondary to an imbalance between the activity of the kinase and the phosphatasis. The identification of mutations of the tau gene on the chromosome 17 responsible for frontal-temporal dementias show that the deregulation of the tau can cause on its own degenerative processes. During the course of Alzheimer's disease, the chronology and the relationships between amyloid plaque and DNF have not yet been completely clarified.

The inhibition of neurofibrillary degeneration linked to the hyperphosphorylation of the tau protein is a highly promising attempt. This can be achieved with the inhibition of the kinase tau, the activation of phosphatases or the inhibition of the tau aggregation.

Inhibitors of kinase tau

Some pharmaceutical candidates that reduce phosphorylation of the tai by inhibiting the kinase tau such as CDK5 or GSK-3 β are being experimented with but the important number of kinases and phosphatases involved in the process make the action of a single kinase aleatory (Buée, 2000).

Phosphatases activators

Some research has suggested that in addition to the inhibition of kinases, the up-regulation of the phosphatese tau could constitute another attempt to inhibit the abnormal phosphorylation of the tau proteins (Iqbal, 2004). In particular, it has been demonstrated that the PP2A phosphatese was involved in the regulation of the phosphorylation of tau *in vivo*.

Is it interesting to observe that memantine, an antagonist of the NMDA receptors, was able to inhibit the phosphorylation and neurodegeneration of sections of mice brains. It has been suggested that this effect took place as result of the re-establishment of the activity of PP2A.

The inhibition of tau aggregation

According to some hypotheses, the aggregation of the tau proteins and the formation of PHF are directly connected with the process of degeneration. Molecules capable of blocking this aggregation could, therefore, turn out to be neuro-protective. Some candidate producers have been identified (Pickhart, 2005). This approach, however, needs to validate the hypothesis of the deleterious role of aggregation which is seen by some as a mechanism of protection (Lee, 2005).

Approaches based upon epidemiological data

Observational epidemiological research has demonstrated that a certain number of substances, taken over a long period for a specific pathology, involve a reduction in the incidence of Alzheimer's disease. Most of the hypotheses have, unfortunately, not been confirmed by controlled trials.

Anti-inflammatory treatment

A certain number of observations indicate an immunity hyperactivity in the course of Alzheimer's disease: microglial reactions around the senile plaque, astrocyte proliferation, the production of inflammatory cytokines some of which (Interleukine-1 and interleukine-6) are thought to increase the precursor synthesis of amyloid protein (McGeer 2003). Various studies have demonstrated an inverse relationship between the arrival of Alzheimer's disease or cognitive deterioration and the taking of anti-inflammatory pharmaceuticals (Szekely, 2004). The anti-inflammatory drugs are thought to act amongst other things by direct action on the gamma secretase and by reducing the production of A beta 42.

The control trials carried out with Cox inhibitors or non-steroid anti-inflammatory drugs have not demonstrated proof of prevention or slowing activity in relation to the disease (Aisen, 2003). Other attempts are underway in the field of mild cognitive impairment (MCI).

The products that work on cholesterol

Cholesterol plays an important part in the metabolism and the APP and possibly in the production of the protein A Beta. Animal experimentation confirms that the lowering of cholesterol inhibits the beta and gamma secrateses of neurons in culture and reduces the pathology linked to A beta in transgenic mice. Lastly, epidemiological studies show a very important lowering in the incidence of Alzheimer's disease in patients who take statine (Jick, 2000; Wolozin, 2004).

On the other hand, three randomised attempts have not confirmed the action of protection of the statines but it should be emphasised that in not one of these tests was cognition a primary criterion (Sheperd, 2000; HPS Collaborative Group, 2002; Li, 2004). Other research is necessary to have a clearer idea of the relationship between a raising of cholesterol levels, the presence of APOE4, which is the most powerful risk factor of sporadic Alzheimer patients, the incidence of the disease and the possible protection provided by the statines (Wolozin, 2006).

Estrogens

A large number of epidemiological studies have demonstrated the beneficial action of estrogens and in particular replacement hormone treatment on cognition or the incidence of dementia (LeBlanc, 2002, Hogervorsr, 2002). Here as well the control trials have not confirmed a protective role, with an emphasis on the risk of cancer and cardiovascular complications in the case of prolonged use. It would be necessary to have other trials on women with minor cardiovascular risk and with through-skin estrogens and natural progestatives used in Europe to confirm or disprove the American data (Mulnard, 2000), Shumaker S.A., 2004).

Anti-oxidant treatment

Here we have another example of the contradiction between observational epidemiological studies and

control trials that eliminate the prospects of selection. Observational studies have demonstrate the beneficial effects of alimentation rich in anti-oxidants (Engelhart, 2002; Morris, 2002). A trial with selegilin and vitamin E showed a modest slowing down of the development of moderately grave Alzheimer's disease (Sano, 1997) but a control test did not show any effects on the conversion of MCI in Alzheimer's disease (Petersen, 2001).

Anti-hypertensive treatment

A very large number of epidemiological studies have demonstrated an association between the level of arterial pressure and the outbreak of Alzheimer's disease or vascular dementia from fifteen to twenty years later (Skoog, 1996; Hanon, 2003 for the revision). Two control tests demonstrated that anti-hypertensive treatment was able to reduce in a significant way the incidence of Alzheimer and vascular dementias for the SYST-EUR study (Forette, 1998; Forette, 2002) and dementias linked to a lapse of a cerebral vascular accident for the PROGRESS study (Tzourio, 2003). Questions remain about the mechanism of prevention which could be connected to the lowering of arterial pressure and/or the specific effect of specific agents (Birkenhäger, 2001; Hanon, 2006). Other tests are indispensable to clarify the links between vascular factors and the pathology of Alzheimer's disease but henceforth it is important to promote balanced nutrition and a reduction of the set of vascular risk factors which have been shown to be useful in the prevention of cardiovascular and cerebrovascular illnesses.

A certain number of studies have, in addition, demonstrated that the consumption of fish (Morris, 2003), physical exercise (Simonsick, 2003), recreational activities (Verghese, 2003) and mental activity can work together to prevent Alzheimer's disease (Coyle, 2003).

To conclude this paper, it should be said that major efforts should be made to improve therapy in elderly patients, reduce the bad use of drugs and medicines, and encourage the right prescription of recommended and essential pharmaceuticals. For this reason, it is indispensable that there is an improvement in the information provided to the population about the use of drugs and medicines as well as in the fight against the discrimination to which elderly patients are often subjected. The example of the intense research that is being carried out in the field of Alzheimer's disease may lead us to hope that a cure for this scourge is not beyond the reach of the advances of medical science.

Prof. FRANÇOISE FORETTE,
Professor of Geriatrics,
Paris V University,
Director of the National Foundation
of Gerontology and
the International Longevity Centre,
France

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FERNANDO ANTEZANA ARANIBAR

4.4 The Political and Social Origins of Illnesses: Political Change, Legislation, Health Systems and Old Age, Pensions, Family Roles and Free Time

To begin these observations it is important to reflect on what we mean today by ageing, which is called the third age. Using kind words we define elderly people as people of a certain age. Whatever the case, this is a relative concept and one that depends on the cultural, ethical-social and – why not? – also biological context of every society.

At the age of twenty, ageing is something to be thought about later on in life. Pains disappear rapidly and wounds heal over rapidly etc. At the age of forty, the first wrinkles become more marked and it is not easy to lose the kilos that have been put on. However, an individual is concerned with many things and also with the responsibilities of his age (family, work, getting on, economics etc.). At the age of sixty being overweight is accepted, as well as a certain rigidity in one's bones and joints and physical pains and disturbances in general, as though this was the normal process of growing old.

Research carried out in various important centres in the medical-scientific world are changing the view that ageing is a process that is to be expected and a generalised process. 'There are enormous differences in the ways in which a human being grows old, both as regards his own physical capacities and as regards the energy that is developed, as well as at the level of his real expression of commitment to life', to employ the words of Prof. Sehiro Kawachi of the Department of Health and Behaviour of the University of Harvard (USA).

The above observation seeks to point out that ageing is not a process that is the same with everyone, that takes place at the same age, with the same intensity, and with the same forms. It also varies in line with the variables and conditioning factors of health and illness, whether they are biological, economic, social, cultural or anything else in character. It is here that one must identify and analyse the elements connected with legislation, laws and regulations and determine whether a health service provides adequate and constant access for the elderly population.

To complete this picture, one must recognise that amongst other things there are three fundamental elements in the changes that have contributed to achieving the objective of reaching a healthy, active and pleasant old age, namely:

The extraordinary increase in life expectancy, which has meant that people who only twenty-five years ago were seen as old, today are at a further stage in the journey of life. It is certainly the case that in many countries legislation continues to utilise old concepts of ageing and thus pension programmes and giving up working take place at an age when a person is still useful and – why should we not make the point? – too early on (at the age of sixty, sixty-two or sixty-five). Prevention, education and notable advances in curative treatment or treatment to keep a person fit have made this improvement possible, with a related reduction in suffering and in the deterioration of people's health. However, we have to acknowledge that these great medical advances have led not only to technical and social problems in the suitable and fair use of improvements but also to false hopes about, and a permanent trust in these technologies, which, in fact, do not improve the lifestyles of a large number of people in the age bands mentioned above, who, indeed, are often taking decisions about their old age.

The second element is the increase in knowledge about the factors that determine health and illness during the course of a person's life, whether they are of a biological, economic, social or political character. Access to, and the dissemination of, information, constitute a weapon of great relevance when strategies and initiatives connected with improving conditions in order to achieve an honourable and dignified old age are discussed.

The third element that I would like to refer to, is connected with technological advances in general and in the field of health in particular. This is not only a matter of medical treatment, which, indeed, has developed a new world at the level of pharmaceuticals and vaccines, but also diagnosis and related activities, hospital equipment, transport and mobile emergency units, communications in general (including mobile telephones and suchlike), which ensure that the health sector can be much more efficient and at times in line with the philosophy of the Good Samaritan.

Thus what are the most significant changes that have arisen from

this situation? I venture to say that in industrialised countries, where the percentage of the population that is elderly is significant, the greatest change relates to an awareness of the economic implications of this phenomenon and the medical care involved, both of which are becoming increasingly difficult and/or complex, at least at the level of continuing the provision of the benefits that are currently provided to elderly people.

Vice versa, in developing countries – in poor societies in general – the changes that are taking place are more significant than is the case with industrialised countries. Thus, for example, we are dealing here with access to medical care, a minimum old age pension, and protection against abuse in all its forms, especially as regards elderly women.

In the paragraphs that follow I will refer to the current situation and to the gaps that need changes and initiatives given the realities of today's world, which, indeed, we define as being modern.

In discussing the generalisations and the specific points of the subject of this paper, one has to point out at least three categories of society which may or may not be countries as well.

There is a first group which includes rich societies, which have extraordinary levels of wealth and power and where on the whole the decisions that count are taken both a national level and at a global level (globalisation?). Then there is a second group which includes the so-called emerging societies or those societies that are in a state of transition. Lastly, there are the less developed societies, which are generally poorer, which are otherwise defined as (permanently?) 'developing countries'.

Never before in history have we witnessed so much wealth concentrated in so few hands and at the same time such a terrible widespread presence of poverty, hunger and misery amongst most people on earth.

It is within this context that we must locate the social situation of elderly people or people of the so-called third age, whose potential numbers are increasing at a dizzy rate. According to international experts (the WHO and industrialised countries), people over the age of sixty-five could reach a figure of 16.9% in the year 2050, as opposed to 6.9% which is said to be the current figure. This urgent situation leads to the identification, promotion and implementation of health-are policies and at a broader level social policies as well, which include laws that seek to provide support to the elderly part of the population.

We all know that the resources of the welfare state both as regards health care and pensions are subject to major financial pressure and in some cases are verging on bankruptcy. At the same time, one can also observe that in developing countries the funds allocated to health care are not increasing at an adequate rate or at the rate that would be possible, at the same time as there is a high growth in other sectors of consumption and – an even more surprising fact – in the sector of armaments as well. Hence the great importance of a new analysis of social policies with regard to the period that we are now going through. Because of all these factors, the new reflections on social policies are not only concerned with health. They are also connected with such other sectors as housing, education, work etc. and they must be carefully taken into account when decisions are taken about the allocation of resources by governments and other sources of funding, because without health and wellbeing there can be no development.

Even when resources are hypothetically adequate, education at the level of lifestyles is probably the most important factor in the future state of health of society. Given that contemporary customs and habits lead only to a society that thinks about accumulating material goods, a constant striving after money or public positions with the use of the advantages that they can offer, not considering the social world which has inequalities, and a way of life that involves transient excesses, we should expect grave consequences in terms of health and wellbeing, with an old age marked by illnesses, malaise and unhappiness.

As regards lifestyles, we should stop for a moment to reflect on elements that have a great influence on the future of health. Elements such as diet, physical exercise, the cleaning up of the environment, the consumption of alcohol, tobacco etc. will have greater influence on life during the third age. Even were there to be policies, laws and regulations, without informed education about such behaviour beginning in infancy it would be very difficult to achieve the ideal of healthy, active and dignified adulthood and old age.

The above paragraph describes what is taking place in industrialised (rich) countries but in developing countries this whole universe of social and health policies only exists in documents and not in practice, and this point applies to the allocation of resources as well. However, the social and family fabric of society remains very strong and solidarity-inspired. This has meant that this culture of society conserves a *modus vivendi* which means that elderly people have a consolidating function, even though they do have available to them the necessary health-care services because there is a lack of economic resources. The WHO has expressed itself on this subject in the following way: 'Despite the enormous medical progress that has been achieved in recent decades, the fact remains that the last years of life are often marked by an increase in illness and often of infirmity'. The key factor in achieving a healthy old age for people is the possibility of remaining as self-sufficient as possible. Real advances that promote a healthy old age and prevent infirmity in elderly people will have as their consequence greater efficiency and less cost in the use of health-care services. This will also allow a higher quality of life for elderly people and will allow them to go on leading independent and productive lives for a greater period of time. One is not dealing here with increasing the number of years that are lived. We have to develop a society that offers elderly people an opportunity to go on being interested in the world around them and feeling that are still part of society.

In today's world in poor coun-

tries, which are also called developing countries, the cultural aspect and social organisation are more generous in terms of time and care in the case of both children and elderly people. Indeed, these countries devote a large part of their resources, which are scarce and limited by their situations, to their elderly people and it is certainly the case that their elderly people have survived many adverse factors.

I will now devote a few words to pensions and this leads us back to the gap that now exists between rich countries and poor countries, where, indeed, pension plans or old age pensions rarely exist after people stop working, or where they do exist (for example in emerging economies and societies undergoing transition) they have to deal with a series of restrictions or inadequacies at the level of economics and management. Once again the social fabric and cultural thinking have to try to solve these problems.

As regards the use of free time by elderly people, there are societies (for example China) which have implemented policies of social participation in use of free time by elderly people so that they can keep their physical, mental, psychic and spiritual conditions of health at the best level possible. This is a matter of physical exercise and voluntary work that uses the experience and knowledge of these people or voluntary work in less industrialised countries to which the knowledge that elderly people have acquired during their lives can be transferred.

I would also like to observe that in developing countries the cooperation promoted by elderly people in daily life is of great value. This is because they perform the function of providing support to the family (I may refer here by way of example to the relationship between grandparents and their grandchildren). I would also like to observe that in our unequal world there are societies where elderly people up to when they die do not have free time.

In ending this collection of observations and ideas, we may state that the changes that have taken place in care for elderly people and their active participation in society require complete revision in the light of today's and tomorrow's world so that elderly people are not seen as a social burden but as a contribution to the social fabric.

We should remember that it is elderly people who worked to create the abundance enjoyed by the modern world and that during their lives they made their own contribution to welfare resources (we may ask ourselves: is the term 'welfare' still valid in this context?).

It may also be observed that there is an unacceptable difference at the level of gender, with women at a clear disadvantage not only at the level of welfare provisions but also at the level of medical care and pensions.

Lastly, is it not right to recognise the contribution that was made by those who are now elderly when they were young people and adults? Is it not perhaps the young people of today who will be the elderly people of today? We have to work in this field.

Dr. FERNANDO
ANTEZANA ARANÍBAR,
President of the Executive Council of the WHO, Geneva, Switzerland, Consultor to the Pontifical Council for Health Care Workers

WANGARI MUTA MAATHAI

4.5 Ecological Change and Old Age: Pollution of Water, Pollution of the Environment

Allow me to thank you most sincerely for the warm invitation to participate in this very important conference on care of the sick and especially the elderly. I want to say that I was looking forward extremely so to be with you and to learn so much about this subject, an issue and a theme that affects all of us. But unfortunately, due to a political process that is going on in my country I am unable to come. Indeed on the very day I was supposed to present this paper I will be undergoing a process of nomination where a person must be present. And therefore, I will miss greatly the opportunity to be with you at the Vatican and to learn a lot about diseases and ailments that affect sick and old people.

Most people hope for a long life. I was privileged to have a mother who grew to be an old lady in her nineties. And even then she was happy and she was looking forward to a much longer life than she was given. And when she left, I was devastated. I think we are never ready for our loved ones to go. It is a great blessing to have our loved ones grow old. But we want them to grow old in grace, we want them to grow old without pain, without ailments. And so indeed that is why we are here to see: How can we take care of them? How can we make it comfortable for them; to be old but healthy, to be happy even in their old age, to be enjoyed by their great grand children indeed?

In many communities old age is admired, is respected; in fact in my own community to be old was considered a great blessing and people were blessed by their old ones usually with a blessing "may you grow old to see your third and fourth generation." That indeed is the way my grandmother used to bless me. But in many other societies youth is glorified, and as you become old and fragile and you lose your energy and vitality, sometimes you are moved away from society and you are put in institutions. In our traditional societies, old people used to take care of children. They used to play the role of story tellers, they were around and when younger people went to the field to work, they stayed at home. And so they were never put away, so to say. They were always there. They played a very important role of being old and being enjoyed and enjoying grandchildren.

But we have changed a lot, even in our poorly developed countries as we try to catch up with the rest of the world, we have moved into cities and we are actually trying to create institutions where we can put our old people, because we are no longer able to take care of them in the extended families that used to be part of the society structure. And so it is extremely important to consider what happens or what should we do to make sure that our old people do not suffer as they age.

As you know my work devolves around the environment and I had the privilege of being named the Noble Peace Laureate of 2004 because of our environmental work and of our being able to make the link between sustainable management of resources, good governance, respect for human rights and peace. And in working for the environment, among the issues we encounter that are very relevant for our health is pollution of the environment, pollution that comes with development, because as we industrialize we use chemicals, as we improve our agriculture we find ourselves polluting the air we breath, polluting the water we drink, polluting the soil in which we grow our crops. And so some of the diseases that indeed afflict us as we grow older, are diseases that are associated with the changing environment, the food we eat, the chemicals that have been used to grow it, the water we drink, the chemicals that many have reached into the wells and rivers and the air we breathe.

Many of the illnesses that aged people are confronted with have to do with the fact that they have changed the traditional food crops that they were eating. I hardly can recognize what my mother and my grandmother were eating. Many of those crops are no longer available to us, we do not grow them, we have become more modern. Ad so, we eat different kinds of foods and we are creating different kinds of biological bodies than our parents. And we do not how our bodies are going to react to the chemicals we are consuming in our water and in our foods.

We do not know what is going to happen to us because of the smoking habits that we have now embraced, because of the drinking habits that we have now embraced, because of the changing habits, for example of eating too much meat, may be taking too much sugar. These are all things that have changed in our environment and which are going to make it very very difficult for us

Our mothers our fathers enjoyed a very good biological constitution, perhaps because they lived within a clean and health environment. But as we progress in development we have seen a lot of changes in the new diseases that

are affecting us and that are going to affect us as we age. One of the most characteristic feature of course of people growing old is loosing their memory. Perhaps scientists will unravel the cause and tell us what we ought to do about it. But it is one of the issues that need to be looked at *vis-à-vis* the environment in which we live, to see what could we be doing to ourselves to our bodies, to our brains to our nerve cells, that brings about loss of memory, which is a very devastating condition for the aged. The other is the loss of energy, the loss of capacity to move, joints especially. We see so many younger people today suffering from joints ailments, they are unable to move. Some are suffering from congestion, especially respiratory diseases which may be associated with smoking and pollution in the atmosphere.

So I want to say that as we work for the environment, it is extremely important for us to pay attention to the environment, to ensure that every person has a right to a clean and healthy environment. This ought to be a basic right. Governments should ensure that every citizen lives and grows old in a clean and healthy environment. Because this is the basic gift that we can give to each one of us in order to avoid some of the ailments that we get as we grow old.

The Bible says, to paraphrase "that there is a time for everything; there is a time to be young and there is a time to be old." It is not possible to live long without loosing the vitality, the energy, the movements that we are used to when we are young. And it is important for all of us to remember that if we are blessed with a long life, we are likely to lose that energy and vitality that is associated with youth. We also know that or we want to believe that when we are in that situation we are not put away, that we are taken care of and we are allowed not to suffer because of ailments that are due to environmental degradation.

I hope that the proceedings of this conference will be widely shared because it is very important for us to learn more about this subject, to spread the message even further and to ensure that as many people as possible understand that as we grow older we shall reflect the lifestyle we lived when we were younger, the environment in which we grew up, and grew old in and that therefore we have a right to clean and healthy environment.

All governments have a responsibility to give all their citizens a clean and healthy environment in which to live and to grow old. I also hope that there will be a commitment to take care of old people. We owe it to them. They lose there energy taking care of us! They need our love, they need our compassion, they need our protection. We should invent or be creative about how to take care of the old people. Whether they are sick or healthy they need our love and our compassion. I am extremely encouraged by the fact that the Vatican has decided to convene a conference on this theme. I am very much looking forward to the proceedings, because I know I will learn a lot and I want to focus on this issue and make it part of my environment agenda. I owe it to those whom God blesses with a long life.

Thank you, and may you have a great and blessed conference.

Prof. WANGARI MUTA
MAATHAI, PH.D
Nobel Peace Prize 2004

Transcription from the Tele-conference

Second Session

What Should Be Thought?

1. Revelation

HANS-WINFRIED JÜNGLING

1.1 Care for Sick Elderly People in Holy Scripture

The Prefect and Vizier Ptahhotep says:
Sovereign, my lord,
Old age has been generated, senility has descended,
Caducity comes, powerlessness is renewed:
Because of this one is a baby every day–
My eyes are weak, my ears are deaf,
My vigour declines because of the debility of my heart,
My mouth is silent and does not manage to speak,
My memory fails me and I no longer remember yesterday,
My bones are painful because of the length (of my age),
Good has become bad,
All taste has gone.
What old age does to people
Is ugly in all respects:
My nose is damaged and cannot breathe,
Standing up and sitting is hard.
May orders be given to this servant so that he can
Become a walking stick of old age,
So that I can tell him the words that will be listened to.
Roccati, Allessandro, *Sapienza egizia* (Brescia, 1994), pp. 34-35.

We these words the Vizier, a man aged a hundred and ten (*ibid.*, p. 53), asked his sovereign, the Pharoh Isesis (c. 2,400 BC), permission to have a successor so that he could, so to speak, assure a walking stick for his old age.

The striking description of disturbances and illnesses that afflict an elderly man in this ancient text of Greek wisdom literature has a parallel with the late book of wisdom of the Old Testament, that is to say in Ecclesiastes. The following verses, which go back to the fourth century before Christ, stress with further emphasis the above-mentioned weakness of an elderly man: 'Remember also your Creator in the days of your youth, before the evil days come, and the years draw nigh, when you will say: "I have no pleasure in them"; before the sun and the light and the moon and the stars are darkened and the clouds return after the rain; in the day when the keepers of the house tremble, and the strong men are bent, and the grinders cease because they are few, and those that look through the windows are dimmed, and the doors on the street are shut; when the sound of the grinding is low, and one rises up at the voice of the bird, and the daughters of son are brought low; they are afraid also of what is high, and terrors are in the way; the almond tree blossoms, the grasshopper drags itself alone and desire fails; because man goes to his eternal home, and the mourners go across the streets; before the silver cord is snapped, or the golden bowl is broken, or the pitcher is broken at the fountain, or the wheel broken at the cistern, and the dust returns to the earth as it was, and the spirit returns to God who gave it. Vanity of vanities, says the Preacher; all is vanity' (Ecclesiastes, 12:1-8).

The Egyptian text contains the disturbances of an elderly man who has reached the venerable age of a hundred and ten. A hundred and ten years constitute an ideal age that was not unknown even in the Old Testament. The Pentateuch is almost presented as framed by the ideal of a centenarian perspective of life. After the angels sinned by uniting themselves with the daughters of men, God ordered that human life could last a hundred and twenty years but no longer (Gen 6:3). Moses was the man who managed to live

so long that he reached this age: 'Moses was a hundred and twenty years old when he died; his eye was not dim, nor his natural force abated' (Deut 34:7).

The life of the fathers in the Book of Genesis is rarely idealised. Abraham and Isaac died old men, full of days and life (Gen 25:8; 35:29); cf. also Job 42:17). Let us have a look at the ages of mothers and fathers: Abraham lived to the age of a hundred and seventy-five (Gen 25:7); Sarah lived to a hundred and twenty-seven (Gen 23:2); Isaac to a hundred and eighty (Gen 35:28); and Jacob to a hundred and forty-seven (Gen 47: 28). Job, after the tribulations that he had to endure, lived another hundred and forty years (Job 42:16).

1. The Limited Duration of Human Life

In the Old Testament a man of eighty was aware without any illusions of his age and of the fact that the vigour of youth had abandoned him. Barzillai, the Galadite, had come down to Roghelim and crossed the Jordan with the king to take his leave of him by the Jordan. Barzillai was very old, he was eighty. It was he who had looked after the king during his stay at Macanaim. In fact he was very rich. The king said to him "Cross over with me, and I will provide for your old age as my guest in Jerusalem." But Barzillai answered the king: "How much longer have I to live, that I should go up to Jerusalem with the king? I am now eighty years old. Can I distinguish between good and bad? Can your servant taste what he eats and drinks, or still appreciate the voices of singers and songstresses? Why should your servant be any further burden to my lord the king? In escorting the king across the Jordan, your servant is doing little enough! Why should the king give me this reward? Please let your servant go back to die in his own city by the tomb of his father and mother"' (2 Sam 19,32-37).

A friend of King David reached the ideal age of eighty. Psalm 90 sees a life of eighty years as in realistic terms the greatest age that could be reached: 'The years of our life are threescore and ten, or even by reasons of strength fourscore; yet their span is but toil and trouble; they are soon gone, and we fly away.' Only in rare cases does this maximum age actually appear to have been reached. The life of the Jewish kings, with the exception of David and Salomon, during the period that went from 926 to 597 BC oscillates around sixty-six (Azariah and Manasseh) and (Ahasja). None of them, therefore, managed to live to the ideal age of seventy. Life expectancy in ancient Israel was not high. For this reason, complaint about the shortness of life is a very recurrent theme in the Bible (Ps 89:49; 39:5-7; 49:13-21; 90:5-6; 102:4-5; 13:15-16; Is 40:6-8; Job 7:1-17; 14:1 ss.).

2. Illnesses are the Cause of the Short Duration of Life

We do not have certain and reliable information to confirm the fact that illness impeded people from reaching an advanced age. We know that two kings of Judah fell ill. The first was Azariah/Uzziah who lived during the first part of the eighth century. He reigned for fifty-two years and died at the age of sixty-six. God put him to the test by making him fall ill with leprosy and he lived with this illness until his death, which took place in a house which we have no information about and which is not described to us: 'And the Lord smote the king , so that he was a leper to the day of his death; and he dwelt in a separate house. And Jotham the king's son was over the household, governing the people of the land'(2 Kings 15:5).

Because of the uncertain interpretation of the Hebrew phrase *bebet hachofschit* we are, unfortunately, not able to establish at what moment in his life this king was struck by leprosy or for how long he had to live with this disease. In addition, we cannot engage in a certain statement about the ways in which he was treated and cared for in this 'separate house'.

The second king was Hezekiah who ruled during the second half of the eighth century BC. The Second Book of Kings reports as follows: 'In those days Hezekiah became sick and was at the point of death. After Isaiah the prophet the son of Amoz came to him, and said to him "Set your house in order; for you shall die, you shall not recover"' (2 Kings 20:1). The king addressed a prayer to God and God spoke again to the prophet Isaiah, entrusting him with the task of telling the king that fifteen years would be added

to his life. In addition the prophet ordered the preparing of a cake of figs, whose curative properties were well known (2 Kings 20:1-11/Is 38,1-22). In this account one reads that the king's head is turned towards the wall: 'Then Hezekiah turned his face to the wall' (2 Kings 20:2). This could mean that the king was lying on a bed. When we are told that the Patriarch Jacob was sick, we are informed that he was lying on a bed. When Joseph together with his sons Manasseh and Ephraim went to his sick father to pay a visit to him, Jacob drew upon all his strength to get up so as to be able to receive his son while being seated: 'After this Joseph was told, "Behold, your father is ill"; so he took with him his two sons, Manasseh and Ephraim. And it was told to Jacob, "Your son Joseph has come to you"; then Israel summoned his strength, and sat up in bed' (Gen 48:1-2, cf. 49:33).

3. God the Physician

The capacity to do anything of the art of medicine in antiquity was extremely limited. As a result, in cases of illness human help was not rated very highly. It was instead to God that the cry for help was addressed. This is to be found throughout the ancient East, especially in ancient Mesopotamia and ancient Israel. With respect to ancient Mesopotamia, we have a large number of ritual texts and prayers used when there was illness which bear witness how in the final analysis illness was a religious question. Even though physicians existed that could be of some help, a god was always the principal recipient of every request for help made by a sick person.

The Biblical text in which the verb 'to heal' (*apr*) appears for the first time is to be found in the Book of Genesis (Gen 20:17). The word is used when God heals the impotence of the King of the Philistines, Abimelech, the sterility of his wife and his female slaves, after Abraham interceded on their behalf: 'Then Abraham prayed to God and God healed Abimelech, and also healed his wife and female slaves so that they bore children' (Gen 20:17). Moses received the revelation from God which defines God as He who cures and heals and this he communicated to the people of Israel: 'There the Lord made for them a statute and an ordinance and there he proved them, saying,

"If you will diligently hearken to the voice of the Lord your God and do that which is right in his eyes, and give heed to his commandments and keep all his statutes, I will put none of the diseases upon you which I put upon the Egyptians; for I am the Lord, your healer (Ex 15:25b-26). And the epilogue to the Code of the Covenant we read: 'You shall serve the Lord your God, and I will bless your bread and you water; and *I will take sickness away from the midst of you*. None shall cast her young or be barren in your land; *I will fulfil* the number of your days' (Ex 23:25-26).

In both these texts the account shifts from the first person referred to God to the first person. The discourse *on* God becomes the discourse *of* God Himself, This passage, interpreted from the theological point of view, means that in reality God alone is He who can be of help, He who can heal.

Similarly to what has been said about the Pentateuch, where God revealed Himself as a 'physician', the Prophets, too, talk about the saving action of God which is expressed in an exemplary way in the divine activity of healing. The Prophets have before their eyes above all else the infirmity of the people: 'Moreover the light of the moon will be as the light of the sun, and the light of the sun will be sevenfold, as the light of seven days, in the day when the Lord binds up the hurt of his people, and heals the wounds inflicted by the blow' (Is 30:26). 'I have seen his ways, but I will heal him; I will lead him and requite him with comfort, creating for his mourners the fruit of the lips. Peace, peace, to the far and to the near, says the Lord; and I will heal him' (Is 57:18-19). 'Behold your God will come vengeance, with the recompense of God. He will come and save you. Then the eyes of the blind shall be opened, and the ears of the deaf unstopped ; then shall the lame man leap like a hare, and the tongue of the dumb sing with joy' (Is 35:4b-6a; cf. Mt 11:5/ Lk 7:22).

What applies to the people also applies to individuals. God will make Jerusalem a city where ever inhabitant can say: '"I am sick"; the people who dwell there will be forgiven their iniquity' (Is 33:24). People who from outside witness the drama of a man struck by infirmity, turn directly to God, knowing well that He alone can

help and heal. Moses implores God to help his sister Miriam who was afflicted by leprosy:

'And Moses cried to the Lord: "Heal her, O God, I beseech thee"' (Num 12:13). More frequently it is the sick themselves who pray to God to be healed. Jeremiah, for example, complains about the illness with which God, for reasons unknown to him, has afflicted him and which he is now forced to bear (Jer 15:18). The complaint of the prophet is, however, at the same time, a prayer, a prayer to be healed (17:14). The psalmists also exclaim 'heal me' (Ps 6:3; 41:5) and subsequently describe their experience of being healed. For this reason, the psalmist was able to say: 'Lord my God I cried out to you and you healed me' (Ps 30:3).

4. The Insufficiency of Human Help in Illness

In the psalms, side by side with complaints because of infirmity, there frequently recurs complaints about being abandoned by relatives and friends and left alone at a moment of especial difficulty: 'Be gracious to me O Lord for I am in distress: my eye is wasted from grief, my soul and my body also, For my life is spent with sorrow, and my years with sighing; and strength fails because of my misery, and my bones waste away. I am the scorn of all my adversaries, a horror to my neighbours, an object of dread to my acquaintances; those who see me in the street flee from me, I have passed out of mind like one who is dead; I have become like a broken vessel. Yes, I hear the whispering of many – terror on every side! – as they scheme together against me, as they plot to take my life (Ps 30:10-14; Ps 38:6-14; 41:6-10). See also Ps 71. The psalm seems here to be recited by an old man. The psalmist complains of the drawing near of the weaknesses of old age (9.18) and of the fact that men have become his enemies (10-11).

To consider such complaints as the projections of the sick man himself without doubt contains some truth. However, one cannot deny that such an explanation is, if not mistaken, at the least limited. It is very probable, in fact, that one is not dealing simply with the wanderings of a mind due to fever. What the psalmists want to express with the words 'I looked for pity but there was none; and for comforters but I found none' (Ps 69:20), is more a profound sense of discomfort felt by a person confronted with a sick man. This last provoked in a healthy and strong man a feeling of pained embarrassment. For the healthy man, the sick man is anything but attractive. The Bible defines a sick man as a repugnant and disgusting reality. The fact that the complaints of the sick who feel isolated and abandoned are not only the projections of their imagination – these projections are often the cause of the fact that sick people are unjust and ungrateful towards the people who are ready to help them. They reflect a true reality, which unfortunately takes place too often, and this is borne witness to in the Biblical text where reference is made to a man afflicted by infirmity 'From the sole of the foot even to the head' (cf. Is 1:6). The suffering servant of the Lord is torment for those who see him; what is provoked is a radical aversion: 'As many were astonished at him – *his appearance, beyond human semblance, and his form beyond that of the sons of men* – Who has believed what we have heard? And to whom has the arm of the Lord been revealed? For he grew up before him like a young plant, and like a root out of dry ground; *he had no form or comeliness that we should look at him, and no beauty that we should desire him. He was despised and rejected by men; a man of sorrows, and acquainted with grief; and as one from whom men hide their faces he was despised, and we esteemed him not*' (Is 52:14; 53:1-3).

5. Infrequent Invitations to Take Care of the Sick

The Biblical evidence on care for the sick is not very rich. This certainly unexpected fact leads one to think that the discomfort of the healthy when faced with human weakness and illness was followed up in the instructions of the books of wisdom and in the Torah. I would like to refer, albeit very briefly, to a fact that is present in some texts of ancient Egypt. Since the times of the Ancient Kingdom a catalogue of works of mercy had existed which included, among other things, 'giving food to the hungry, clothing the naked, and giving a boat to those who have to cross a river'. This threesome makes up the core of that literary genre that developed over the following centuries and which is defined by Egyptologists as 'ideal biography' or also 'moral profile'.

We learn about 'ideal biography' from a large number of inscriptions. The long history of this literary genre began in about 2,400 BC and continued until 600 BC. However, examples of this literary genre can also be found subsequently, during the Christian epoch. The literary production of the first thousand years, that is to say from 2,400 to 1,400, almost completely lacks references to care provided to sick people. This lack is certainly not accidental. It was caused by very precise factors and can be explained by the fact that help for the poor and the hungry belonged to the range of common human possibilities. In contrary fashion, human capacities were revealed in all their limits when the question in hand was that of healing a man with an illness. For this reason, there were not many Egyptian functionaries who had the courage to have written on their tombstones, 'I healed the sick'. But there were exceptions. For example, an inscription going back to the first intermediary period, that is to say the period of the tenth and eleventh dynasties (c. 2,000 BC) reads as follows: 'I was a son for the old, a father for the child, a commander of citizens everywhere. *My food belonged to the hungry, my oil to those who were not oiled. I gave my clothes to those who were naked. I enchanted the face of the sick; I removed bad odour. I am*

one who buried he who died blessed. I decided things according to their correctness and ensured that two contracting parties came out of the judicial court with their hearts content'.

Similar examples of works of mercy are reported, albeit in a reduced quantity, in the Old Testament as well. The twenty-ninth chapter of the Book of Job, in which Job narrates his happy past, can be characterised as an ideal biography. Amongst other things, one can read the following words: 'I delivered the poor who cried, and the fatherless who had none to help him. The blessing of him who was about to perish came upon me, and I caused the widow's heart to sing for joy. I put on righteousness, and it clothed me; and my justice was like a robe and a turban. *I was eyes to the blind, and feet to the lame,* I was a father to the poor, and I searched out the cause of him whom I did not know. I broke the fangs of the unrighteousness and made him drop his prey from his mouth' (Job 29:12-17).

Even though on the whole the exegesis of this text affirms that the words 'I was eyes to the blind, and feet to the lame' should be seen as metaphors, the character of the metaphor itself communicates a specific meaning: the commitment to the poor and the oppressed, which the metaphor wants to mean and express, is compared to help for handicapped people. This represents a work of mercy which, on a par with commitment to the poor, is worthy of praise.

In Leviticus, together with other commandments, there is the injunction not to be an obstacle to the deaf and the blind: 'You shall not curse the deaf or put a stumbling block before the blind; but you shall fear your God. I am the Lord you God' (Lv 19:14).

Amongst all the commandments, the Decalogue has a value and a level that are completely special. But within its texts, it does not lay down that the elderly and the sick should be cared for and treated. However, the commandment to honour one's father and one's mother is directed to adult children (Ex 20:12/Dt 5:16). It does not constitute in the first place the duty of small children to obey their parents (cf. Col 3:20; Eph 6:1-3), but rather the commitment of adult children of take care of their parents once these have become old or fallen sick. This task of adult children is further emphasised by the promise that is added to the commandment (cf. Eph 6:2) – the only case on the Decalogue. Jesus, too, interpreted this commandment to honour one's parents in the sense of looking after one's elderly parents (Mk 7:8-13/Mt 15:1-6).

But before Jesus, Jesus the Son of Sirach, Jesus Ben Sirach, the wise man of the second century BC, interpreted this commandment of the Decalogue in the same sense. The reference to the fourth commandment appears twice, in the third and the seventh chapters. Let us now dwell on these two passages so that we can analyse them more closely.

Within the book of Jesus ben Sirach (Sir 3:1-6 and 7:27-28) they form a framework that includes the first series of thematic discourses of this wise author. The first text is marked out by two aspects: 1. the comment on the Decalogue constitutes the *first* thematic discourse after the prologue. This last defines the foundations and the principles of the whole of the book: wisdom and fear of the Lord constitute what brings out divine mercy (Sir 1-2). After the prologue, which has a very precise structure and contents of great weight, the first discourse addresses a concrete problem and recommends: 'Listen to me your Father, O children; and act accordingly, that you may be kept in safety. For the Lord honoured the father above the children, and he confirmed the right of the mother over her sons' (Sir 3:1-2).

With regard to the value and the precedence of the admonitions of parents, the book of ben Sirach agrees with a series of commandments that are to be found in Leviticus and to which references have already been made in this paper. This series does not contain only the commandment of love for neighbour and commitment to the deaf and the blind (Lv 19:18 and 14) but also begins with the command: 'Every one of you shall revere his mother and his father' – and in that order! The father comes after the mother (Lv 19:3). This commandment has precedence over all the other commandments and even over those that refer directly to relationships with God. The second aspect of the first discourse of Sirach lies in the theological motivation for the exhortation to honours one's parents which runs through the whole text: 'Whoever honours his father atones for sins' (Sir 3:3a), 'whoever obeys the Lord will refresh his mother' (Sir 3:6b).

The text in an explicit way talks about the illness and weakness of an elderly father. The weakening of intellectual powers is a real possibility that a son must take into consideration. Even were a father to lose his mental faculties, a son should not despise a father who presents signs of dementia: 'O son, help your father in his old age, and do not grieve him as long as he lives: even if he is lacking in *understanding*, show forbearance; in all your strength do not despise him. For kindness to a father will not be forgotten, and against your sins it will be remembered in your favour (Sir 3:12-14, in the Latin text: *sensus*). Verse 13 should be translated 'even if his mind fades, show forbearance, following the Hebrew and Greek text: *maddao; synesis.*

The commandment to honour one's parents is taken up again in the book of Sirach at the end of the first series of thematic discourses: 'With all your heart honour your father, and do not forget the birth pangs of your mother. Remember that through your parents you were born; and what can give back to them that equals their gift to you?' (Sir 7:27-28).

The admonition of the wise man here, too, has great theological weight. 'With all your heart' is the phrase referred to the commandment to love God as found in Deuteronomy (Dt 6:4 f.). The close connection between honouring one's parents and love for God is further emphasised by the fact

that the wise author goes on to exhort one to fear God with all one's heart (v. 30a) and to love the Creator with all one's strength (v.31a). Honouring one's parents has an immediate relationship with love for God.

The wise author than enjoins care for the ministers of worship (Sir 7:29b-30b) and emphasises sacrifices (Sir 7:3cde). The discourse thus ends with reference to the poor, honouring the dead, and visiting the sick: 'Stretch forth your hand to the poor, so that your blessing may be complete. Give graciously to all the living, and withhold not kindness from the dead. Do not fail those who weep, but mourn with those who mourn. Do not shrink from visiting a sick man, because for such deeds you will be loved. In all you do, remember the end of your life, and then you will never sin' (Sir 7:33-36).

The verse that provokes greatest interest, 'Do not shrink from visiting a sick man, because for such deeds you will be loved', unfortunately is not certain from the point of view of textual criticism. The Hebrew text has something totally different which should, however, be seen as a corruption of the text. The ancient translations are clear and testify in particular to care for the sick. The verb 'to visit' in the Greek text is the same that Jesus used in his discourse on the final judgement when he lists works of mercy (Mt 25:36).

The commandment to honour one's elderly parents also recurs in the book of Tobit where there is a reference to an elderly mother who survives the death of her husband: 'when I die, bury me, and do not neglect your mother. Honour her all the days of your life; do what is pleasing to her, and do not grieve her. Remember, my son, that she faced many dangers for you while you were yet unborn. When she dies, bury her beside me in the same grave' (Tb 4:3-4).

The discourse of the old Tobit addressed to his son does not only appear in many Biblical traditional passages but also demonstrates notable similarities with Egyptian texts. The catalogue of good works, known in the ideal biographies of ancient Egypt, continues also here. Just as in the ideal biographies the authors only in rare cases praise themselves for having helped the sick, so in the discourse of wisdom of Tobit there is no exhortation to take care of the sick. This fact stands out even more when we think that he is a handicapped person, a blind man who acts as a teacher.

6. What was Done for the Sick? What was Taken for Granted?

Let us begin with the doctrinal account of the book of Tobit: the account describes the healing of Sarah (Tb 8:1-3) and of Tobit (11:1-5). The book presents the remedies of traditional medicine for cases of possession by a demon and cases of blindness (Tb 6:6-9). Even more important in this story is that the fact that the Archangel Raphael points out to the young Tobit what the necessary methods are. The name of the archangel clearly communicates that in reality one can restore health, whether one is dealing with a sick young man or with an elderly person.

In antiquity the art of medicine was certainly not unknown but in most cases people did not know how to react to illness. The Book of Sirach recommends consulting a physician but at the same time it warns that too much should not be expected of him (Sir 38:1-15). The text of Ben Sirach, in which there is an explicit reference to a physician, is worthy of especial interest because it alludes to the passage in Exodus where God is defined explicitly as the physician of Israel (Ex 15,26).

But what do we find in the Bible as regards purely human help for the sick? It is narrated that the wife of Isaac, Rebecca, together with her favourite son, treated her old and blind husband badly. The weakness of the husband and father is exploited in a shameless way! This contempt for an elderly and blind man cannot be taken as a model to be imitated. The elderly priest from Bethel known as Eli is ninety-eight years old and cannot see (1 Sam 4:15; 3,2). His sons see him as a despot who is without any moral sense. The old man no longer has any power over his sons because they do as they please (1 Sam 2:22-26). This is also a case that cannot be taken as an example of behaviour to be followed.

Are there examples to be followed? The friends of Job come 'to condole with him and to comfort him' (Jb 2:11; 42:11 cf. 2:13). They do this but the absence of such care is complained about by the psalmist: 'I looked for pity but there was none; and for comforters, but I found none' (Ps

69:21). The friends of Job, as they are presented in the account given to us, which on the one hand make up a framework of discourses by Job and his friends, and, on the other, of the discourses of the Lord and of Job, have the intention of focusing everything on the sick man.

'Naaman, commander of the army of the king of Syria…was a leper'. He is perhaps a good example of what a sick person expected of a prophet-physician: 'Behold, I thought that he would surely come out to me, and stand, and call on the name of his Lord his God and wave his hand over the place, and cure the leper' (2 Kings 5:1,11).

What one could expect in the case of an illness or a wound is to be found in the Book of Isaiah through the image of a human body afflicted by illness from the sole of his foot to the top of his head – where the human body represents Judah, whose territory has been notably reduced: 'What will you still be smitten, that you continue to rebel? The whole head is sick, and the whole heart faint. From the sole of the foot even to the head, there is no soundness in it, but bruises and sores and bleeding wounds; they are not pressed out, or bound up, or softened with oil' (Is 1:5-6). The body that is described is destroyed: the wounds, the bruises and the sores should have been cleaned, bound up and dressed with oil, but of all this has not been done. Here, between parentheses, we find the same sequence of actions that is reported in the narrative of Jesus about the Good Samaritan: binding wounds and then dressing them with oil (cf. Lk 10:34): 'and he went to him and bound up his wounds, pouring on oil and wine'.

The prophet Ezekiel also offers an image: God accuses the false pastors, those who lead the people, of not showing the least sign of responsibility for their sheep, whereas, instead, they should comfort the weak, bind the wounds of those who are wounded, and treat the sick: ' The weak you have not strengthened, the sick you have not healed, the crippled you have not bound up, the strayed you have not brought back, the lost you have not sought, and with force and harshness you have ruled them' (Ez 34:4).

Because the pastors do not act as they should act, God Himself takes responsibility for His sheep: 'I myself will be the shepherd of my sheep, and I will make them lie down, says the Lord God. I will seek the lost, and I will bring back the strayed, and I will bind up the crippled, and I will strengthen the weak, and the fat and the strong I will watch over; I will feed them in justice' (Ez 34:15-16). In the Jewish world visiting sick people is seen as an act of imitation of God. Probably the verb present in Ezekiel 34:11.12, *biqqer* 'to heal', 'to be concerned', is at the base of the phrase *biqqur cholim*.

7. Caring for the Sick in the Epistolary Letters of the New Testament

The letters of the New Testament do not explicitly deal with the subject of sick people. Only occasionally is reference made to a sick person: 'Epaphroditus my brother and fellow worker and fellow soldier…has been distressed because you heard that he was ill. Indeed, he was ill, near to death. But God had mercy on him, and not only on him but on me also, lest I should have sorrow upon sorrow' (Phil 2:26f.). Timothy received the following advice: 'No longer drink only water, but use a little wine for the sake of your stomach and your frequent ailments' (1 Tim 5:23). In the same way reference is made to a certain Trophimus who was left ill at Miletus: 'Trophimus I left ill at Miletus' (2 Tim 4:20). Who left him alone? Paul?

In the letter of James we find advice addressed to sick people themselves: 'Is any among you sick? Let him call for the elders of the church, and let them pray over him, anointing him with oil in the name of the Lord; and the prayer of faith will save the sick man, and the Lord will raise him up; and if he has committed sins, he will be forgiven. Therefore confess your sins to one another, and pray for one another, that you may be healed. The prayer of a righteous man has great power in its effects. Elijah was a man of like nature with ourselves and he prayed fervently that it might not rain, and for three years and six months it did not rain on earth. Then he prayed again and the heaven gave rain, and the earth brought forth its fruit' (Jm 5:14-18). This passage from James is the classic Biblical foundation for the sacrament of the anointing of the sick.

Although references to how sick people should be cared for in

the letters of the New Testament are very rare, in the Gospels a completely different kind of situation is encountered.

8. The Behaviour of Jesus towards the Sick and his Exhortation to those who Follow him to Care for the Sick

The material offered by the Gospels on the subject of 'the sick' cannot, unfortunately, be presented in all its breadth. A number of observations will have to suffice.

a. *Jesus and the sick*

'That evening, at sundown, they brought to him all who were sick or possessed with demons. And the whole city was gathered together about the door. And he healed many who were sick with various diseases, and cast out many demons; and he would not permit the demons to speak, because they knew him' (Mk 1:32-34; cf. Mt 8;16; Lk 4:40-41). This is the first summary in the oldest Gospel, the Gospel of Mark. The text is preceded by the account of the healing of Peter's mother-in-law who had a fever (Mk 1:30-31). This summary is followed by two accounts: of the healing of a leper (Mk 1:40-45) and the healing of a paralytic (Mk 2:1-12). The vocation of the publican Levi (Mk 2:13-14) leads to the discussion between Jesus and the scribes and the Pharisees about eating with sinners and publicans. The account reaches its climax with the words of Jesus: 'Those who are well have no need of a physician, but those who are sick; I came not to call the righteous, but sinners' (Mk 2:17).

Jesus heals elderly people such as the woman who 'had had a flow of blood' and restored life to a young girl, the daughter of Jairus (Mk 5:21-43; Mt 9:18-26; Lk 8:40-56). In another summary in the Gospel of Mark we read as follows: 'And when they had crossed over, they came to land at Gennesaret, and moored to the shore. And when they got out of the boat, immediately the people recognized him, and ran about the whole neighbourhood and began to bring sick people on their pallets to any place where they heard he was. And wherever he came, in villages, cities, or country, they laid the sick in the market places, and besought him that they might touch even the fringe of his garment; and as many as touched it were made well' (Mk 6:53-56; Mt 14:34-36).

The summaries of the Gospel of St. Mark are further developed and broadened in the other two synoptic Gospels where they are placed within very precise and significant contexts. Cf. for example Mt 4:23-25. The passage that is parallel to the first summary of the Gospel of Marl (Mk 1:32-34) has been enriched by a quotation from the book of the prophet Isaiah taken from the fourth song of the Servant of the Lord: 'That evening they brought to him many who were possessed with demons; and he cast out the spirits with a word, and healed all who were sick. This was to fulfil what was spoken by the prophet Isaiah, "*He took our infirmities and bore our diseases*' (Mt 8:16-17; cf. also Mt 9:35-38; 12:15-22;14:14).

What the summaries express is interpreted by Jesus himself when to the messengers of John the Baptist he says that his coming is the beginning of the time of the Messiah: 'Now when John heard in prison about the deeds of the Christ, he sent word by his disciples and said to him, "Are you who is to come, or shall we look for another?" And Jesus answered them, "Go and tell John what you hear and see: *the blind receive their sight* and the lame walk, lepers are cleansed and *the deaf hear, and the dead are raised up*, and the poor have good news preached to them. And blessed is he who takes no offence at me' (Mt 11:2-6/ Lk 7:18-23).

Unfortunately, I am here forced to interrupt the discussion of the behaviour of Jesus towards the sick. To conclude, I would like to refer briefly to how Jesus entrusted his disciples with the task of completing his care for the sick.

b. *Jesus' charge to his disciples to heal the sick*

The speech with which Jesus sent out the twelve begins in the following way: 'And he called to him his twelve disciples and gave them authority over unclean spirits, to cast them out, and to heal every disease and every infirmity' (Mt 10:1). This speech explicitly contains the charge to heal the sick: 'And preach as you go saying, 'The Kingdom of Heaven is at hand'. Heal the sick, raise the dead, cleanse lepers, cast out demons. You received without pay, give without pay' (Mt 10:7-8; cf. Lk 9:1-6; 10:1-12).

The speech on sending out the twelve in the Gospel of Mark, which is much shorter than in the Gospel of Matthew and the Gospel of Luke, ends with the news that the disciples had managed to call many to repentance and had already healed many sick people: 'So they went out and preached that men should repent. And they cast out many demons, and anointed with oil many that were sick and healed them' (Mk 6:13/ Lk 9:6).

The words of Jesus at the end of the Gospel of Mark addressed to the unbelieving Eleven (cf. Mk 16:11,13,14) contain the statement that those who have received baptism will place their hands on the sick and will heal them: 'He who believes and is baptised will be saved…' (Mk 16:16). (Believers) 'will pick up serpents, and of they drink any deadly thing, it will not hurt them; they will lay their hands on the sick, and they will recover' (Mk 16:18).

In the context of the announcing of the coming of the Messiah as the son of man, Jesus speaks of the final judgement and lists the six works of mercy: giving food to the hungry, giving drink to the thirsty, welcoming strangers, clothing the naked, *visiting the sick*, and going to see those who are in prison (Mt 25:35-36, 37-39; 25:42-43 and 44).

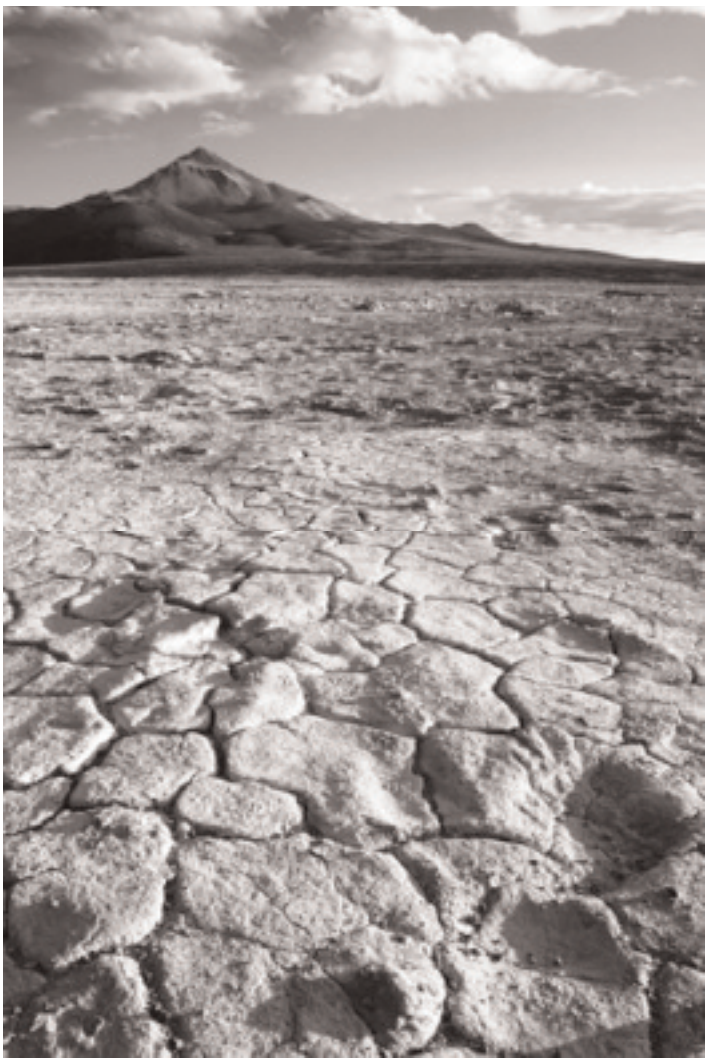
Together with the example of the Good Samaritan (Lk 10:30-37), this list of works of mercy has inspired Christianity in its care for the sick.

I would like to end this paper of mine by observing what in the accounts of healing in the Gospels emerges in a special way on two occasions. When Jesus heals the paralytic – this is the first of the healings worked by Jesus – the paralytic is carried by his friends. Because he could not reach Jesus directly because of the crowd, they opened a hole in the roof of a house and lowered the pallet on which the paralytic was lying down in front of Jesus. This must be a injunction for Christians. They must behave like the friends of the paralytic: care for the sick must be as serious and an effective as this action of the four men. A sick man must be taken to Jesus and to do this one must even open a hole in the roof of a house (Mk 2:1-11/ Mt 9:1-8/ Lk 5:17-26).

There is also a disconcerting 'anti-tale'. There was a blind beggar in Jericho called Bartimaeus, the son of Timaeus. When he heard that Jesus was nearby he cried out with all his strength and said "Jesus, Son of David, have mercy on me!". But the crowd around Jesus told him to be quiet: 'And many rebuked him, telling him to be silent". But Bartimaeus did not allow himself to be discouraged and cried out even more. Nobody managed to silence him (Mk 10:46-52/Mt 20:29-34/Lk 18:35-43). This, too, is a warning for Christians; they should be attentive to the laments and the cries of the sick.

The dignity of sick people is assured and defended by the care of those who are near to them. This care and this being neighbours is a valuable source of help for sick people. The friends of Job, in this sense, are a true example: they do what they have to do at the side of a suffering man. They sit down and keep quiet with the suffering Job. Then, instead, they begin to answer the speeches that Job makes to them, they become enemies of the suffering man, like God whom Job condemns as his enemy (cf. Jb 19:22; 13:24).

Rev. HANS-WINFRIED JÜNGLING SJ,
Professor Emeritus of Exegesis of the Old Testament, Philosophisch-Theologische Hochschule Sankt Georgen, Frankfurt am Main, Germany.



GABRIELE MARASCO

1.2 Care for the Elderly in the Fathers of the Church

In a book that is still a textbook on the history of old age, Georges Minois presents a rather negative vision of the condition of elderly people during the first centuries of Christianity: only old people with authentic wisdom are said to have been appreciated and the Church, even though it was a gerontocratic society, is said to have used the elderly without any gratitude or thanks.[1] This book has been the subject of criticism both at a philological level[2] and at a specifically historical level,[3] and, for that matter, very different interpretations have, instead, laid emphasis on the appreciation of elderly people in Christian society and culture.[4] However, very little attention has been paid to the special topic of care for the elderly,[5] in particular at a health-care level, and to the approach of the Fathers of the Church to this question. I believe, instead, that this subject can throw rather interesting light on the action of Christianity in the social field, whose development and evolution can, in my view, be clarified first and foremost if they are seen in connection with the advances in medical science at the time, taking into account the special interest that the Church has always shown towards medicine.

In the Greek world care for the elderly was generally seen as the task of their family relatives.[6] The approach of the Jews was similar. For them, however, an old person who did not live with his or her family, and did not have heirs who were able to care for him or her, belonged to the more general problem of poverty and the precepts of charity were thus applied to that person.[7] In the Roman world as well care for the elderly was the task of the family, even though the state took responsibility for certain special categories such as veterans and favoured the elderly through a policy of immunity.[8]

Into this consolidated tradition Christianity immediately introduced profound elements of change which later evolved and modified with time. The first reference to the subject appears in the account of the Acts of the Apostles when this text speaks about the beginnings of Christian preaching when the Apostles, answering the 'Hellenists'[9] who complained about their widows being neglected at the level of daily care, chose ten deacons to look after them.[10] This complaint with every probability referred to help for the poor which in this case did not involve giving food to widows[11] and which the Apostles immediately accepted as an essential task of their communities. But the profound significance of this task and its organisation were then clarified in an indelible way by St. Paul.

In his First Letter to Timothy, in fact, Paul states that it is necessary to care for and to honour widows who are really widows. If they have children or grandchildren these last should help them and demonstrate pity for the family. If, on the other hand, the widow is on her own, she must be helped by the community, as long as she has demonstrated her faith, has led an irreproachable life, she has not re-married, and is not less than sixty years of age. However Paul further exhorts believers who are relatives of widows and can help them to help them so that the Church does not have to take responsibility for them and thus can help those who are really in need.[12] Through these clarifications of St. Paul, therefore, care for elderly women without means of subsistence and relatives able to help them became a prominent task of the Church and it appears evident that this had to involve, in addition to subsistence, also health care, even though no evidence confirms the thesis that at that time there was specific organisation for this purpose. It is also important to observe the effort that the Apostle made to try to limit the role of the Church to cases of real need and this was a result of the evident awareness of the limits to the resources that the Christian communities of that epoch had available to them and to a concern to avoid their dispersion and to lack being created as regards those who needed such resources.

The prescriptions of Paul remained the basis of the action of the Church, for which care for widows was a constant commitment,[13] and also of the thought of the Fathers of the Church, beyond the explicit and recurrent exhortations to conform to the teaching of Christ who, according to the accounts of Matthew and Luke, exhorted us not to trouble about the future needs of the body but to take care of the future needs of the soul instead.[14] Thus Evagrius Ponticus exhorted monks to be careful about an avidity that was linked to thinking about a long old age, the impossibility of working, hunger and the illnesses that would arrive with old age, and the shame of having to turn to the charity of others.[15] This, however, was linked to Basil of Caesarea and Gregory of Nazianzus,[16] who as we will see later were particularly committed to care for the elderly, whereas Jerome, who cites the passage in Matthew to exhort Eustochius to be careful about avidity and not to work with the prospect of possible old age and illness and people not having any compassion for him, immediately afterwards observes the commitment of the faithful to support elderly women, blaming those who engaged in abuses because of pride.[17] He elsewhere observes the injunctions of Paul with approval, injunctions which limited the care of the Church to widows over the age of sixty who were of good habits.[18] Em-

phasis should be laid in considering these passages on the connection between old age and illness which were seen as complementary as regards fear about the future. But the reference to the words of Christ are connected in both cases with trust in charity, which would make old age less severe, in the case of those who did not have heirs who were able to maintain them.

However, the care provided to elderly widows should not be underestimated. By the middle of the third century in Rome, where the Christian faith was widespread but not predominant, the letter of Pope Cornelius to Fabius, the Bishop of Antioch, bears witness to the fact that the Church maintained a thousand widows and poor people.[19] The breadth of this action and the burden that it involved were confirmed by Jerome who reminded the presbyter Nepozianus that were he to fall ill he could encounter difficulties in being cared for because the Church fed many old women who returned such charity by looking after the sick, which was, indeed, a way, as one can see, of taking advantage of resources and at the same of time of ensuring that these elderly women did not feel useless.[20] Elsewhere Jerome himself laid stress on condemning those who refused to help their own mothers, thereby forcing the Church to take care of them and reducing what was available for those elderly women who were really in need, and were also not ashamed of seeing their own mothers in church begging for alms.[21] In an even more sorrowful way Ambrosiastrus praised the farsightedness of Paul who established precise criteria for those widows who could be looked after: this commitment, in fact, was a major burden on the Church, above all because of those faithful who, although they were economically able to help them and even to extend their charity to other categories, sought to avoid this obligation, thereby forcing widows to turn to the Church for help.[22] Thus it was necessary to help a large number of widows rather than a few and people complained about, and delayed, the help they gave. In addition, in opposition to the prescriptions provide by St. Paul, widows of more than one husband who had led a dissolute life took advantage of the help of the Church both because of negligence and because of the intervention of powerful people.[23]

Despite these difficulties and the possible examples of abuse, help for widows over the age of sixty remained an essential institution of the Church. However, elderly men, even though in a state of need, remained excluded from such help, and this help was directed above all towards providing food, housing and clothes. However, no special form of organisation seems to have been dedicated, at least at the outset, to dealing with illnesses. This situation, however, evolved progressively at both levels. Indeed, widows and orphans appear as the beneficiaries of the care provided by the Church in the Letter of Barnabus.[24] Ignatius of Antioch, who was martyred under Trajan, prescribed charity for widows, orphans, the oppressed, prisoners, the hungry and the thirsty.[25] Towards the middle of the second century Polycarp of Smyrna thought that it was the duty of presbyters to help the sick, widows, orphans and the poor.[26] But already by the end of the same century Clement Alexandrine refers to the old, together with widows and orphans, as categories dear to God.[27] Elsewhere Clement sharply attacked ladies who rejected widows, old people and orphans, and spent their money on exotic or monstrous animals, whereas in fact they should have provided help to the elderly who taught them wisdom and had faces that were much more beautiful than monkeys. He referred to the words of Christ who warned that everything done to these brethren of his was done to him.[28]

Although the testimony of Clement could appear to be a personal stance marked by special concern about the condition of elderly people, much more significant at a practical level is the testimony offered to us by Tertullian in his *Apologetics*, which was written in 197. He states in this work that the money collected thanks to the offerings made by the faithful should not be wasted in useless expenditure but should be used to give food and burial to those in need, to help orphans, elderly servants and the victims of shipwrecks, and all those who, because of their faith, had been condemned to work in the mines, deported or imprisoned.[29]

And at the beginning of the third century Origen, a pupil of Clement, stated that it was necessary to be careful in the distribution of ecclesiastical goods so as not to waste them and the needs and the dignity of every person had be considered with prudence. Indeed, those who were always having to make economies and those who had lived for a long time in comfort but only later fell into poverty were not to be considered as being on the same level. Equally, the same things should not be offered to men and women or to the elderly and the young who because of their conditions were not able to maintain themselves. It was also necessary to ask people if they had a large number of children, if they had abandoned them, or if they were not able, despite their efforts, to help them in an adequate way.[30] In a more explicit way Ambrose, when addressing the duties of ecclesiastics, stated that in helping people it was necessary to take into account age and infirmities and to give more to those elderly people who were not able to maintain themselves through their own efforts and to the sick.[31] With reference to this passage, as with that taken from Origen, we should draw attention to the juxtaposition of the old and the sick, based upon their shared situations, as individuals who were unable to obtain enough to live. This juxtaposition, for that matter, is to be found in the monastic rules of Pacomius who roundabout 321 established coenobitism in Egypt by founding the monastery of Tabennisis, to which six other monasteries were soon added.[32] Old people, children and the seriously ill appeared in these monasteries to be the only categories that were exempted from the fasts that were required of the monks.[33] This bears witness to an awareness of the special condition of weakness that they shared, which in this case clearly had physical causes rather than economic ones.

These passages testify to a clear evolution, as a result of which, beginning with the last decades of the second century, old people became one of the categories that were particularly attended to by the Church, on a level with orphans, widows and the sick. The consequent effects of this evolution became evident beginning above all else with the reign of Constantine when the triumph of Christianity and its full conformity

with the Roman state created the pre-conditions for a much more incisive intervention to help those who lived in a state of need, and this within the context of the impetus that the Christians gave to health care through the foundation of hospitals, above all in the eastern regions of the empire.[34] This intervention took place exceptionally early on. Indeed, whereas the first reference to a Christian old people's home in which the sick were also treated is that connected with an initiative of Eustace, the Bishop of Sebaste nel Ponto, in the middle of the fourth century,[35] the *Patria* of Constantinople provides us with information about an old people's home called Psamathia which had been founded by Helena, Constantine's mother, in a neighbourhood of the same name, together with a church.[36] In my view there is no reason to doubt this information when one takes into account its exact historical and chronological context. Indeed, Helena had been living in Rome since 322[37] and she left it only in 327 in order to engage in a pilgrimage in the East which would lead her to Jerusalem. On the occasion of this visit we have notice of her great acts of charity and generosity not only in the form of the foundation of churches but also of generous donations to communities and to individuals in need, with the freeing of people in prison and the recalling of people from exile.[38] After returning to Rome, Helena died between 329 and 330.[39] The foundation of the old people's home in Constantinople can only be dated to the epoch of her pilgrimage and the historicity of this foundation seems to me to be clearly confirmed by the action of Helena as a whole. In my view, the figure of the creator of this new institution is emblematic. Here there were three features: the private benefactress, the saint who would shortly be recognised by the Church, and the mother of the Emperor. Her activity on behalf of elderly people in need was in fact characterised from that moment on, in my view, specifically by a perfect harmony, at the level of intention and action, of the Church, the state and private individuals.

The importance of the role of private benefactors is in fact borne witness to in particular in Constantinople by the *Patria* and it was performed above all else in the form of the creation of foundations.[40] Thus under the Emperor Arcadius the patrician Fiorentius left his home at his death as an old people's home, with a chapel attached to it.[41] The same initiative was taken, while he was still alive, by the patrician Dexiocrates under Theodosius II.[42] The *magistros* Antemius, who became Emperor of the West in 467, also transformed his home into an old people's home and into a church,[43] and under Justin II the Eubulus bothers and Isodorus converted their homes into an old people's home for foreigners and into one for elderly people.[44]

The example of Helena remained for that matter an inspiration for

women of the imperial family: Eudocia, the wife of Theodosius II, is credited with having founded a large number of homes for the elderly,[45] of which we know of one that was located in Jerusalem.[46] Pulcheria, the daughter of Arcadius and the wife of the Emperor Marcian, together with her husband founded in Constantinople a home for the elderly that was known as Prasina.[47]

The direct role and involvement of the Church was also notable. In particular Basil, on the occasion of a famine that had struck Cappadocia,[48] collected food for women, children and old people, and he himself, together with his servants, attended to the bodies of those who needed such care.[49] Gregory of Nazianzus, in one of his poems written on the occasion of his withdrawal from Constantinople at the end of his patriarchate,[50] uttered the following words: 'widows, orphans, the sick, who looked at my hands as though they were the hands of God, and sweet homes that took in the elderly, I will never forget your love, even if I wanted to'.[51] The reference here is to the Church of Santa Anastasia and these verses seem to bear witness to the existence of one or more homes for the elderly that were managed by the patriarchate. It is an important fact that Gregory puts side by side in an explicit way the activities engaged in to help widows, orphans and the sick.[52] This testified to the putting of these categories on a par which had taken place in the care that was provided by the Church.

The context that I have outlined raises three problems: the reasons for the development that led the Fathers of the Church, beginning at the least from the last decades of the second century, to add elderly people to the list of categories that were deserving of special care; the reasons that led to the creation of institutions specially designed to accommodate and care for elderly people,[53] a reality that was totally unknown previously; and the reasons for the breadth of such activity, namely the special commitment shown in this area by the state, the Church and private benefactors. To answer these points it is necessary, in my view, to pay attention, on the one hand, to the development of medical science in relation to old age and the illnesses that characterised old age, and, on the other, to the influence of social

and economic phenomena that were then developing within the Empire.

In Greek medicine, and in particular in the *Corpus Hippocraticum,* old age was seen as being characterised by a progressive cooling of the body which, it was thought, was prevalently accompanied by a drying up of the humours, even though a minority of writers spoke instead of an excessive humidity.[54] The tendency to have specific illnesses in old age was well known about and in particular the author of *Aphorisms* considered the typical illnesses of old age as being feeling cold, maladies of the urinary-genital apparatus, nephropathies, apoplexy, problems with bones and joints, insomnia and maladies of the ears and the eyes.[55] However, there was no reference to the existence of a specialisation in geriatrics which was, it appears, totally unknown.

This situation changed in a net way during the Roman epoch. Whereas Celsius confined himself to observing that young people were more subject to acute illnesses, elderly people had chronic illnesses and elderly people in substance had the same illnesses that were referred to in the Hippocratic *Aphorisms*,[56] we do have available to us works on the illnesses of elderly people dated to the period between the first and second centuries AD.[57] It was above all else Galen who seems to have provided an overall systematic approach to the subject and he offers us valuable information on the situation as it existed during his epoch, that of the last decades of the first century and the first decades of the second century, in the fifth book of his *De sanitate tuenda* and *De marcore,* a work dedicated to marasmus, a characteristic disturbance of old age.[58] On the basis of the theory of the humours,[59] Galen agreed with the idea that dryness was characteristic of old age, quite apart from the false impression of dampness that was created by an abundance of secretions.[60] He believed that old age was not an illness but a condition in line with nature.[61] Above all else he offers us valuable information on the activity of the physicians of the time. He observed in this work that it was difficult to deal with the health of elderly people just as in the same way as it was difficult to deal with convalescents because both these realities did not involve perfect health but were intermediary conditions between health and illness. He also testified to the fact that the youngest physicians called that part of their art that was concerned with the health of elderly people *gherokomikón*. [62] Elsewhere, when addressing the subject of marasmus and its affliction of the elderly, he stated that it was impossible to impede it but that one could prolong life and that this was the task of the branch of medicine that was called *gherokomikón*, whose objective was to avoid as far as possible that the body of the heart became desiccated to the point of it ceasing to function.[63] In the opinion of Galen a good physician of the elderly was a person who knew their condition, which was provoked by dryness and cold, and learnt about simple remedies that provided humidity and cold.[64] The therapies that Galen proposed, in fact, sought to obviate a lack of warmth and humidity and gave major space above all else to a suitable diet and hot baths.[65] But he also paid notable attention to the psychological aspects of the conditions of elderly people and to the consequences of age for their minds.[66]

The testimony of Galen demonstrates first of all that in his time geriatrics was a specialisation that was by then well established, with physicians who devoted themselves in particular to the treatment of elderly people. The special illnesses of the elderly were well known about and required specific therapies and therapies that were ongoing because the maladies of elderly people belonged to the sphere of chronic afflictions and threatened them with death, as well as being expensive because they were based first and foremost on diet and hot baths. For that matter, Galen's theories enjoyed a wide diffusion and not only amongst the pagans. It is sufficient to remember here that according to Eusabius the adherents of the heresy of Arthemon venerated their contemporary Galen almost as a god.[67] It should not amaze us, therefore, that bishops of great learning such as Clement, Tertullian and Origen, who lived shortly after Galen, rightly understood, in the light of the theories and practice of the medical science of the time, the importance of health care for elderly people.

For that matter, the approach offered by Galen to geriatrics and the therapies suggested by it remained uncontested, and to such an extent that we find them expressed again during the fourth century in Oribasius, in the sixth century in Aezius, in the seventh century in Paul of Egina,[68] and during the medieval period they constituted the uncontested basis for the treatment of elderly people.[69] In this way there became established the need for special therapies that had been promoted by Galen's work, therapies that were substantially distinct, because of their specific character and their long period of application, from those that were held to be necessary for people who were sick in the strict

sense. Thus it is that one can understand, in my view, the need for the creation of special places of care for elderly people which were separate in terms of terminology from other centres providing care.[70] Indeed, the homes for the poor and for foreigners had in essential terms to offer accommodation to those who had no places to stay; orphanages and places for women about to give birth had a well defined function in chronological terms as well; and the hospitals themselves took in and treated patients whose period of stay was limited to the effects of the treatment they received; and, lastly, the lepers' hospitals took in sick people who were seen with special horror by most of the public.[71] The people who stayed in old people's homes needed accommodation, suitable food and heat, as well as special forms of treatment and also human and psychological care given their conditions of health. They thus required a personnel that was available and able to attend to their need, whereas the length of their stay was not predictable because it would continue until the arrival of death. Lastly, although we have no evidence available to us about the forms of care and treatment provided in the homes for elderly people, a source of great importance informs us about the treatment that was in use in the monasteries. The Rules of St. Benedict, in fact, grant to sick people both baths and exemption from the prohibition on the eating of meat, laying down an obligation on the *cellarii* and servants to attend to all their needs.[72] Immediately afterwards the same provisions are applied to the alimentation of the old.[73] It seems to me here evident that there is a reference to the forms of treatment prescribed by Galen which therefore must have been well known about, and applied, in the monasteries of the sixth century.

Although these factors explain the creation of homes for old people, very different reasons, in my view, of a social and economic kind, explain their widespread presence and the interest in them. Studies on ancient demography have demonstrated through analysis of the evidence, and in particular of tomb inscriptions, a clear increase during the imperial age in the number of people who reached an advanced age, even above a hundred, albeit with notable geographical differences, as a result of which, for example, Africa seems to have been a privileged paradise for elderly people. At the same time, however, infant mortality remained at a rather high level.[74] We should also take into account the effects of epidemics. For example, the ecclesiastical historian Evagrius of Epiphany, writing in 594 at the age of fifty-eight, stated that the plague had struck Antioch four times before over a period of fifty-two years and had carried off many of his sons, his wife, various members of his family, a large number of servants and peasants, and two years previously his daughter and her son.[75] If one takes into account the gravity first of the 'Antonine' plague which took place between the second and the third centuries, and secondly the Justinian plague, which for a long time remained endemic and gave rise to a very large number of deaths,[76] one can understand how the conditions in which Evagrius had to face up to old age were not exceptional. In addition, the exposure of babies was a rather widespread phenomenon and concerned above all else less well-of families that were not able to provide for them[77] and had no scruples in selling children they could not maintain into slavery. Thus in the year 315 Constantine issued an edict which established urgent help for parents who were prevented by poverty from bringing up their children so as to stop these children being killed, and in the year 322 he issued similar rules to help those people in grave economic difficulties who were induced to pawn their own children.[78] In 329 a further decree of Constantine regulated the ransoming of young men sold as slaves, which was evidently tolerated given the more serious threat that they would be killed,[79] and in 331 another decree established that whoever rescued a baby that had been exposed and had brought it up was able to keep it as a free person or a slave, with the rejection of any claim of the person who had exposed the baby to have property rights over it.[80] It is evident that the intention was to encourage the adoption of children who had been subjected to the practice of exposure.

The policy of Constantine in this field had, however, very little effect when we take into account the sharp criticisms levelled at him by Zosimus as regards the creation of the *crisargirum*, a rather heavy tax, which forced many parents to sell their children,[81] and the evidence which demonstrates that the sale and exposure of babies remained common practices during the whole period of the Low Empire.[82] It is evident that all of these phenomena could not but increase to a very great extent, above all amongst the poorer strata of society, the number of elderly people who did not have children or grandchildren and were able to maintain them, thereby making the need for institutions that provided for their welfare impelling.

The most important confirmation of this and at the same time the most vivid illustration of what has been argued so far in this paper is, however, offered by a passage, which has generally been ignored, from John Chrysostome. This evidence is fundamental, not least because it comes from one of the Fathers of the Church who was most sensitive to the social aspects of the mission of the Church[83] and was involved in the first person in works of care and marked himself out by creating a large number of hospitals in Antioch and Constantinople.[84] In his work *Suspicious Cohabitations*, which was written at the beginning of his patriarchate at Constantinople,[85] John Chrysostome wrote as follows; 'Women, it is said, require greater protection, whereas men find in their nature a thousand resources. However, there are many men who are weaker than women because of their advanced age, because of illness, because of the loss of a limb, because of grave illnesses and because of similar things'. However, because public opinion was more sensitive to women, he pointed out how they could be helped: 'Indeed, there are women exhausted by old age, some with withered hands, others with various illnesses, aggravated by poverty and lack of resources. They are not difficult to take in: if you have money, spend it on them, if you are strong, place the strength of your body at their service. There are many needs which require physical help and money. It is necessary to obtain housing for them, prepare medicines, buy them a bed and clothes, provide them with the necessary food and everything else, even though ten in number, but the city is full of them. In looking after

the weak and the old rather than the strong and the young one can obtain salvation'.[86]

Chrysostome, as one can see, attests to a clear preference that was still granted to elderly women at the level of care being provided by the faithful, but he reacts to it by emphasising how the essential discriminating element is not gender but age and illnesses, which make all old people in need of care. He also bears witness to the gravity of the social problem which was caused by the high number of elderly people who were poor and without family relatives who were able to help them.[87] Lastly, he confirmed the special character of help that was required in these cases, which was not confined to medical care and treatment but also involved housing, food, clothes and beds, all of which were elements that were needed to avoid that the condition of elderly people degenerated into ruinous illness. As was very common amongst the Founders of the Church, he also emphasised that the faithful were not only required to provide help in the form of money – they were also required to provide personal involvement.[88] But in this case the involvement required was of a special character and this was to such an extent that Chrysostome emphasised the factor of physical strength which was necessary to help people who were often unable to move autonomously.

In the Byzantine East care for the elderly remained very alive and promoted and we have evidence on a large number of institutions.[89] The existence of homes for the elderly is attested to in particular in Egypt by papyruses[90] but the literary sources also demonstrate that they were widespread and that the Church, private benefactors and the authorities took part in this field. For example, Maximus the Confessor, when listing the merits of Georgius, who was the Prefect of Africa,[91] refers among other things to his work in creating and supporting homes for elderly people.[92] In September 600 Pope Gregory the Great sent beds and blankets to the abbot of the monastery of Sinai to equip a home for old people that was to be built by a certain Isaurus.[93] John the Almsgiver, who was patriarch of Alexandria from 611 to 619,[94] was praised by his hagiographer for having established homes for the elderly.[95] Activity in this area appears to have been widespread amongst those missionaries who worked outside the empire. Thus in the *Laws of the Homerites*, which is attributed to Gregenzius, the Bishop Tafar in the Yemen, who lived during the first decades of the sixth century and was famous for his missionary work amongst the Homerities,[96] the King of the Ethiopians, who at that time also governed the Homerites and had converted to Christianity, was said to have created homes for the poor and for the elderly.[97]

Activity in this field in the West seems to have been on a much more modest scale, in line, for that matter, with the much lower diffusion of centres that provided care and their low level of specialisation,[98] but also, in my view, with the very different political and economic situation that prevailed. Towards the end of the sixth century Pope Pelagius II[99] had a home for poor elderly people built in his own home[100] but this evidence is in a category of its own. In my view the information provided by the *Regula monachorum communis,* a text attributed to Fructus, the Bishop of Braga during the middle of the seventh century,[101] is much more interesting. This text, even though the attribution of its authorship is contested is nonetheless in large measure based upon his thought.[102] These Rules lay down that sick people must be treated with special care and the administrator of a dispensary should not deny them anything[103] and should pay special attention to them. They also provide wide ranging regulations on the problems of elderly people. Indeed, the author of these Rules states that many old people come to the monastery as novices and he well knows that they are led to do this not out of a vocation but because they are in a state of need.[104] When these people are discovered they must be severely punished, in particular they should be condemned to silence except when they are asked questions. They speak without purpose and if they are rebuked for this by the monks they get angry and are struck by the malady of sadness, only to fall once again into the vice of empty chattering. They must be thus brought into the monastery in a way that they do not pass their days and nights speaking uselessly and they should be induced, instead, to engage in exercises of penance and lamentation which must be the more heavy and felt because they relate to grave sins which have been committed for seventy years and even more.[105] If after all of this they do not change their ways they much be excommunicated and after being warned fourteen times they must be judged by an assembly of the elders which can expel them from the monastery if they do not reform themselves. On the other hand those old people who behave well and demonstrate their devotion must be treated as children with heartfelt compassion. They are to be exempted from heavy work and in addition they are to be granted tender foods, meat and wine which are suited to their special diet, as well as clothes and shoes that defend them against the cold without them needing a fire.[106]

These last prescriptions confirm the continuing existence, in that epoch as well, of an awareness of special dietary conditions and warmth that were needed by the elderly. But what us most important, in my view, is the social situation to which these Rules bear witness and the response of the Church. The very fact that the Rules see the taking of refuge of elderly people on monasteries in order to escape need as a rather frequent phenomenon demonstrates to what point poverty and insecurity were widespread and also bears witness to the powerlessness of the state and private individuals in providing help to elderly people who were without it. The Church was thus the only refuge and its involvement was such that these Rules even derogated the fundamental principle of a novice having a vocation and real faith as yardsticks to decide on his entrance to a monastery. The commitment towards, and pity for, elderly people forced to do what they did because of their state of need was of such a character and so great that they laid down a rather long procedure for their possible expulsion which, indeed, could only take place after numerous rebukes, when it had been established that it was impossible to reform them and to convince them to follow at the least the rules of the community, thereby not creating scandal amongst the brothers. Faced with the very large number of elder-

ly people who were poor and who without family relatives who were able to help them, the monastery opened its doors on the sole condition that they did not disturb the order of the monastic community and did not hinder its spiritual life, thereby transforming itself in substance into an equivalent of those homes for elderly people which in the East continued to perform their functions in an effective way.

Prof. GABRIELE MARASCO
Lecturer in Roman History,
the Faculty of Humanities and Foreign Languages,
La Tuscia University,
Viterbo, Italy.

Note

[1] G. MINOIS, *Histoire de la vieillesse en Occident de l'Antiquité à la Renaissance* (Paris, 1987) (Italian edition: *Storia della vecchiaia dall'Antichità al Rinascimento* (Roma/Bari 1988), pp. 129-174.

[2] Cf. V. CITTI, *Lexis*, 4, 1989, pp. 107-111; A. Casanova, *Prometheus*, 16, 1990, pp. 190-192.

[3] Cf. U. MATTIOLI, 'Per la storia della vecchiaia (Note ad un libro recente)', *Paideia*, 44, 1989, pp. 39-56.

[4] Cf. in particular C. GNILKA, *Aetas spiritalis. Die Überwindung der natürlichen Altersstufen als Ideal früchristlichen Lebens* (Köln-Bonn, 1972); Id., *Neues Alter, neues Leben. Eine antike Weisheit und ihre christliche Nutzung, Jahrbuch für Antike und Christentum*, 20, 1977, pp. 5-38; Id., *Kalogeros. Die Idee des Guten Alters bei den Christen*, *ibid.*, 25, 1980, pp. 5-21; 'Greisenalter', in *Reallexikon für Antike und Christentum*, XII (Stuttgart, 1983), coll. 1052 ss.; U. MATTIOLI, 'Cura e promozione degli anziani nel cristianesimo primitivo', in E dal Covolo and U Giannetto (eds.), *Cultura e promozione umana. Fondamenti e itinerari. Convegno Internazionale di Studi (Oasi "Maria Santissima" di Troina, 29 ottobre – 1° novembre 1995)* (Troina, 1996), pp. 95-105; H. BRANDT, *Wird auch silbern mein Haar. Eine Geschichte des Alters in der Antike*,(Munich, 2002), pp. 221-242.

[5] On this subject albeit with all the limits of a heading in an encyclopaedia, GNILKA, 'Alterversorgung', in *Reallexikon…* cit., Supplementband I (Stuttgart, 2001), coll. 279-289 and D.J. CONSTANTELOS, *Byzantine Philanthropy and Social Welfare* (New Rochelle, New York 1991[2]), pp. 163-175, which goes very much beyond the period of interest to us here; both, however, offer a partial documentation.

[6] Cf. e.g.. W. K. LACEY, *The Family in Classical Greece* (London, 1968), pp. 116 ss.; Gnilka, 'Alterversorgung', col. 267-273.

[7] Cf. e.g. H.H. BEN SASSON, 'Age and the Aged (Care of the Aged)', in: *Encyclopaedia Judaica,* 2, Jerusalem 1971, col. 346; GNILKA, 'Alterversorgung', col. 279.

[8] GNILKA, 'Alterversorgung', coll. 271-78; cf. W. Suder, *A Study of the Age and Sex Structure of Population in the Western Provinces of the Roman Empire* (Wroclaw 1990), p. 60. Measures for elderly military and civil functionaries near to the end of their careers are attested to as existing at the beginning of the Byzantine empire and were reduced by Justinian (Procop. *Hist. Arcan.* 24, 30-31; cf. *Cod. Iust.* 3, 2, 2; 3, 2, 5).

[9] In all probabilità Jews who spoke Greek: cf. in particular M. HENGEL, 'Zwischen Jesus und Paulus. Die "Hellenisten", die "Seben" und Stephanus (Apg 6,1-15; 7,54,-8,3)', *Zeitschrift für Theologie und Kirche*, 72, 1975, pp. 151-206; *Commentario teologico al Nuovo testamento. Gli Atti degli Apostoli,* I, Testo greco e traduzione, Commento di G. Schneider, (Italian translation), (Brescia, 1985), pp. 565-579 with bibliography.

[10] *Acts* 6: 1-7; cf. in particular SCHNEIDER, *op. cit.*, I, pp. 579 ss., with an estensive bibliography.

[11] Cf. in particular SCHNEIDER, *op. cit.*, I, p. 589 and n. 26.

[12] *I Tim.* 5:3-16; cf. C. SPICQ, *Saint Paul. Les épîtres pastorales* (Paris, 1947), pp. 165 ss.; *Commentario Teologico del Nuovo Testamento. Le lettere pastorali,* I, *La prima lettera a Timoteo,* Testo greco e traduzione, Commento di L. Oberlinner, (Italian translation) (Brescia, 1999), pp. 354-394, con bibliography; R. GRYSON, *Il ministero della donna nella Chiesa antica* (Rome, 1974), pp. 34-35.

[13] Cf. in particular J. REVILLE, *Le rôle des veuves dans les communeautés chrétiennes primitives: Études de critique et d'histoire* (Paris, 1889); J. GAUDEMET, *L'Église dans l'Empire romain (IV[e]-V[e] siècles)* (Paris, 1958), pp. 186-188; Gryson, *op. cit*., pp. 37-42; E. DAL COVOLO, *Chiesa Società Politica. Aree di "laicità" nel cristianesimo delle origini* (Rome, 1994), pp. 138-140; J.-U. KRAUSE, 'La prise en charge des veuves par l'Église dans l'Antiquité Tardive', in C. Lepelley (ét. réun. par), *La fin de la cité antique et le début de la cité médievale. De la fin du III[e] siècle à l'avènement de Charlemagne. Actes du Colloque tenu à l'Université de Paris X-Nanterre les 1, 2 et 3 avril 1993)* (Bari, 1996), pp. 115-126. On the rules relating to widows in the *Didascalia degli Apostoli* and the *Costituzioni Apostoliche* cf. also MATTIOLI, *Cura e promozion*, pp. 98-99.

[14] Cf. Mt. 6:25-34; Lk. 12, 22-31. On echoes of these precepts in the thought of the Fathers cf. e.g. MATTIOLI, *Cura e promozione*, p. 95.

[15] Evagr. Pont. *Cap. prat.* 9, 'Souces chrét.', N°. 171 (Paris,1971), p. 512.

[16] Cf. e.g. J. QUASTEN, *Patrology,* III (Utrecht/Antwerp, 1960), pp. 169-176; J. GRIBOMONT AND D. HOMBERGER, 'Evagrio Pontico', in A. Di Berardino (ed.), *Nuovo Dizionario Patristico e di Antichità Cristiane,* I (Genoa-Milan, 1983, col. 1879).

[17] Hieron. *Epist.* 22, 31-32.

[18] Hieron. *in Es.* 2, 3, 4, CCL 73, 48: *Nec ecclesiasticis vidua sustentatur alimentis, nisi quae sexaginta annorum est et maturitatem habet morum pariter et aetatis.* Cf. also *epist.* 79, 7.

[19] Euseb. *Hist. Eccl.* 6, 43, 11. On the gravity of the problem above as a result of the large numbers of widows in antiquity cf. above all J.-U. KRAUSE, *Witwen und Waisen im römischen Reich,* I-II (Stuttgart, 1994).

[20] Hieron. *Epist.* 52, 5:… *multas anus nutrit ecclesia quae et officium praebeant et beneficium acccipiant ministrando, ut infirmitas quoque tua fructum habeat elemosynae*. Jerome narates elsewhere (*epist.* 1, 13) of an event connected with the death of elderly widower maintained by the Church.

[21] Hieron. *in. Luc.* 8, 75-76, CCL, 14, 326-327: *O fili, quantum tibi sumis iudicium, si non pascas parentem!... Quantum iudicium, si pascat ecclesia quos tu nolis pascere… Ne commiseris, fili, ut parentes tuos aliorum fames pascat, ne commiseris, fili, ut ieunia pauperum parentibus tuis cibum quaerant?* Elsewhere the same Jerome (*epist.* 123, 5) stresses the fact that widows who were young and good health had to work so as not to be a burden for the Church.

[22] Ambrosiast. *in I Tim.* 5, 16, 1, CSEL, 81, 3, p. 283-84: *Quid mirum, si apostolica potestas futura potuit praevidere? Nam apparet quod dixit, quia fidelium viduae nunc multum gravant ecclesiam, et eorum qui locupletes videntur mundi et per senectutis causam desistentes eas ab opere lanificio, retrahunt eis et vestitum et victum, si non totum, tamen ex parte, ut illae ipsa inopia ad piam ecclesiam covertantur, ut vivant.*

[23] Ambrosiast., *loc. cit.*: *Nam cum praecipiat unius viri uxorem eligi viduam, nunc inveniuntur inter eas non tantum duum aut trium maritorum uxores, sed et quae turpius vixerint, quod aliquando per neglegentiam fit, aliquando potentatu insinuantis.*

[24] *Epist. Barnab.* 20, 2d, *Sources Chrét*., N.° 172 (Paris, 1971), p. 212. On this work and its dating see in particular L. W. BARNARD, 'The 'Epistle of Barnabas' and its Contemporary Setting', in *Aufstieg und Niedergang der römischen Welt,* II, 27, 1 (1993), pp. 159-207 with bibliography.

[25] *Epist. ad Smyrn.* 6, 2, *Sources Chrét.*, N°. 10 (Paris, 1958), p. 160.

[26] Polycarp. Smyrn. *Epist. Ad Philipp.* 6, 1, *PG* V 1009. Cf. also on the catechumens Hippol. *Trad. Apost.* 20, *Sources Chrét*., N° 11bis (Paris, 1968), p. 78.

[27] Clem. Alex. *Quis div. salv.* 34, 2.

[28] Clem. Alex. *Paed.* 3, 40, 3, 2-3.

[29] Tert. *Apol.* 39, 6: … *egenis alendis humandisque et pueris ac puellis re ac parentibus destitutis, iamque domesticis senibus, item naufragis…*

[30] Origen. *in Matth. Comm. Ser.* 61 (CGS, *Origenes Werke*, XI, Berlin, 1976, p. 142).

[31] Ambros. *De off. min.* 1, 31, 160: *Consideranda etiam in largendo aetas atque debilitas, nonnumquam etiam verecundia, quae ingenuos prodit natales; ut senibus plus largiaris, qui sibi labore iam non queunt victum quaerere. Similiter et debilitas corporis, et haec iuvanda promptius.*

[32] On Pacomius and his *Regola* cf. in particular A. SCHMIDT, 'Pachomius der Ältere', in *Biographisch-Bibliographische Kirchenlexikon*, VI, 1993, coll. 1413-1419; J. QUASTEN, *Patrology,* III (Utrecht/Antwerp, 1960), pp. 154-159*,* with bibliography.

[33] Hieron. *Reg. Pachom., praef.* 5 (in *Pachomiana Latina. Règle et Épitres de S. Pachome, Épitre de S. Théodore et "Liber" de S. Orsesius*, *Texte latin de S. Jérôme*, éd. par A. Boon, Louvain 1932, p. 7). Cf. also Benedict. *Reg.* 36-37: *…Licet ipsa natura humana trahatur ad misericordiam in his ætatibus, senum videlicet et infantum, tamen et regulæ auctoritas eis prospiciat. Consideretur semper in eis inbecillitas et ullatenus eis districtio regulæ teneatur in alimentis; sed sit in eis pia consideratio et præveniant horas canonicas*; Benedict. Anian,. *Concord reg.* 46. See MATTIOLI, *Cura e promozion,*, p. 99.

[34] On this see in particular O. HILTBRUNNER, 'Xenodocheíon'*, R.E.* IX A 2 (1967), coll. 1490-1503; U. LINDGREN, 'Frühformen abendländischer Hospitäler im Lichte einiger Bedingungen ihrer Entstehung'*, Historia Hospitalium*, 12, 1977-78, pp. 32-51; D.W. AMUNDSEN, 'Philanthropy in Medicine: Some Historical Perspectives'*,* in E.E. Shelp (ed.), *Beneficence and Health Care* (Dordrecht, 1982), pp. 15 ss.; U.B. BIRKLER-ARGYROS, 'Byzantinische Spitalgeschichte – Ein Überblick'*, Historia Hospitalium*, 15, 1983-1984, pp. 51-80; T.S. MILLER*, The Birth of the Hospital in the Byzantine Empire* (Baltimore, 1985); E. KISLINGER, 'Xenon und Nosokomeion – Hospitäler in Byzanz'*, Historia Hospitalium*, 17, 1986-1988, pp. 7-16; G.B. FERNGREN, 'The Organisation of the Care of the Sick in Early Christianity'*,* in H. Schadewaldt-K.H. Leven (eds.), *Acts/Proceedings of the XXX International Congress of the History of Medicine* (Düsseldorf, 1988), pp. 192-198; O. Hiltbrunner, *Herberge,* in: *Reallexikon für Antike und Christentum,* XIV (Stuttgart, 1988), coll. 602-626; Constantelos, *Byzantine Philanthropy,* pp. 113 ss; P. van Minnen, 'Medical Care in late Antiquity*,* in Ph. J. van der Eijk, H.F.J. Horstmanshoff, and P.H. Schrijvers (eds.), 'Ancient Medicine in its Socio-Cultural Context. Papers Read at the Congress Held at Leiden University (13-15 April 1992)'*,* I, *Clio Medica*, 27, Amsterdam- Atlanta, 1995, pp. 153-69; U. MATTIOLI, 'Assistenza e cura dei malati nell'antichità cristiana'*,* in E. Dal Covolo and I. Giannetto (eds.), *Cultura e promozione umana. La cura del corpo e dello spirito nell'antichità classica e nei primi secoli cristiani. Un magistero ancora attuale? Convegno Internazionale di Studi (Oasi "Maria Santissima" di Troina, 29 ottobre – 1° novembre 1997)* (Troina, 1998), pp. 257 ss. On the health care provided by monasteries see in addition the recent A.T. CRISLIP, *From Monastery to Hospital. Christian Monasticism and the Transformation of Health Care in Late Antiquity* (Ann Arbor, 2005), which, however, pays very little attention (cf. p. 136) to care for the elderly.

[35] Epiphan. *Panarion haer.* 75, 1, 7, ed. K. Hohl, III, p. 333; cf. J. GRIBOMONT, 'Saint Basile et le monachisme enthousiaste'*, Irénikon,* 53, 1980, pp. 123-44.

[36] *Patria* 3, 5 (in *Scriptores originum Constantinopolitanarum,* rec. Th. Preger, II, Lipsiae 1907, p. 216). Cf. J.P. RICHTER, *Quellen der byzantinischen Kunstgeschichte* (Vienna, 1897), p. 134; CONSTANTELOS, *op. cit.*, p. 163.

[37] Cf. T. K. KEMPF, 'Das Haus der heiligen Helena'*, Neues Trierer Jahrbuch*,, (Beiheft, 1978), p. 9.

[38] Euseb. *Vita Const.* 3, 41-45; Socrat. *Hist. Eccl.* 1, 17, 13, p. 57 Hansen. On Helena's pilgrimage and its dating see above all B.Kötting, *Peregrinatio religiosa: Wallfahrten in der Antike und das Pilgerwesen in der alten Kirche* (Münster, 1950), pp. 20 ss.; L. VOELKL, *Der Kaiser Konstantin* (Munich, 1957), p. 158-159; KEMPF, *art. cit.*, p. 10; J.W. DRIJVERS, *Helena Augusta. The Mother of Constantine the Great and the Legend of Her Finding of the True Cross,* (Leiden, 1992), pp. 55-76.

[39] Euseb. *Vita Const.* 3, 46; cfr. VOELKL, *op. cit.*, p. 177; J. VOGT, *Constantin der Grosse und sein Jahrundert* (Munich, 1960[2]*,* p. 249; KEMPF, *art. cit.*, p. 10; DRIJVERS, *op. cit.*, pp. 13 and 15.

[40] The foundation of the old people's home called Eufrata after the name of its founder, a patrician who had moved from Rome to Constantinople during the reign of Constantine seems to go back to the fourth century; it was still functioning and was known by the same name during the thirteenth century, an epoch when we have information from it from the chronicler Theodore Scutariotes (ed. Sathas, *Mesaion. Bibl.*, 7, 1894, p. 53); cf. CONSTANTELOS, *op. cit.*, p. 165-166.

[41] *Patria* 3, 105 , (Preger, II, p. 251); cf. R. JANIN, *La géographie ecclésiastique de l'Empire byzantin. Première partie, Le siège de Constantinople et le patriarcat oecuménique*, Tome III, *Les églises et les monastères* (Paris, 1953), p. 569, n. 24.

[42] *Patria* 3, 72 (Preger, II, p. 241); cf. JANIN, *op. cit.*, III, p. 566, n. 4.

[43] *Patria* 3, 106 (Preger, II, p. 251); cf. JANIN, *op. cit.*, III, p. 565, n. 1; Constantelos, *op. cit.*, p. 166.

[44] *Patria* 3, 120-121 (Preger, II, p. 254-255); cf. JANIN, *op. cit.*, III, p. 567, n. 9; p. 571, n. 5.

[45] Cyrill. Scythop. *Vita Euthim.* 35 (ed. Schwartz, 'Kyrillos von Skythopolis'*, Texte und Untersuchungen*, 49, 2, Leipzig 1939, p. 53).

[46] Cyrill. Scythop. *Vita Johan. Esych.* 4 (Schwartz, *op. cit.*, p. 204); Niceph. Call. *Hist. eccl.* 14, 50, *PG* CXLVI 1240.

[47] *Patria,* 3, 63 (Preger, *op. cit.*, II, p. 239); cf. W. ENSSLIN, 'Pulcheria'*, R.E.* XXIII 2 (1959), col. 1961-62; CONSTANTELOS, *op. cit.*, p. 166.

[48] Cf. in particular S. HOLMAN, The Hungry Body: Famine, Poverty and Basil's Hom. 8'*, Journ. of Early Christ. Stud.* 7, 1999, pp. 337 ss.

[49] Greg. Naz. *Or.* 43, 35, *Sources Chrét.*, N° 384, Paris 1992, p. 204.

[50] On the patriarchate of Nazianzus, on its end and on its writings, and in particular the poetic ones which Gregory dedicated to it cf. the recent work N. Gómez Villegas, 'Gregorio de Nazianzo en Constantinopla. Ortodoxia, heterodoxia y régimen teodosiano en una capital cristiana'*,Nueva Roma*, 11, Madrid, 2000.

[51] Greg. Naz. *Carm.* 2, 1, 16, 87, *PG* XXXVII 1216.

[52] For his part Gregory of Nyssa, bearing witness to a sensitivity that was shared by the Cappadocian Fathers, exalted charity that 'helped the old': *De benefic.* (*De paup. am.* I), ed. A. VAN HECK, in: *Gregorii Nysseni Opera,* IX (Leiden, 1967), p. 100, l. 10.

[53] The evidence that I have examined lead me in this case to reject the thesis (A. Philipsborn, 'Der Fortschritt in der Entwicklung des byzantinischen Krankenhauswesens'*, "Byzant. Zeitschr.*, 54, 1961, p. 348) according to which specialisation became established only beginning with the fifth century.

[54] Cf. in particular H. ORTH, '*Diaita Geronton. Die Geriatrie der griechischen Antike, Centaurus*, 8, 1963, pp. 19-47; S. BYL, 'La vieillesse dans le Corpus Hippocratique', in F. Lesserre and P. Mudry (eds.), *Formes de pensée dans la Collection Hippocratique. Actes du IV[e] Colloque International Hippocratique (Lausanne, 21-26 septembre 1981)* (Geneva, 1983), pp. 85-95*;* GNILKA, 'Greisenalter'*,* coll. 1030 ss.; G. PISI, 'La medicina greca antica'*,* in Senectus. *La vecchiaia nel mondo classico,* ed.by U. MATTIOLI, I, *Grecia* (Bologna, 1995), pp. 447-487; H. HORSTMANSHOFF, 'Alter'*,* in K.-H. Leven (ed.), *Antike Medizin. Ein Lexikon* (Munich, 2005), col. 31-32.

[55] Hippocrat. *Aphor.* 3, 31, Littré IV, pp. 500-502. For the recurrence of these statements in other tracts of the *Corpus Hippocraticum,* cf. Pisi, *art. cit.*, p. 465-66.

[56] Cels. *De med.* 2, 1, 22-23: *In senectute spiritus et urinae difficultas, gravedo, articulorum et renum dolores, nervorum resolutiones, malus corporis habitus (καχεξίαν Graeci appellant), nocturnae vigiliae, vitia longiora aurium, oculorum, etiam narium, praecipueque soluta alvus, et quae secuntur hanc, tormina vel levitas intestinorum ceteraque ventris fusi mala. Praeter haec graciles tabes, deiectiones, destillationes, item viscerum et laterum dolores fatigant. Obesi plerumque acutis morbis et difficultate spirandi strangulantur, subitoque saepe moriuntur; quod in corpore tenuiore vix evenit*. Cf. in general H.T. HOWELL, 'Celsus on Geriatrics'*, Journ. Amer. Geriatr. Soc.*, 18, 1970, 9, pp. 687-691.

[57] In particular M. Artorius Asclepiades who was Augustus's physician, and wrote *Perí makrobiotías* (Clem. Alex. *Paed.* 2, 23, 1); cf. GNILKA, *Greisenalter,* col. 1030-1031. The subject was even addressed by Rufus of Ephedeus (cf. I. Ilberg, 'Rufus von Ephesos. Ein griechischer Arzt in trajanischer Zeit'*, Abhandl. d. Sächsl. Akad. d. Wissensch*, Phil.-hist. Kl. 41, 1930, p. 48), by Aretaeus of Cappadocia (cf. H.T. HOWELL ('Aretaeus on Disease in Old Age'*, Journ. Amer. Geriatr. Soc*., 19, 1971, pp. 902-912) and by an anonymous writer whom Galen ironically called 'philosopher' who has been identified by some authorities as his contemporary Philipp of Cesarea (cf. C. THEOHARIDES, 'Galen on Marasmus'*, Journ Hist. Med.*, 26, 1971, pp. 369-90).

[58] On this point see above all THEOHARIDES, *art. cit.*, pp. 369-90; S. BYL, 'La gérontologie de Galien'*, Hist. Phil. Life Sci.*, 10, 1988, pp. 73-92; G. WÖHRLE, *Studien zur Theorie der antiken Gesundheitslehre* (Stuttgart, 1990), pp. 235-38; I. MAZZINI, 'La geriatria di epoca ro-

mana', in *Senectus*, ed. by U. Mattioli, II, *Roma* (Bologna, 1995), pp. 346 ss.

[59] Cf. ORTH, *Diaita Geronton,* pp. 30-33; Gnilka, 'Greisenalter', col. 2031.

[60] Cf. MAZZINI, *art. cit.,* p. 348.

[61] Galen. s*an. tu.* 1, 5 (Kühn VI, p. 20); 6, 2 (Kühn VI, p. 387-388).

[62] Galen. *san. tu.* 5, 4, 2 (Kühn VI, p. 330).

[63] Galen. *mar.* 5 (Kühn VII, p. 681); cfr. *san. tu.* 5, 9 (Kühn VI, p. 357); 6, 2 (Kühn VI, p. 389).

[64] Galen. *san. tu.* 5, 10 (Kühn VI, p. 358).

[65] Cf. above all ORTH, *Diaita Geronton,* pp. 26-30; GNILKA, 'Greisenalter', col. 1031-1032; Mazzini, *art. cit.*, pp. 356-360; M.-L. DEISSMANN, 'Altersversorgung', in Leven (ed.), *Antike Medizin*, col. 34.

[66] Cf. MAZZINI, *art. cit.*, pp. 352-353.

[67] Euseb. *Hist. Eccl.* 5, 28, 14.

[68] Oribas. *Synops. ad Eustath.* 5, 18 (*CMG* VI 3, p. 161); Id., *ad Eunap.* 1, 11 (*ibid.*, pp. 327-328); Aët. 4, 30 (*CMG* VIII 1, pp. 372-375); Paul. Aeg. 1, 23 (*CMG* IX 1, pp. 19-20).

[69] Cf. in particular M. T. LORCIN, 'Vieillesse et vieillissement vus par les médecins du Moyen Age', *'Bulletin du Centre Pierre Leon*, 1984, n. 4; Ead., 'Gérontologie et gériatrie au Moyen Age', in *Vieillesse et vieillissement au Moyen Age* (Aix-en-Provence, 1987), pp. 201-213.

[70] For the terminology involved cf. above all HILTBRUNNER, *art. cit.*, col. 1491; MATTIOLI, *Assistenza e cura,* p. 259 with bibliography; A. MARCONE AND I. ANDORLINI, 'Salute, malattia e 'prassi ospedaliera' nell'Egitto tardoantico', in R. Marino, C. Molé and A. Pinzone (eds.), *Poveri ammalati e ammalati poveri. Atti del Convegno di Studi (Palermo, 13-15 ottobre 2005)* (Catania, 2006), pp. 21 ss. and 32. On the various typologies of these care institutions see above all CONSTANTELOS, *op. cit.*, pp. 113 ss.

[71] Cf. MARASCO, 'Le malattie infettive e i Padri della Chiesa', *Dolentium hominum*, n°. 64, 22, 2007, n. 1, pp. 56-57 and 60-63.

[72] *Reg. Bened.* 36: *Balnearum usus infirmis quotiens expedit offeratur, sanis autem et maxime iuvenibus tardius concedatur. Sed et carnium esus infirmis omnimo debilibus pro reparatione concedatur; at ubi meliorati fuerint, a carnibus more solito omnes abstineant. Curam autem maximam habeat abbas ne a cellarariis aut a servitoribus neglegantur infirmi…*

[73] Cf. *supra,* note 33.

[74] On this point cf. e.g. M. CLAUSS, 'Probleme der Lebensalterstatistiken auf Grund römischer Grabinschriften', *Chiron*, 3, 1973, pp. 395-417; P. SALMON, *Population et dépopulation dans l'Empire romain (*Brussels,1974); SUDER, *A Study of the Age, cit.*, *passim*; R.S.L. BAGNALL AND B.W. FRIER, *The Demography of Roman Egypt* (Cambridge, 1994); W. SCHEIDEL, 'Measuring Sex, Age and Death in the Roman Empire. Explorations in Ancient Demography', (*Journ. Rom. Arch.*, Supplement 21) (Ann Arbor, 1996); J.-N. CORVISIER AND W. SUDER, *La population de l'Antiquité classique* (Paris, 2000), pp. 100-110; BRANDT, *Wird auch silbern,* pp. 158 ss.

[75] Evagr. *Hist. eccl.* 4, 29.

[76] Cf. e.g. R. BREITWIESER, 'Pest, (Antoninische)', in Leven (ed..), *Antike Medizin.,* col. 686-687; LEVEN, 'Pest, (Justinianische)', *ibid.*, coll. 689-691 with bibliography.

[77] On this point see the recent work W.V. HARRIS, 'Child-Exposure in the Roman Empire', *Journ. Rom. Stud.*, 84, 1994, pp. 1-22; P. SALMON, 'La limitation des naissances dans la société romaine', *Collection Latomus*, 250 (Brussels, 1999), with bibliography.

[78] *Cod. Theod.* 11, 27, 1-2; cf. in particular M. BIANCHINI, 'Provvidenze costantiniane a favore dei genitori indigenti: per una lettura di CTh. 11.27.1-2', *Annali della Facoltà di Giurisprudenza di Genova*, 20, 1984-85, pp. 23 ss.; J.A. EVANS-GRUBBS, *Munita coniugia: The Emperor Constantine's Legislation on Marriage and Family* (Ann Arbor, 1990), pp. 179 ss.; F. ELIA, 'L'"alienatio liberorum" in età imperiale: problemi sociali e interventi normativi', *Quaderni Catanesi di cultura classica e medievale*, 4-5, 1992-1993, pp. 385 ss.; C. LORENZI, *Si quis a sanguine infantem… conparaverit. Sul commercio di figli nel tardo impero* (Perugina, 2003), pp. 33 ss.; R. MARTINI, 'Su alcuni provvedimenti costantiniani di carattere sociale', in F. Sini and P.P. Onida (eds.), *Poteri religiosi e istituzioni: il culto di san Costantino Imperatore tra Oriente e Occidente* (Turin, 2003), pp. 183 ss.; C. CORBO, *Paupertas. La legislazione tardoantica* (Naples, 2006), pp. 11 ss.

[79] *Cod. Theod.* 5, 10, 1; cf. LORENZI, *art. cit.*, pp. 27 ss.; CORBO, *op. cit.,* pp. 70 ss. with bibliography.

[80] *Cod. Theod.* 5, 9, 1,; cf. LORENZI, *art. cit.*, pp. 49 ss.; CORBO, *op. cit.*, pp. 73 ss. with bibliography.

[81] Zosim. 2, 38, 3.

[82] Cf. in particular M. BIANCHI FOSSATI VANZETTI, 'Vendita ed esposizione degli infanti da Costantino a Giustiniano', *Studia et Documenta Historiae et Iuris*, 49, 1983, pp. 190 ss.

[83] Cf. e.g. O. PLASSMAN, *Das Almosen bei Johannes Chrysostom*, diss. (Bonn, 1960); W. MEYER, 'Poverty and Society in the World of John Chrysostom', in W. Bowden, A. Gutteridge, and C. Machado (eds.), 'Social and Political Life in Late Antiquity', *Late Antique Archaeology*, 3.1, Leiden, 2006, pp. 465-486.

[84] For Antioch cf. Joh. Chrys. *ad Stagyr.* 3, 13, *PG* XLVII 490; *in Act. Apost. Hom.* 45, 4, *PG* LX 319; *in ep. I ad Corinth. Hom.* 21, *PG* LXI 180; *in Matth.* 66, 3; *PG* LVIII 630; for Constantinople Pallad. *Dial.* V 134-35, *Sources Chrét.*, N° 341 (Paris, 1988), p. 122; Sym. Metaphr. *Vita Chrys., PG* CXIV 1097. It is curious that Minois (*op. cit.*, pp. 141-142) saw Chrysostom as the least sensitive of the Fathers of the Church to the needs of the elderly; *contra,* without reference, however, to the problem of care, cf. rightly U. MATTIOLI, 'Vecchi e vecchiaia in Giovanni Crisostomo', in E. dal Covolo and I. Giannetto (eds.), *Cultura e promozione umana. La cura del corpo e dello spirito dai primi secoli cristiani al Medioevo: contributi e attualizzazioni ulteriori. Convegno internazionale di studi (Oasi «Maria Santissima» di Troina, 29 ottobre – 1° novembre 1999)* (Troina, 2000), pp. 299-314.

[85] Cf. e.g. QUASTEN, *op. cit.*, III, p. 464.

[86] Johann. Chrys. *Subintr.* 7 (J. Dumortier, *Saint Jean Chrysostome. Les cohabitations suspectes. Comment observer la virginité,* Paris 1955, pp. 68-69).

[87] For that matter elsewhere Chrysostom (*in Matth.* 66, 3, *PG*) testifies to the fact that in his time in Antioch the Church supported over 3,000 widows and vrigins in addition to prisoners, sick people, foreigners, the lame and poor people who crowded around churches in the hope of being given food and clothes. This figure, which was more than double for widows and virgins compared to that for the Rome of Pope Cornelius, attests to the changed social situation and the increased role of the Church. Chrysostom himself (*in Act. Apost.* 11, 3) also states that at Consantinople half of the population of a hundred thousand Christians were poor.

[88] The best illustration here seems to me to be provided by the account by Teodoretus (*Hist. Eccl.* 5, 19, 2-4, p. 314 Parmentier-Hansen) of Flacilla, the first wife of Theodosius, who personally took care of the sick and cooked and cleaned as thought she was a servant.

[89] Cf. in particular HILTBRUNNER, *art. cit.*, coll. 1495 ss.; GNILKA, *Alterversorgung,* col. 287; CONSTANTELOS, *op. cit.*, pp. 167 ss.

[90] Cf. R. TAUBENSCHLAG, 'La γηροκομία dans le droit des papyrus', *Revue Internationale des Droits de l'Antiquité*, 3e Série, 3, 1956, pp. 173-179.

[91] Cf. *PLRE*, III A, *Giorgius* 50.

[92] Maxim. Conf. *Epist.* 44, *PG.* XCI 648A; cf. 645D.

[93] Greg. Magn. *Epist.* 11, 2 (*Monumenta Germaniae Historica* 2, 261); cf. J.W. WILKINSON, *The Social Welfare Program of Pope Gregory the Great,* diss. (New York, 1973), pp. 49-86 (in particular p. 77).

[94] Cf. e.g. O. BARDENHEWER, *Geschichte der altkirchlichen Litteratur*, V (Darmstadt 1962^2), pp. 135-137; G. FEDALTO, *Hierarchia ecclesiastica orientalis: series episcoporum ecclesiarum Christianarum Orientalium* (Padua, 1988), II, p. 583; C.D.G. MÜLLER, 'Johannes V der Almosengeber', in *Biographisch-Bibliographische Kirchenlexikon,* III, 1992, coll. 251-53.

[95] Leont. Neap. *Vita Johan. Elemos.* 45 (*Leontios' von Neapolis. Leben des heiligen Johannes des Barmherzigen*, *Erzbischofs von Alexandrien*, ed. by H. Gelzer, Freiburg /Leipzig, 1893, p. 92).

[96] On him cf. A. BERGER, 'Gregentios', in *Biographisch-Bibliographisches Kirchenlexikon,* XXII, (2003), coll. 460-461 with bibliography; A. LABATE, 'Gregenzio', in A. Di Berardino (ed.), *Nuovo Dizionario patristico e di antichità cristiane,* I (Genoa/Milan, 2007), col. 2439.

[97] Gregent. *Hom. leg.* 45-46, *PG* LXXXVI 609-612.

[98] On this point cf. above all HILTBRUNNER, *art. cit.*, coll. 1491 and 1499-1500; MATTIOLI, *Cura e promozione*, p. 101; *Assistenza e cura,* pp. 257-258 and 263-265.

[99] He was Pope from 579 to 590: cf. L. KOLMER, 'Pelagius II', in *Biographisch-Bibliographischer Kirchenlexikon,* VII, 1994, coll. 167-168 with bibliography.

[100] *Liber Pontificalis* 65 (Duchesse, I, p. 309): *Hic domum suam fecit ptochium pauperum senum.* Cf. WILKINSON, *op. cit.*, p. 52, n. 10 on the proposed identification with the *venerabile ptochium Lateranense*, borne out in subsequent sources.

[101] Cf. F.W. BAUTZ, 'Fructuosus', in *biographisch-Bibliographisches Kirchenlexikon,* II, 1990, coll. 145-146 with bibliography.

[102] Cf. *Sanctos Padres Españoles*, II, *San Leandro, San Isidoro, San Fructuoso. Reglas monásticas de la España visigoda. Los tres libros de las "Sentencias"*, Introducciones, versión y notas de J. Campos Ruiz, I. Roca Melia, Madrid 1971, pp. 165 ss.; E. REICHERT, 'Fructuosus von Braga', in S. Döpp and W. Geerlings (eds.), *Lexikon der antiken christlichen Literatur* (Freiburg/Basel/Vienna, 1998), p. 240; M. DÍAZ Y DÍAZ, 'Fruttuoso di Braga', in A. Di Berardino (ed), *Nuovo Dizionario patristico e di antichità cristiane,* I (Genoa/Milan, 2007), col. 2011 with bibliography.

[103] *Reg. mon. comm.* 7, CAMPOS RUIZ, *op. cit.*, p. 184 (= *PL* LXXXVII 1116).

[104] *Reg. mon. comm.* 8, CAMPOS RUIZ, *op. cit.*, p. 184 (= *PL* LXXXVII 1116): *Solent plerique novicii senes venire ad monasterium, et multos ex his cognoscimus necessitatis imbecillitate polliceri pactum non ob religionis obtentum.*

[105] *Reg. mon. comm.* 8, p. 185:*... proinde cum tali cautione in cenobio introducantur, ut die noctuque non fabulis evagentur, sed in singultu et lacrimis cineree t cilicio versentur, et retroacta peccata cum gemitu cordis paeniteant, et paenitendo ulterius non committant; et quantum habuerunt in peccando pravae suae mentis intentionem duplam habeant in lamentando plenam devotionem. Quia per LXX et eo amplius annos abrupto peccaverunt; et ideo congruum est ut arta paenitentia coarceantur.*

[106] *Reg. mon. comm.* 8, p. 186:*… cibi tamen quibus reficiantur teneri et molles ex industria ab ebdomadariis coquantur, et care ne set vinum propter imbecillitatem moderate eis praebeantur… Vestimentum vero et calciamentum sic eis praebeantur ut absque foco frigoris ab eis asperitas arceatur.*

2. Reflection on Revelation

WOJCIECH GIERTYCH

2.1 Faith, Charity and Sick Elderly People

Introduction

In the few words of my reflection on the subject that was entrusted to me, I do not intend to look into the faith and charity of those who care for sick elderly people. I prefer to restrict my paper to the question of the growth in faith and charity of those who, due to old age and sickness, are approaching death. While death looms ahead of all of us, questions concerning its mystery, its theological significance and the immediate preparation for the final passage become more acute in the final stages of life, even when in these last moments intellectual proficiency and psychic awareness may be reduced or seriously impaired. What insights can theological reflection offer us to illuminate the spiritual experience of the final journey? How do changes caused by the development of medical techniques influence this spiritual experience? As always, theological questions have to look towards Christ in the search for an answer. Jesus Christ, the Son of the eternal Father passed through death and resurrection. The paschal mystery therefore, has to be penetrated in the search of meaning for the final passage of Christians.

The Death of Christ

In his meditation on the passion of Christ as it is presented in the Gospel of St. Matthew, the Belgian theologian Fr. Servais Pinckaers OP focused primarily on the gift of self of Jesus. In popular piety a painful focus on the various shades of suffering of Jesus sometimes predominated in such meditations. An attentive reading of the Gospel, however, shows that it is not suffering that is in the centre of the drama. The women who looked from afar at the cross were not just weeping in the face of the brutality. In their contemplative gaze they looked at Jesus giving himself totally to the Father and to humanity.[1]

Cardinal Albert Vanhoye insists that the sacrifice of Christ does not consist uniquely in his death but in the transformation of that death into a source of new life.[2] In the modern understanding of the words 'expiation' and 'sacrifice', we think of punishment and suffering. But just as 'to simplify' means 'to make something simple', and 'to sanctify' means 'to make something holy', so also 'to sacrifice' means 'to make something sacred'. The *sacrificium* of Jesus, his sacrifice, is the making of his human will supremely holy as that will is filled with the love that is the Holy Spirit. Giving himself totally, in utter openness to the Father, Jesus has shown us how the human will can be fully enriched and expanded beyond its natural limitations by the love that flows from the Trinity. The role of the Holy Spirit in the passion of Christ lay in the filling of Jesus' human heart with all the force of divine love, in such a way that in that death, suffered against all justice, an ultimate covenant between God and humanity was made. The fire of the Holy Spirit transformed that death into a sacrifice of union, a means of making the human heart of Jesus and our hearts as we unite with him, holy. Through his total gift of self, in his solidarity with sinners, Jesus gave us access to this divine love, which flows out to us from his open heart. We meditate in the paschal mystery on the change of the death of a man, treated as a criminal and punished with a cruel death, into a means of supreme communion with God and with humanity. This change is of greater import and the ultimate source of that further change that is then the transubstantiation of bread and wine into the body and blood of Christ.

John Paul II in his Apostolic Letter *Salvifici doloris* of 1984 reflected upon human suffering with similar attention to the paschal mystery understood as a mystery of divine love, redeeming human sin by the power of that love. In Jesus' suffering 'sins are cancelled out precisely because He alone as the only-begotten Son could take them upon Himself, accept them *with that love for the Father which overcomes* the evil of every sin; in a certain sense He annihilates this evil in the spiritual space of the relationship between God and humanity, and fills this space with good…The words of the prayer of Christ in Gethsemani prove *the truth of love through the truth of suffering*… Human suffering has reached its culmination in the Passion of Christ. And at the same time it has entered into a completely new dimension and a new order: *it has been linked to love*, to that love… which creates good, drawing it out by means of suffering, just as the supreme good of the Redemption of the world was drawn from the Cross of Christ, and from that Cross constantly takes its beginning'.[3]

Jesus could have saved us by adding supreme divine love to his smile in the crib in Bethlehem. Since every human act can be nour-

ished from within by the love of God, and in Jesus his divine love was supreme and infinite, although also subject to human growth, theoretically, he could have made manifest his supreme love in a simpler way than by dying on the cross, even though we would have had greater difficulty in recognising that love. By continuing to give himself in his death, in spite of his rejection and persecution, by being totally in control of himself, even though it seems that in the events of his passion and death Jesus was being led by others and constrained in his liberty, by saying during the entire passion only what he wanted to say and saying it when he wanted, by refusing to use his divine power to constrain his persecutors,[4] Jesus showed the fullness of divine love, which is more powerful than suffering and death. In the death of Jesus and in his resurrection, which express his prayer in Gethsemane, we see his gift, his total surrender to the Father and his total openness to the gift received, in which his obedience consists. The suffering of Jesus in his death made his transparency to the Father and to the power of the Spirit more visible.

We can try to bring home this mystery by a simple comparison. A doctor who goes to work in a distant country where he contracts a serious disease and dies from it, or a priest who goes as a missionary to a foreign country and is killed there, manifest the power of their love. The parents of the doctor or the missionary will feel pain that their son has died or has been killed. But at a deeper, spiritual level, they will feel joy that in the heart of their son the love that they had taught him has won, that in his death which humanly seems to be pointless the power of love has shown its complete force, generating a supreme generosity that gives itself to the very end. Of course the son could have expressed his love without dying as a missionary in a foreign country, but his death manifested clearly with no tarnishing the quality of his love. Similarly, we can presume a similar joy in the heart of the eternal Father, who views the victory of the love that animates the Trinity made manifest in the ultimate gift of self of the Son. 'This is my Son, in whom is the fullness of my love!' (cf. Mt 3:17; 17:5; Mk 1:11; Lk 3:22) The eternal Father, moved by the love of His original grace which preceded the creation of the world and the sins of humanity (Ep 1:4) is pleased by the power of love, which His Son not only manifested, but also extended in his death towards wounded humanity.

The perception of the profound significance of the paschal mystery can throw light upon the final stages of the human spiritual journey in which elderly people prepare for their ultimate passage.

Since the paschal mystery human death has no longer been just a horrible moment of the final separation of the body and the soul, of the person and his or her family and community. A Christian death is a gain, a supreme union with God (Phil 1:21) to be lived out in love, and not in fear (Heb 2:15), on the basis of that supremely divine love that has been freely offered to us. The question therefore is not how to escape death (which we cannot do), but how to enter death in such a way that the spiritual richness of this passage, in union with Christ's own passage through death and resurrection to glory, will be an occasion for supreme openness to the freely given divine life. That is why St. Paul wrote: 'If we live, we live for the Lord; and if we die, we die for the Lord, so that alive or dead we belong to the Lord' (Rm 14:8) and 'we know that when the tent that we live in on earth is folded up, there is a house built by God for us, an everlasting home not made by human hands, in the heavens' (2 Cor 5:1), and also: 'when this perishable nature has put on imperishability, and when this mortal nature has put on immortality, then the words of scripture will come true: death is swallowed up in victory" (1 Cor 15:54).

Learning how to Love

Viewing the utter gift of self of Christ who loved us to the very end, up to the manifestation of that love in the suffering of the cross and its manifestation in the Eucharist, we can learn how to love, which is the sense of our life's pilgrimage. The secret of growth in love lies in openness to the supernatural love that flows from the Trinity. The essence of charity is that it is a supernatural love, that same love that animates the Trinity and can be incarnated in our human loves, purifying them and giving them their full splendour. 'The love of God has been poured into our hearts by the Holy Spirit which has been given us' (Rm 5:5). St. Thérèse of Lisieux in her meditation on the sacerdotal prayer of Jesus recognised the secret of divine love. Jesus gave us his own love, and he invites us to live out that love in our human relationships.[5] We merit growth in that love not by our meagre human efforts but by receiving with greater trust that

love which is freely given. The saint of Lisieux said: 'It is said that it is sweeter to give than to receive, and this is true, and so when Jesus wants himself to enjoy the sweetness of giving, it would be impolite to refuse'.[6] St. Thérèse had heard about a sister who died in great suffering, offering herself in reparation to divine justice. St. Thérèse rejected this type of devotion and instead she offered herself to the merciful love of God. Since God is infinite mercy, that infinite mercy needs souls that will accept it, and live it out to the full. There is an inherent need within the divine love that wants to expand. *Bonum est diffusivum sui*. St. Thérèse therefore offered herself to that merciful divine love so that within her it would find a space for its expansion.[7] Her openness to God consisted in a completely filial trust in the goodness and concern of the divine Father. This did not, however, dispense her from faith. Even though her death can be physically attributed to tuberculosis, she died of love. Her heart accepted the fullness of the divine love that she was willing to receive, while that divine gift had to pass through her heroic faith, perplexed by temptations similar to the positions of many atheistic philosophers.

The supernatural virtue of charity in which we receive God's love and try to apply it in our approach towards God and others, even if we may open to it fully only in the last moments of life, is the only reality of heaven that we can experience already here on earth. As we love one another on the basis of that divine love, we already have one foot in heaven. To understand this mystery, or rather to accept it intellectually, because we cannot fully exhaust this mystery by our understanding, we need to overcome a philosophical presupposition that has distorted thinking, at the least since the end of the Middle Ages. The prime cause can act completely within the secondary cause without in any way depriving it of its natural quality, dignity and rights, and so the two causes do not face each other as rivals.[8] Divine grace can manifest itself within truly human action. We may elicit an act of love, flowing from the inner movement of grace that is completely supernatural, transparent to the supreme love of God, and at the same time it is fully our own act, with all our human involvement, inventiveness, and personal responsibility. The human will, since it is created, can be moved from within by God, without losing in any way its own human nature, finality and personal quality. This means that the love of God, made manifest in the total gift of self of Christ, can pass through our human love. In fact, God is begging for our hearts, our minds and our hands, for our generosity and creativeness, so that something of the divine love of God will manifest itself in the here and now of our lives.

A difficulty arises, however, from the fact that we easily erect resistance to the movement of God's grace within us. Through our own ambitions, through the convictions of our special capacities and rights, we may block the purity of divine grace within us. A great spiritual effort and spiritual poverty are needed to distance ourselves in humility from attachment to our own projects and ideas, allowing the fecundity of God to manifest itself within them.

There is also a further difficulty in total surrender to God. While, on the one hand, it is true that there is a correspondence between nature and grace, grace making nature more natural, more graceful, on the other hand there is a certain opposition between the two. The gift of supernatural grace extends the human faculties beyond their natural limits. Grace, in particular as it becomes more dominant in the soul, is then experienced by nature as a foreign intrusion, something like a virus that generates feverish opposition. When God's gift of grace becomes more powerful, when it takes control of the soul, the forces of nature protest. What happens on the spiritual level is then countered by the crisis of the dark night experienced strongly at the psychic level. A deeper immersion in the mystery of God does not indicate with such lights that faith would become unnecessary. On the contrary: it obliges one to make deeper, more heroic, acts of faith in which the mystery is received in utter blindness against an opposition of nature.

As we advance in life, we learn how to love, and how to let go of our own projects, imaginations, self-condemnations and ambitions, so that divine love, given freely by Christ on the cross, will be hosted in the depths of our heart. Those who have learnt during their active lives to live out the love that is more powerful than human love, recognising the weakness of their own natural efforts and opening in faith to the love that is freely given to them as an unmerited gift, enter eternity while still among us. Those who have left openness to the divine gift to the final moments of their lives, learn humble submission to divine grace at their last moments, when sickness, suffering

and fragility force them to trust only in God. Death is a transfer in which the magnitude of divine love can overcome the person to the full. We go to heaven so as to love and to love more with that divine love that we have learnt to live out already here on earth.

It is in the light of the mystery of divine love that we need to view old age. In the past, people lived with a deeper awareness of their dependency upon God because they knew that their survival depended on the weather, on the harvesting of the crops. Today with economic affluence people may live most of their active lives without thinking about God. God has therefore replied to this situation by extending the lifespan of people. People now live longer, and sometimes they spend extensive periods in their old age, when they are sick, alone and forgotten by their families. This is a privileged period of time, given by God, when the old and sick, who had been independent and successful in their lives, learn how to let go of all their attachments and become children before God. It may seem that the old and sick, limited to their hospital or nursing home beds, can do little, that the scope of their charity is reduced. But God does not need great projects and enormous human activities. God is waiting only for the response of the human heart. The person who in old age lives out his boring monotonous days in prayer, in abandonment to God alone, because all those who were close are gone, who no longer tries to impose upon God life's projects, because history has moved on and what seemed to be important and dramatic in the past is no longer relevant, such a person can become transparent to the exchange of love that flows from the Trinity. This is a God-sent moment that should not be ignored or unnoticed. It is a time for the ultimate deepening and purification of faith and divine charity in the soul.

Encounter with God and Extended Dying

In the past, hospitals were places where the sick were cured. When the doctors arrived at the conclusion that it was impossible to cure a patient, the sick were sent back home to die. This meant that the final agony took place at home, often in the presence of a close family, amidst the furniture, the holy pictures and mementoes that had accompanied the person in life. The final moment was a time to make adieus to one's family and to receive the viaticum for the ultimate journey. Accompanying prayers assisted in the maintaining of a lively faith, a deep trust in God, and surrender to the loving arms of the awaiting eternal Father. Contemporary advances in medical techniques and in the organisation of terminal health care have prolonged the duration of the last moments and transferred the final agony to impersonal institutions where people die, attached to machines, often far from their loved ones, and without the close support of their ardent prayers. Do these circumstances assist or do they hinder in maintaining alive within the suffering dying and within their dimmed awareness a lively faith and confident trust in God's love?

The theological virtues do not belong to the psychic level but to the spiritual level, and this means that their exercise does not necessarily involve conscious feelings or sentiments, even though the presence of these virtues in the faculties may elicit an echo at the psychic level. The repercussion of the theological virtues does not therefore necessarily generate an experimentally perceptible reaction, while making the soul amenable to grace. We cannot experientially perceive the movement of grace, even though we can consciously experience the fact that we make an act of faith or an act of love, based uniquely upon the foundation that is trust in God. A theological exposition of the theological virtues, of their nature and mode of functioning, is applicable to all situations in life. The faith of a child receiving his first Holy Communion is the same in its nature as the faith of a profound mystic. It is a gift of grace, which sets the soul on its encounter with God. The question, however, is how these virtues function in moments of sickness and human fragility. Can a senile person, being unconscious, under the influence of drugs or in depression, exercise the theological virtues? Can a mentally retarded person, incapable of intellectual endeavour, make acts of faith and charity? Of course it is difficult to judge observing the weak person from without, but happily it is not our task to judge them and to ascertain the quality of their theological virtues. Who are we to exclude them from an encounter with God? Certainly we can sometimes witness expressions of religious trust and devotion amongst the profoundly mentally disabled. When human qualities are undeveloped or diminished, trust in God may be the only spiritual reality that will remain, with the Trinity finding supreme joy in meeting the poor in spirit (Lk 10:21). Faith and charity are given by God so as to enable a contact with Him and it is up to God to ascertain whether and how they are exercised. We can believe, therefore, that the utter purification that senility, suffering and the agony of death bring with them can so purify the soul that trust in God will be the only important decisive reality that will remain, even in the state of a dimmed, reduced consciousness. Multiple examples of holy deaths, in which the final passage is a moment of conversion, of letting go of all ephemeral hopes and of passing into the hands of the loving Father, show that this is possible, that this is in fact the most important moment of life, which begins the richer, resurrected life, on the other side of eternity.

In conclusion, I would like to add a short remark by taking into account new bioethical issues that have been provoked by the development of medical sciences and the possibility of the extension of the time span of the final agony. In Polish medical terminology, some new terms have been coined to describe emerging situations and they are now acquiring precision.[9] A death which comes about spontaneously as a natural result of sickness in spite of appropriate medical care or as a result of the fact that limited medical equipment had to be transferred to another patient who was deemed to need it more, is described as 'orthothanasia', meaning a good death. It has none of the morally evil connotation of 'euthanasia', which strictly refers to the direct killing of a suffering per-

son supposedly out of mercy. An aggressive medical treatment that attempts to prolong the life of the patient at all costs, irrespective of the patient's pain and hopeless situation, is defined as 'dysthanasia'. In fact, more than the prolonging of life, this is the prolonging of the process of dying. Perhaps following the logic of the new terminology, we could coin the hitherto unused term 'heterothanasia' for an inappropriate way of dying that would be an antonym of 'orthothanasia', the 'good death', with 'dysthanasia' being a form of 'heterothanasia'. As with distinguishing between 'orthodoxy' and 'heterodoxy', we would then distinguish between an appropriate way of dying and an inappropriate way of dying. It may happen that the process of dying will be prolonged artificially for a variety of reasons that do not deserve moral approval. If this is done without concern for the patient's real good, but uniquely for the purpose of gathering material for scientific research, or for the 'harvesting of organs', or as may happen in the case of a dictator, so as to arrange political manoeuvres before his death, these concerns for the prolongation of life would be a form of 'heterothanasia'. The morally acceptable decision to forego 'dysthanasia', burdensome and disproportionate aggressive medical treatment,[10] has to take into account the true good of the patient. Returning, therefore to the issue discussed in this paper, it is important that for the true good of the patient which should always be a subject of focus, the patient's spiritual good and encounter with God are included. The fact that the dying patient has received the sacraments may be a factor, which will enter, apart from the strictly medical arguments, into the assessment of whether the prolongation of further treatment is seen as extraordinary and disproportionate and whether palliative means which may result in decreased consciousness can be applied. The principle formulated by John Paul II needs however to be maintained: 'as they approach death people ought to be able to satisfy their moral and family duties, and above all they ought to be able to prepare in a fully conscious way for their definitive meeting with God'.[11]

Fr. WOJCIECH GIERTYCH, O.P.
Theologian of the Pontifical House, the Holy See.

Notes

[1] *Un grand chant d'amour. La passion selon Saint Matthieu*, (Saint-Maur , Parole et Silence, 1997), pp. 131-133.

[2] *Dio ha tanto amato il mondo. Lectio divina sul "sacrificio" di Cristo* (Paoline, Milan 2007), pp. 5-6.

[3] Nm. 17, 18.

[4] St. Thomas Aquinas wondered whether the death of Jesus could be interpreted as suicide. Directly, Jesus was not responsible for his death, but he was indirectly, as someone who by opening a window is responsible for the fact that rainwater floods the room. Jesus' gift of self and refraining from the prevention of his executors was the cause of his death. *S. Th., II-Ia*, q. 47, art. 1: *Quia ergo anima Christi non repulit a proprio corpore nocumentum illatum, sed voluit quod natura corporalis illi nocumentum succumberet, dicitur suam animam posuisse, vel voluntarie mortuus esse.*

[5] *Œuvres complètes,* (Cerf, Desclée de Brouwer, 1992) p. 250, Manuscript C, 12 v°: ' *Ah! Seigneur, je sais que vous ne commandez rien d'impossible, vous connaissez mieux que moi ma faiblesse, mon imperfection, vous savez bien que jamais je ne pourrais aimer mes sœurs comme vous les aimez, si vous-même, ô mon Jésus, ne les aimez encore en moi*'.

[6] *Op. cit.*, p. 463, LT 142.

[7] *Œuvres complètes,* (Cerf, Desclée de Brouwer, 1992) p. 212, Manuscript A, 84 r°.

[8] Charles Morerod OP, *Ecumenism and Philosophy. Philosophical Questions for a Renewal of Dialogue*, (Sapientia Press, Ann Arbor, 2006), p. 68.

[9] L. Niebrój, M. Fajler, and M. Olejniczak, 'Refleksja nad eutanazją w polskiej literaturze medycznej', in L. Niebrój and M. Kosińska, *Health Care: Professionalism and Responsibility*, (Wyd. ŚAM, Katowice, 2005) pp. 93-106.

[10] Cf. John Paul II, *Evangelium vitae*, n. 65.

[11] N. 65.

friday
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DONATUS FORKAN

2.2 The Testimony of Saints Devoted to Caring for Elderly Sick People

1. Preamble

I have to admit that when I agreed to make a presentation at this conference I was more concerned by the prospect of making a presentation to this prestigious gathering, in this sacred space, than the topic itself. That was before I came to understand the full ramifications of the topic. At that point I became very concerned because, at first, I was not able to think of many saints who had devoted their lives specifically to caring for the elderly. Then I found, in an address by Bishop Albino Luciani (known to us now as Pope John Paul I) to the Women's Youth Congress on 1 October 1963 these words: "Tell the young it is not only those in Heaven and in pictures on the walls of churches and houses who are saints, but also all the faithful who love the Lord with a strong commitment."

Given my topic today, these words of Bishop Luciani resonate with my personal experience of "saints caring for the elderly".

I grew up in the West of Ireland in the 1950s. It was a place and time when so many families lived with the scourge of poverty, isolation and the need to migrate. Elderly persons were particularly affected in this situation and suffered from neglect and, the greatest suffering of all, a sense of worthlessness and loneliness. However, in that society I came to know many 'saints' who sacrificed themselves and their careers and even postponed following a vocation to the religious life, the married life or the priesthood in order to care for an elderly father or mother, uncle or aunt or other relative.

I recall an Irish confrere, Brother Sebastian Mills, who wanted to join our Order when he was in his twenties but postponed pursuing his vocation until he was forty-five years of age so that he could care for his elderly parents. After he eventually become a Brother of St. John of God he only lived for a short time. However he was remarkable for his holiness and great sensitivity towards people who were suffering.

2. All cultures have an inbuilt respect for their elders

I spent most of my religious life working as a missionary in Korea, a country that is predominantly Buddhist and greatly influenced by the teachings of Confucius (551-479 BCE). While Confucius believed that people live their lives within parameters firmly established by Heaven – which, often, for him meant both a purposeful Supreme Being as well as 'nature' and its fixed cycles and patterns – he argued that human beings are responsible for their actions and especially for their treatment of others. For Confucius, the acceptance of the fact that a person is responsible for his or her actions is demonstrated *par excellence* through the practice of the Golden Rule: 'What you do not wish for yourself, do not do to others.' He regards devotion to parents and older relatives as the most basic form of promoting the interests of others before one's own and teaches that such altruism can be accomplished only by those who have learned self-discipline.

Confucian philosophy permeates every aspect of life in Korea – the manner of greeting one's seniors or juniors, the relationships within the family and relationships in society and with friends and acquaintances. Confucian philosophy also influences life in China and other countries of the Asian region.

When I went to Korea in the late 1960s there was no need for nursing homes for the elderly because grandparents were seen as the family's 'treasure of great price' and were treated as such. They enjoyed pride of place, precedence and respect because they were seen as the custodians and transmitters of the family history, its customs, privileges and learning. Their wisdom was sought on a variety of issues – especially in relation to arranging marriages, naming new family members, teaching their grandchildren the customs and practices of the family and even the Chinese characters used in writing.

I recall remonstrating with a taxi driver in Korea about the uncritical way in which Koreans seem to accept western customs and values to the detriment of Korean traditional values and customs – especially with regard to the position of the elderly members of the family. Both Ireland and Korea have experienced the benefits of the so-called *Asian Tiger* and *Celtic Tiger* economic developments respectively. These have brought much needed prosperity to both countries but, in my opinion, they both have lost something very precious – respect for, and care of, the elderly. As a consequence of the free market economy there are many positive aspects that have benefited people, but also there are negative consequences that are causing hardship and creating a 'new poor', amongst whom the elderly find

themselves. In some countries political expediency has caused house prices to increase to such an extent that they are out of the reach of an average family income. Other basic items such as food, clothing and education have increased in price and the result of this is that both parents have to find employment. This has increased pressure on the parents and their relationship with each other and their children, and brought enormous pressure to bear on the traditional family unit. In this situation both the young and the old are exposed to possible neglect, not from lack of love or good will, but from being caught in a desperate situation that can cause burnout in the parents and lead to a sense of hopelessness and even violence. In this situation there is the danger that the elderly persons who are the 'family treasure' will be sacrificed on the altar of consumerism and will end up being neglected.

Before getting to the core of my talk, I would like to draw attention to, and express appreciation of, another group of people, men and women, who with enormous dedication and skill, devote their lives to the provision of care, various programmes, respite-care in nursing homes and day centres, as well as other types of home-based services to so many elderly people. Their work is not always appreciated, rewarded or resourced as it should be. If we look at past history we can see that circumstances were quite different, because few people managed, for various reasons, to reach an advanced age. That is not the case in many places today and the problems in those earlier times were of quite a different nature. Now we often look to strangers to care for our elderly.

3. The innate dignity of every human being

Dignity is not conferred on an individual: he/she is born with an innate dignity that reflects the image and likeness of God. Moreover the dignity of the human being is such that disease, disability or the infirmities of old age in no way can destroy or diminish it. This is true of every phase in our journey though life, from the newly-born baby to grandma or granddad who, like the elderly Simon and Anna, thank God for the gift, the wonder and the preciousness of the new life they are holding in their arms.

Some of the followers of Dr. Martin Luther King, the great civil rights leader of the 1960s, said to him, why is it that whites have all the jobs that give dignity and we blacks are left to sweep the streets and clean the windows? Dr. King responded, there is no dignity in work there is only dignity in human beings. When you clean the windows or clean the streets, he exhorted, do it the best way you know how and by so doing you confer dignity on the work that you do. Elderly people want to be recognised for who they are now, not for what or who they once were. Often times elderly people are only recognised for the position they once held in society or in the Church, rather than who they are now. From time to time you will hear an elderly person being introduced with words like, he *was* a doctor, she *was* a university professor, he *was* a school teacher, a farmer or she *was* a fashion designer as if work or position gives a person dignity.

When we meet God in death the question will not be, *who were you or what degrees did you have on earth?* There will be only one question: *how much did you love?* The answer to this question by many people rejected in this life, the homeless, people with all kinds of disability, the stranger whom society refused to offer hospitality, may well be that of Peter, "You know all things, Lord, you know I love you" (Jn 21:15). These silent prophets in our midst who were ignored at best, at worst marginalised and maligned. They were considered a burden on society, and yet in the words of the great prophet of hospitality, St. John of God, 'one human being is of more value than the combined wealth of the entire world.'

4. The Church's teaching

The parable of the Good Samaritan (Lk 10, 29-37) has drawn the attention of the Church across the centuries to a fundamental and constituent dimension of our faith, namely the fact that preaching and worship find their ultimate truth in serving our neighbour. This is a belief that is informed and fashioned by compassion. Christ invites the Church to be both annunciation and prayer, as well as service to bear witness to the loving closeness of God to people who are old, sick, poor and needy. The Church performs her mission by taking the side of everyone specifically to take care of them.

We read in St Paul's letter to the

community of the Galatians (Gal 5:13), a reminder to that young community that it is 'Through love that you will be servants of one another'. Obviously this is the core of the Christian message and was taught and exemplified by Jesus himself and is the blueprint for all Christians of all time. Therefore, the Church must always be on the side of the poor, the sick, the marginalised. Conscious of the fact that everything she does, in all she chooses, and in all her preferences for the needy, she is seeking to be the manifestation of the Love of God, moved at all times, as Benedict XVI has reminded us in his encyclical *Deus Caritas Est*, by the Spirit who is 'the energy which transforms the heart of the ecclesial community, so that it becomes a witness before the world to the love of the Father, who wishes to make humanity a single family in his Son. Love is therefore the service that the Church carries out in order to attend constantly to man's sufferings and his needs, including material needs' (n. 19).

The Church has received a mandate to continue to practice throughout time the example left to us by Jesus the Good Samaritan, performing his identical mission, thereby embodying the love of the Father through tangible acts of care shown to suffering humanity: 'and he sent them out to preach the kingdom of God and to heal' (Lk 9:2). For it was from the day of Pentecost that the history of the Church became the history of love, written throughout the centuries by a huge multitude of believers who, like Jesus, took care of injured humanity, and have ever since been the leaven in moments of darkness and difficulties in the Christian community, referring the Church back at all times to the holiness of her origins.

Every period in history has its own forms of poverty and the Church has always tried to encourage solidarity, and it is precisely charity-love which has given a fresh impetus to the faith and a new face to the Church, and still continues today to emphasise the fact that everyone, including the elderly and the aged, have their place and their usefulness within the Christian community. We only have to recall Pope John Paul II's Letter to the Elderly of 1 October 1999.

Looking back, even summarily, at the Saints who have devoted themselves to caring for the elderly in the past, that is to say viewing the Christian experience of those who took to heart the Our Lord's commandment to love others as he loved them, and to be like Christ to others, we can see this obviously entails making a choice. This presentation makes no attempt to be complete, but merely seeks to show how the Church, through her sons and daughters, has always had this particular dedication across the centuries to the elderly, as the expression of deep Gospel-inspired love, transforming it into an appeal and a value.

On these terms, charity – that is self-giving – becomes an act which epitomises the whole Gospel. The *Agape* style is Christ's style, and it is this that all these Saints took upon themselves. They found the courage to choose this love of their aged brothers and sisters for Christ's sake, expressed through the typical gentleness of the Christian who knows that he or she is practicing the mercy which has preceded him.

It was the Saints, the women and the men who were in love with Christ, and seized by the mysterious power of the Holy Spirit who is, as our Holy Father Benedict XVI has reminded us in his first encyclical, *Deus Caritas Est*, 'that interior power which harmonises their hearts with Christ's heart and moves them to love their brethren as Christ loved them, when he bent down to wash the feet of the disciples and above all when he gave his life for us' (*DCE*, n. 19), through whom Jesus has continued to be close to every man and woman to this day. In them, Jesus has continued to travel not only through the small regions of Judea and Galilee, but the most impervious pathways throughout the world.

Earlier I mentioned 'saints,' holy men and women but not canonised by the Church as such, who devoted their lives to caring for an elderly parent or an elderly neighbour who lived alone. These are the ones of which Bishop Luciani speaks, whose images are not on icons or holy pictures, but men and women whose names are truly written in the Book of Life.

Now I want to draw your attention to those men and women whom the Church holds up to as models of Christian living as an inspiration and guide for us on our journey through life. Some of them lived to be elderly themselves and so understood how we feel, what it is like to suffer from arthritis, to feel unwanted and lonely at times, to run out of steam and nod off during a community meeting or in the chapel, to fall into the trap of talking of the 'good old days' and see the vacant look coming into the young face sitting opposite one! The few people named in this paper belong to the host of holy men and women of charity who made the face of the Church of Jesus shine out by embodying the Gospel of Mercy in their words and deeds.

5. By caring for the elderly they gave witness to the central core of the Gospel: the merciful love of the father

ST. JOHN OF GOD

St. John of God was born at Montemor-o-Novo, just outside Lisbon, in 1495 as João Cidade. After going to live in Spain, John had an adventurous life, including a hazardous military career and selling books. Having had a conversion experience that was interpreted as a mental illness he was admitted to the Royal Hospital of Granada and there he received the treatment of the day for mental illness which included scourging, starvation and humiliation. John accepted this as a way of making recompense for his wasted life but when he saw his fellow patients, some of whom were old and weary, being treated in this way, he was outraged. He resolved to do something about it when he was discharged from hospital. When John began to put his resolution into practice people considered him to be insane and many made fun of him. What sane per-

son would try to give shelter to the homeless, care for the sick and the dying, befriend and brother the marginalised and outcasts of society? Yet twelve years later, when John died on 8 March 1550, the entire city of Granada mourned his death and gave him the equivalent of what today would be a 'state funeral'. What a transformation for the citizens of Granada who had already 'canonised John' by giving him the name John OF GOD! What an example of Christian charity and selfless giving to one's brothers and sisters in need by John of God! John of God was beatified in 1630 by Pope Urban VII and in 1690 he was canonised by Pope Alexander VIII. Between the end of the nineteenth century and the beginning of the twentieth he was proclaimed the Patron Saint of the sick, hospitals, nurses and their associations, and then Co-Patron Saint of Granada.

ST. CAMILLUS DE LELLIS

He was born into a noble family on 25 May 1550, near Chieti. He lived as a mercenary soldier and, having gambled away all his possessions, he went into service with the Capuchins at Manfredonia. After his conversion he went to Rome to have an old wound treated at the hospital of St. James for the Incurables where he dedicated himself, above all, to caring for the sick. He devoted himself to Christ crucified and began studying at the Collegio Romano. After his priestly ordination he founded the 'Company of Ministers to the Infirm', better known to us as the Camillians. His Order stood out from others not only by the Red Cross worn on the front of the habit but also by its spirit of merciful love. St. Camillus devoted particular attention to the sick and laid the foundations for the profession of nurses and chaplains as we know them today. He died in Rome on 14 July 1614.

ST. VINCENT DE PAUL

He was born at Pouy in Gascony on 24 April 1581; up to the age of fifteen he looked after pigs to pay for his studies. He was ordained priest at the age of nineteen and in 1605, on his way from Marseille to Narbonne, he was taken prisoner by Turkish pirates and sold as a slave in Tunisia. He was freed by his 'slave master' who was converted to the faith. As a result of this experience he was left with the desire to bring physical and spiritual relief to deportees and persons in prison. In 1612 he became a parish priest near Paris. At his school, priests, religious and lay people were given training and formation and became animators of the Church in France; he spoke out to those in power on behalf of the weak and disadvantaged. He promoted a simple and popular form of evangelisation. He first founded the Priests of the Mission (Lazarites) and then, with St. Louise de Marillac, founded the Daughters of Charity (1633). He died in Paris on 27 September 1660 and was canonised in 1727.

ST. JOAN ANTIDA THOURET

She was born near Besançon in France on 27 November 1765, as the daughter of a tanner. At the age of twenty-two she joined the Congregation of the Sisters of Charity of St. Vincent de Paul in Paris. On the outbreak of the French Revolution the Community was dissolved by the authorities and she returned to her native village of Sancey where she ran a school. In 1799 she opened a school in Besançon with four assistants, marking the beginning of the Congregation of the Sisters of Charity under the protection of St. Vincent de Paul. The Congregation grew rapidly and spread to Switzerland and Savoy. In 1810 Joan was invited to run a large hospital in Naples. She spent almost the remainder of her earthly life there, opening many Institutes in Italy, and died on 24 August 1826.

BLESSED CHARLES STEEB

He was born at Tubingen in Germany on 18 December 1773, into a Protestant family. Like all the members of his family he was an ardent evangelical but was fascinated by the vibrant world of Verona with its lively cultural and religious life. He was ordained priest four years later to the great disappointment of his family who disinherited him. This was the time of the war between Napoleon and Austria and Charles spent some time working in infirmaries, military hospitals and isolation hospitals for people suffering from infectious diseases, as a priest, nurse, and an interpreter in three languages. He devoted himself to the sick, the needy and the elderly. In 1840 he founded the Institute of the Sisters of Mercy in two small rooms, who devoted themselves to every kind of suffering and need, which came into being not only thanks to him but also to the financial support and the practical assistance of Luigia Poloni, a woman from Verona, who subsequently became Mother Vicenza. He died in Verona on 15 December 1856 and was beatified by Pope Paul VI in 1975.

BLESSED JEANNE JUGAN

She was born at Cancale, in France, in 1792. Her fisherman father died at sea when she was only four. Jeanne worked as a domestic servant in a castle and then began to develop her vocation: to help lonely old people. At the age of twenty-five she left her village and worked as a nurse at the hospital of Saint-Servan. In the meantime she had joined the Third Order of the Mother Most Admirable, founded by John Eudes. With her friend, Francesca Aubert Jeanne a rented house and began to take in lonely and sick elderly people. Jeanne was being prophetic when she said to her mother: 'God wants me for himself. He is keeping me for a work which is not yet known, for a work which is not yet founded'. One winter's evening, Jeanne opened her home and her heart to an elderly, half-paralysed blind woman who had found herself suddenly all alone, she gave up her bed for her. This act committed her forever. Soon another old woman followed, then a third. In 1843, there were forty such old women around Jeanne and her three young companions, who had chosen her as the Superior of their small association which was slowly taking the form of a religious community. This was the core of her Congregation. Jeanne spent

her last years begging for alms. She died in 1879 and was beatified in 1982.

BLESSED MARIE EMILIE TAVERNIER GAMELIN

Emilie Tavernier was born in Montreal on 19 February 1800. In 1823 she married John-Baptiste Gamelin whom she had discovered to be a friend of the poor – which was wholly in line with her own aspirations. They had three children but her joy in them was short-lived: they all died in childhood and she was soon widowed after a happy, faithful married life. The void left by the death of her children and her husband was filled by the poor: her house became their home and she worked hard to expand the premises so that she could take in the impoverished, the elderly, orphans, prisoners, immigrants, the unemployed, the deaf, young people or couples in difficulty, the physically and mentally disabled. Very soon her house became the 'Home of Providence' for everyone, because she herself was considered a 'true providence'. For fifteen years she increased her acts of heroism and dedication under the grateful and kindly oversight of Bishop Jean-Jacques Lartigue and subsequently the second Bishop of Montreal, Monsignor Ignace Bourget. Such an invaluable life could not be allowed to disappear, and had to continue. Msgr. Bourget therefore turned to his diocese and young Canadian girls were sent to Mrs Gamelin who trained them to practice the compassionate charity that she had practiced with such love, devotion and sacrifice, and to undertake the mission of Providence, proclaimed in deeds which speak louder than words. Emilie Tavernier Gamelin died on 23 September 1851. John Paul II beatified her on 7 October 2001, proposing that the People of God take her as a model of holiness for a life spent at the service of our poorest brothers and sisters in society.

BLESSED FREDERICK OZANAM

Frederick Ozanam, the founder of the Society of St Vincent is an example of lay holiness and charity. He was born in Milan in 1813 (his father was in the Napoleonic army) and after Waterloo he returned home. In Paris he joined the Catholic circles that gathered around the physicist André-Marie Ampère and Emmanuel Bailly. In 1833 he created the 'Conferences' which still share the lives of the poor today. He graduated in law and letters and taught at the Sorbonne University, becoming a Member of the Academy of the Crusca in Florence. In 1841 he married and had a daughter, while continuing to follow his Movement. He died in Marseilles in 1853.

BLESSED JOSEPHINE GABRIELLA BONINO

She was born at Savigliano (Cuneo) in the diocese of Turin on 5 September 1843, into a wealthy and deeply religious family. In 1855 she moved with her family to Turin, due to the professional commitments of the father who was a physician. At the age of twenty-six she returned to Savigliano. For five years, until his death, she lovingly cared for her sick father. In 1875 she established close bonds with Giovanna Colombo's Centre for assisting orphaned girls in the town. Even though she felt the desire to enter the cloistered life she decided to create a new religious family, the Congregation of the Holy Family, to care for orphans, the elderly, the sick, or girls to be educated. She took as her model the Holy Family of Nazareth: humble and hard-working. At the age of thirty-eight she was elected Superior and remained in this post until her death. She died in Savona on 8 February 1906. Mother Josephine Gabriella was beatified by John Paul II on 7 May 1995.

BLESSED JOSEPH NASCIMBENI

He was born in 1851 in the Province of Verona, and at the age of twenty-three was ordained priest, and qualified as an elementary school teacher. Three years later he was posted to Castelletto di Brenzone on Lake Garda where he was to remain for forty-five years, until his death. He was engaged in a huge amount of pastoral activities, where he was able to deploy all his talents; there was an absolute explosion of initiatives, but the township was in a catastrophic situation, with neglected children, young people who had never been to school and had never been given a religious education, old people left unassisted and alone, families that had broken down due to mass migration to find the employment which their country was unable to offer them. He opened up houses to take in boys and organised home-care services for all the people who lived alone, a kindergarten, a

school for orphans and so many other initiatives. He founded the Congregation of the Little Sisters of the Holy Family which still continues to carry forward his charism. He died on 21 January 1922 and was beatified by Pope John Paul II in 1988.

BLESSED FRANCIS SPINELLI

He was born in Milan on 14 April 1853 and was ordained a priest in 1875. He founded the Institute of the Sisters Adorers of the Most Holy Sacrament whose mission is to adore Jesus in the Eucharist day and night and to serve their poor and suffering brethren in whom they 'see the Face of Christ'. Francis saw Christ among the distressed, marginalised and rejected, and whenever there was any kind of need: in schools, oratories, caring for the sick, or lonely elderly people. He became widely considered a saintly man, and died on 6 February 1913. He was beatified by John Paul II on 21 June 1992.

BLESSED TERESA OF CALCUTTA

Mother Teresa of Calcutta, whose original name was Agnes Gonxha Bojaxhiu, was born on 26 August 1910 in Skopje (the former Yugoslavia, today's Macedonia), into an Albanian Catholic family. At the age of eighteen she decided to join the Congregation of the Missionary Sisters of Our Lady of Loretto. In 1928 she left her country for Ireland, and within a year she was already in India. In 1931 the young Agnes took her first vows and the religious name of Maria Teresa of the Child Jesus. For some twenty years she taught history and geography to girls from wealthy families in the Loreto Sisters'' school at Entally, in east Calcutta. But just outside the boundary walls of the convent was the poverty-stricken neighbourhood of Motijhil which, with its overpowering and nauseating stench, was one of the most depressing slums in the Indian megalopolis. On 10 September 1946 she heard the 'second call' while she was on a train on the way to Darjeeling for spiritual exercises. She felt that she was being required to quit the convent to work with the poorest of the poor, for those who lived on the margins of the world, the derelict people who were dying daily on the footpaths of Calcutta without being given the dignity of even dying in peace. That was 16 August 1948.

Our Lady is considered to be the first Missionary of Charity because of the visit she paid to Elizabeth, demonstrating her burning love in freely-given service to her elderly cousin who was in need. "You can find Calcutta anywhere in the world", said Mother Teresa, "if you have eyes to see. Everywhere you will find those who are unloved, unwanted, and cared for, rejected and forgotten". Her spiritual children continue to work throughout the world serving 'the poorest of the poor' in orphanages, leprosy hospitals, homes for the elderly, unmarried mothers, and the dying. She once said, "when I am dead I can help you even more...". She died in Calcutta at 9.30 p.m. on Friday, 5 September 1997, at the age of 87.

6. Conclusion

To conclude, if we look at past history we can see that circumstances were quite different, because few people managed, for various reasons, to attain an advanced age. Today is very different – especially in the industrialised countries where people are living much longer than previously – and the problems in those days were of quite a different nature to those of our times. Today's better standard of living, good nutrition, scientific advancements related to the ageing process which advises on diet, exercise, gainful employment and involvement in society, has led to people living longer in the industrialised north. Unfortunately, the converse is true in the developing countries because of a lack of the above with wars and violence adding dramatically to early deaths among these populations. The increasing numbers of elderly people in the South and all the challenges relating to this, such as multiple illnesses, financial straits, loneliness, isolation, inadequate housing, are a relatively recent phenomenon. It shows that our societies have undergone a radical transformation in attitude and values which makes it difficult to address the issue with the determination, imagination and commitment that it calls for. It is not a matter of a lack of resources in most countries of the south, but of the political will not only to confront the challenges that a more senior population entails, but even more importantly to promote it as a positive resource for the whole of society, as demonstrated in countries like China, Korea and Japan where Confucianism has a deep influence. As a person of pensionable age myself, I can say that the financial resources are there in most countries because of the hard work, taxes paid, innovativeness and sacrifices of the elderly people of today.

The axiom of Confucius, "What you do not wish for yourself, do not do to others" is as valid today as it was five hundred years BC. The elderly person is not a problem, no more than a baby is a problem, he or she is a blessing. In the Old Testament you have the aged Zachariah taking the Youth of God in his hands in the temple and, with words of hope and thanksgiving, asking God to let him go in peace for his eyes has

seen the Light that will Enlighten Israel.(Is 52:46:13:42-6,49. Jn 8:12b) The Gospel of St. Luke begins with four elderly people Zechariah and Elizabeth, Simeon and Anna all of whom have a dream, the hope for what is new. Maybe society today needs to utilise, listen to and care for its elderly citizens, grandfathers and grandmothers, who have the time, patience to listen, to counsel, to accompany others as they struggle with life issues and concerns, and not treat them as 'cheap labour', baby sitters or – even worse – a burden. With such a high suicide rate among our young population, dependency on chemicals – drugs and alcohol – as St. John of God said to a young man searching for his vocation in life, many young people are *like a boat without a rudder, going around in circles*. Instead of seeing the elderly as a burden we must accept them as productive members of society, obviously with health and other needs that go with their age and stage in life, who have so much to contribute to a needy society from their experience that can be useful and nurture the hope that springs eternal.

Across the centuries the Church's response to the elderly in need has been generous and creative and has taken so many different forms; the service of charity on behalf of the elderly has always had an important place in the life and interests of the Church.

Faced with a constant increase in the care requirements of the elderly as a phenomenon of the modern age, and the development of increasingly more complex forms of services, our Saints have had to seek out and develop new approaches and new working methods to keep pace as closely as possible with the new and increasingly more complex emergencies in this field.

At the end of this short backward glance we have seen many consecrated and lay people who have dedicated their lives to looking after the elderly. Their generous, patient and sensitive love and service gave the elderly not only the medical care they needed but, even more importantly, a feeling or sense of being valued and respected, with a dignity that the infirmities of old age in no way destroyed or diminished. These dedicated men and women gave great human comfort and spiritual assistance to those they served, bringing them great hope through which men and women live as a sign or an instrument of Christ's love and as a manifestation of the love of the Church for the suffering members of the body of Jesus.

Br. DONATUS FORKAN O. H.
Prior General of the Hospitaller Order of Saint John of God

RINO FISICHELLA

2.3 The Sick Elderly and Christian Hope

'Let us hold fast the confession of our hope without wavering , for he who promised is faithful' (Heb 10:23). The text of the author of the Letter to the Hebrews seems to foreshadow our subject matter by twenty centuries; perhaps it would be more appropriate to say: he is able to express the original experience of believers faced with limits. This is an experience that does not know the passing of time because it is connatural with every man who has to provide an answer to the question of the reasons for limits, in the various guises they appear, in order to draw near to the meaning that transcends him and satisfies him. What is required in our reflection, however, are three observations of the Biblical text which should be explained. First of all, faithfulness to God is referred to. This is one of the dominant themes of the whole of Holy Scripture: from the Old Testament to the New Testament the leitmotif returns that God is faithful to the promises that He makes. In this case, the believer is called to verify directly the truth of this statement: God has kept the promise that He made. But even more than this the believer is called to believe that specifically because of this, God's other promises will be kept in due time. A second reference in the above quotation is to the unity that is made between faith and hope. Profession (*omologhia*) normally concerns faith in the Lord; in our case, on the other hand, we find a reference to hope. The mind of the believer is immediately referred to the celebration of baptism and of Easter. In other words, to profess faith in the Lord is equivalent to hoping in him and in his return, when he will complete everything so as to then present it to the Father (cf. 1 Cor 15:24). This dimension of hope is expressed in great optimism; the holy author wants to tell us that we must be full of joy and trust, optimists that is to say, because the death and the resurrection of the Lord are our salvation. The evil that is always present and the limits that are imposed on our lives are not the last word because Christ has defeated them. Good and evil, to go back to the teaching of the Apostle Paul, are present in the life of each and every man and fight each other but the believer possesses the certainty that they are not on the same level. Good always defeats evil and destroys limits because it good is the fruit of the Spirit of the Risen Christ (cf. Gal 5:22-25). The third observation revolves round the adverb that could easily move into the background but in fact allows a reinforcing of what has already been said – 'fast'. The profession of hope must be made without wavering. The Greek reads ακλινή and indicates the wavering way in which Christians live their faith – limping! We are brought here to the certainty of faith and the hope that must be lived with equal strength and consistency. To summarise, in the face of the mystery of the death and the resurrection of the Lord in whom so many have believed and of which we have solid testimony, we cannot allow ourselves to be wavering. Hope, therefore, is a certainty that is placed on our pathway; in it we must grow, but with a constant process that fixes our eyes on the faithfulness of God who loves those who believe in Him and gave his Son for them.

The Inexorable Character of Faces

'Nature does nothing in vain': this Aristotelian principle allows us to address with due reasonableness the question of the limits that are placed within us. They are reflected in the traits that daily experience obliges us to address and which demonstrates its innumerable faces in the most desperate situations. One of these faces is certainly that of illness, suffering and death. Life is not a uniform flow; it is enough to look at our faces to perceive how in a few square centimetres one can write the entire history of an existence. 'Man', writes R. Guardini, 'characterises himself constantly anew. His psycho-physical conditions constantly change. The images that a man offers of himself when he is working or when he is resting, when he is struggling or when with calm and serenity he enjoys what he possesses, are very different, With each new characterisation of man new aspects of his nature appear. The various conditions of health, professional situation or social status can penetrate deeply into the depths of his spirit. The differences that are created are at times so great that they openly call into question the identity of a person…however, one is always dealing with the same man. The diversity of situations does not eliminate his unity; indeed it is specifically his unity which is affirmed in diversity'. God decided to write the book of life within certain stages that inexorably pass for each and every human being. It is up to us to understand the meaning of this story and to live it with a freedom that enables us not to ever be subjected to what we are living. Indeed, we are called to provide a meaning so that we can express to the full our personal participation in the dynamic of the passing of events. God decided not for a man in general but for a precise face, and for everyone He has a project that develops from birth to death as a call to life. The response that we offer allows us to see the completion of this project or its failure. This is a fact: only to the extent that we are aware that we grasp the meaning of the movement of the life are we able to ac-

quire an identity that allows the formation of our personalities. Each stage of life that is lived is always new; it was not lived before and it will not be lived in the future. It is the καιρός, the instance of the present that makes us each time different and yet always the same.

As long as we live with the impetus of youth our gaze is often directed towards understanding the requirements and the expectations that will arise in the future; we draw near to adulthood and old age and the truth that has been accumulated over the years opens our eyes so that we can look ahead and touch with our hands the end of the life cycle. Each stage of life has its phases and its crises: adolescents and young people feel the crisis of identity; a mature man feels the crisis of limits; and the elderly feel the crisis of detachment…At all these moments one always perceives something that is unique, autonomous, and yet that is destined to prepare for what is coming afterwards. The problem that poses itself with the arrival of old age is that of knowing how to accept the inexorable passing of time, how to understand its meaning, and how to actuate it in an active way without being subjected to it. What must be observed, however, is that we increasingly live immersed in a culture that identifies the value of life with youth; in this way the condition of the elderly is marginalised and a maturation of this stage of existence is not fostered thereby leading it to be accepted and lived in a dignified way. If an elderly person no longer has a social presence and no longer performs a function for society, then it is inevitable that he or she will become a superfluous burden because he or she is not productive. A spiral of the juvenile is created which seduces people in a devastating way because it impedes an acceptance of what one is so as to take refuge in the illusion of a dream. It appears that in the current portrayal of life are absent those special values of the elderly person such as wisdom produced by accumulated experience and the transparent behaviour that is the outcome of a life that has been lived.

In such a context, the question inevitably arises: what is the use of the various specialisations in geriatrics or all the new forms of welfare provision if the elderly do not become aware of their state? If the way in which that state is presented and received is on the same level of a diminished young person which remains such because of the ability of medical doctors to prolong his or her life with miracle-working forms of treatment or with the various mystifications of a cosmetic restoration of varying degrees of difficulty, is the result not in the end the idea that life is only an appearance, a deception and a tiresome illusion? He or she will certainly remain alive but when sadness and loneliness nail him or her and lead him or her to touch with his or her own hand what he or she really is, how can he or she be able to react? What meaning will he or she be able to give to things beginning with himself or herself and the experience that he or she is undergoing? To put up with things or to accept things? This is the true dilemma that must provoke and keep alive the conscience and maintain dynamic awareness of the moving on of life.

In elderly people at a certain point there inevitably arises a perception of the meaning of the perishability of things. Life becomes a serious examination of conscience, one begins to assess one's own strength, what one manages to do and what life can give one; the earlier a man grows old the more he intensely perceives the end. With a healthy realism one should say that in an increasingly strong way one has the sensation that something is coming to an end; one does not know the time that separates one from it but one perceives waiting for it and this prolongs time whereas awareness of what will come counters it.[1] It is at this stage that typical phenomena are developed that enable us to perceive limits: senile obstinacy, the exaggerated wish to be seen, talking too much, the tendency to behave in an authoritarian way, becoming a torment for one's children…to summarise: all those manifestations that lead to the belief that one is someone. If one wants to overcome this moment one must necessarily accept the idea itself of time that passes and we with it. One is still face to face with the great challenge of having to accept the condition one finds oneself in. Whether this is illness or old age – *ipsa senectus morbus* – does not matter; one must accept the end of oneself without succumbing to limits but equally without taking away the value that it has by becoming cynical or banal.

The challenge becomes strong at the moment of illness. Suffering increases the question about meaning and obliges us to provide an answer. And it is at this moment that the forms of behaviour that have been at the base of an entire existence must find a synthesis. Here, in fact, what we have been during the previous stages of our lives enters the picture. In these moments there develops to the utmost the preparation

of an entire life for addressing suffering, pain, illness and death. If one has lived one's life with the wisdom of discernment, with the strength of courage and the calm of judgement, with respect and a correct assessment of what has been done, without jealousy and envy for other people, always giving meaning to the value of life, then limits are no longer an insurmountable obstacle but a moment that must be lived in a responsible way. It is certainly the case that it is not easy to speak in a credible way about illness if one has not experienced illness and the suffering and pain that illness produces. And yet specifically because of this fact we can affirm the value that it has for meaning about life. In the end credibility about ourselves is at stake, what one is and what one believes specifically at the moment when it is necessary to provide a response to pain. If one is not able to respond, one will not even be able to love. However paradoxical this may appear, suffering and love are always companions in life. Those who love know how to accept suffering in themselves and provide an answer to it that is full of meaning; those who love without loving will live in rancour and rejection without drawing near to a serene vision of things. When a culture is no longer able to provide an answer to pain, illness and death, it is destined for eclipse because it is no longer able to provide reasons for living in a dignified way. There returns with contemporary relevance the crude analysis of Pascal: 'Men after not being able to heal death, misery and ignorance, decide, in order to make themselves happy, not to think about them'.[2] If one does not know how to give love in suffering, one has to seriously ask oneself what love today's man is living. Pity is not love; this stops at deploring and compassion, whereas love communicates direct participation so that the person who is loved is never left alone.

Hope does not Disappoint

In this way one returns to the need for faith and hope as a condition for drawing near to the meaning of limits. When one lives a moment of suffering this is when hope comes into play. The firmness and the certainty of faith do not endure traumas if everything goes well; when the moment of suffering arrives it is then that certainty is subjected to a severe trial and the hope to which one clings enters a state of crisis. It is easy to observe this even in the various experiences that Scripture proposes to us: the exodus is seen as the great moment of liberation and yet as soon as the first difficulties appear, and hunger and thirst appear unforgiving, it is then that faith collapses and the altar is erected to the golden calf, with nostalgia for the ancient times of slavery. And how should we understand the lament of those who were deported to Babylon, for whom

singing hymns to the Lord no longer has any meaning, if not as a great crisis of hope on the promises that Jehovah made? The Prophets Jeremiah and Ezekiel had to arise to give again strength and certainty in the hope that the homeland would be reached. And is not the answer of the disciples on their way to Emmaus, 'But we had hoped that he was the one to redeem Israel. Yes, and besides all this, it is now the third day since this happened' (Lk 24:21), perhaps a lament of disappointment because of hope not fulfilled?

What is Christian hope? In a single line, which is as simple as it is dense in meaning, it is expressed by the Apostle Paul: 'Christ in you, the hope of glory' (Col 1:27; 1 Tim 1:1: 'Jesus Christ our hope'). The presence of Christ in the life of every believer – for Paul the believer and the Church are often used in an interchangeable way without any distinction – is the full and total mystery that God wanted to reveal and this is a source and object of hope. In other words, at the origin of Christian hope there is a full and total act, freely-given, of the love of God. In consists in the call to salvation through participation in His life itself. In the Christian approach, therefore, hope is not born with man. It is not primarily understood as a wish that opens to the future, the fruit of consciousness that tends to always go beyond itself while awaiting fulfilment. On the contrary: it is understood as a freely-given call that begins with the revelation of God. It is here that one perceives the novelty of our approach and discernment is achieved as regards every other form of hope that belongs to humanity as its peculiar effort to tend towards the future. To the extent to which one perceives the wealth of our heritage of faith and value is given to it, one will be able to take a step forward both in knowledge about mystery and thus in deepening faith, prayer and witness, and at the same time in contributing in an original way to the history of thought.

All of us can hope but it is the contents of hope that define an act and enable it to be understood as being different from feeling or utopias. As the philosopher Kierkegaard wrote in his diaries, even the person who wants to commit suicide hopes for a better life

and because of this hope engages in the madness of his action. But is that act really hope? Christian hope does not arise at the moment of need, suffering or dismay caused by various factors. If such was the case it would not be in the least different from general feelings or the desire to hold on to something as an extreme solution to evil. Christian hope, in contrary fashion, has as its travelling companions, who will never abandon it, faith and charity. An efficacious famous page written by C. Peguy reminds us of this: 'Hope is a baby girl from nowhere who came into the world last Christmas…And yet it is this baby girl who will traverse completed worlds…Small hope advances between its two older sisters and one does not even notice which one is married (faith) and which one is a mother (charity). And one does not notice, the Christian people does not notice, the two older sisters, the first and the last, and almost does not see who is in the middle, the baby girl, the one who still goes to school and walks lost amidst the skirts of her sisters. And it willingly believes that it is the two older sisters who hold the baby girl by her hand, in the middle, between them, to make her follow that road that is marked by salvation. Blind are those who do not see that it is she in the middle who brings behind her her older sisters'. Hope, to summarise, arises from faith and is nourished by love. Without this circularity, it would not be possible to understand the specificity of the hoping believer who lives by certainty and not by disappointment. In this context, it is interesting to observe the phrase used by the author of the Letter to the Hebrews when he has to 'define' faith. He writes in that verse that comes immediately after the one quoted at the beginning of this paper: 'Now faith is the assurance of things hoped for' (Heb 11:1). The term 'assurance' is a translation of the Greek *hypostasis* which means reality, substance! What faith hopes and waits for, therefore, is real!

The Apostle Paul for his part is extremely clear on this point. At crucial moments when he has to describe Christian existence he always puts together the triad of faith, hope and charity. Here a reference to three texts in which this teaching returns is sufficient: 'remembering before our God and Father your work of faith and labour of love and steadfastness of hope in our Lord Jesus Christ' (1 Th 1:3); 'put on the breastplate of faith and hope, and for a helmet the hope of salvation' (1 Ts 5:8); 'So faith, hope and love abide, these three; but the greatest of these is love' (1 Cor 13:13). Being certainty of the keeping of a promise, Christian hope 'does not disappoint' because it has its roots in love (Rm 5:5). In the same way, you can never be separated from love: 'Who shall separate us from the love of Christ? Shall tribulation, or distress, or nakedness, or peril, or sword?...No in all these things we are more than conquerors through him who loved us. For I am sure that neither death, nor life, nor angels, nor principalities, nor things present, nor things to come, or powers, nor height, nor depth, not anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord' (Rm 8:35-39). A more careful look at this text will enable us to further understand the characteristics of Christian hope that Paul describes despite the fact that the term does not appear explicitly.

A few verses previously the Apostle says that for those who live in faith and hope the condition of suffering of the present, with all its tribulations and wickedness, is not comparable to the glory that will be granted to them: 'I consider that the sufferings of this present time are not worth comparing with the glory that is to be revealed in us' (8:18). This glory is nothing else but the revelation of the Son of God, knowledge of his face or, to put it otherwise, the full revelation of the mystery that will lead to a contemplation that has no end. The future that awaits those who today hope and believe will not only compensate the present but will also and above all else rise above it in the intensity of happiness. Here, however, the question arises that today accompanies many of us: who will be able to guarantee all of this? Who will ever be able to provide a guarantee as to the justifying of this wait and the satisfaction of this hope? To answer this question the Apostle unexpectedly introduces the concept of freedom: both the creation and man, St. Paul states, await liberation from the 'slavery of corruption' (Rm 8:21). Christians as well, who have already been saved through the death of Christ, equally await the fullness of their salvation. This time that we are living, therefore, become the time of patient waiting: 'In the hope that we have been saved' (8:24). Patience, observes Paul, contains in itself hope, it stewards it, it strengthens it, and it progressively leads it to a more solid hope. What gives certainty to our hoping and constitutes the guarantee of the correctness of our waiting is the fact that the believer, specifically because he or she is a believer, perceives and 'feels' within himself or herself that he or she is still waiting for something. The presence of the Spirit of Christ in us does nothing else but confirm this prospect. Because we do not even know what is important as regards asking for our fulfilment, the Spirit comes to our aid in our weakness. There is, therefore, a dual guarantee for the certainty of our hope, the subjective guarantee, which is the 'feeling' of everyone of going towards fulfilment; and the objective guarantee, the presence of the Spirit that provides strength while we wait.

Let us return again to our text where Paul proposes the same question: who provides a guarantee for our hope and our victory over the suffering of the present? Who provides confidence to the Christian that current suffering will not be definitive and allow him or her to hope in the glory that will be given to him or her? The answer of the Apostle is immediate: God's love for us is the foundation, guarantee and support of our hope. It because of God's love that everything that today is a cause of suffering will be overcome. And Paul is fully entitled to speak in this way and he even lists the seven experiences of that concrete suffering that are certainly not imagined that he describes in the Second Letter to the Corinthians: 'Five times I have received at the hands of the Jews the forty lashes less one. Three times I have been beaten with rods; once I was stoned. Three times I have been shipwrecked; a night and a day I have been adrift at sea; on frequent journeys, in danger from rivers, danger

from robbers, danger from my own people, danger from Gentiles, danger in the city, danger in the wilderness, danger at sea, danger from false brethren, in toil and hardship, through many a sleepless night, in hunger and thirst, often without food, in cold and exposure'. (2 Cor 11:23-27).

Over all these sufferings there is not only victory but also triumph (*hypernikòmen*). However strong and powerful the forces of evil may be, the Apostle, and with him every other believer, 'is persuaded', that is to say he lives with an uncontested certainty that cannot be knocked down by anything – the hope of

faith in the present. In a few words one could say that in this approach all the suffering that is present in the world for the Christian represents not the pain of the end but the pain of being born: 'For the creation waits with eager longing for the revealing of the sons of God; for the creation was subjected to futility, not of its own will but by the will of him who subjected it in hope; because the creation itself will be set free from its bondage to decay and obtain the glorious liberty of the children of God. We know that the whole creation has been groaning in travail together until now; and not only the Creation, but we ourselves, who have the first fruits of the Spirit, groan inwardly as we wait for the adoption as sons, the redemption of our bodies (Rm 8:19-23). This is the certainty of love. As one can observe, Biblical hope appears to revolve round certain elements that explain it and define it: waiting, first and foremost, for the full and definitive revelation of the Lord; trust in his promise that he will come again and that where he will be we will be; patience, in addition, that does not give way to discouragement and knows how to persevere in suffering; and lastly the freedom to act with and in the Spirit that allows us to move in this world, foreshadowing the total liberation of the future.

Hope, to summarise, is not the fruit of the ephemeral or the passing; it proclaims, instead, stability and continuity. It is no accident that the Hebrew term to express this evokes the image of a 'drawn cord' (*tiqwah*). Those who hope are drawn towards a completing, they are totally dedicated to the task that is to be performed and do not allow anything or anyone to distract them from this task. A tension, therefore, towards a future as a moment of definitive realisation that already belongs to the present. The tension specific to hope, however, is not a feverish waiting or one full of anxiety about the uncertainty of what will happen. It is, rather, the ability to overcome the difficulties of the present and discover that one already possesses a gift.

It is no accident that Paul says 'So faith, hope and love abide, these three; but the greatest of these is love' (1 Cor 13:13). Therefore we need hope now in this existence because henceforth we are participants in the goods that we will possess in the future and we will contemplate in the future. No flight, therefore, no escape of any kind, in taking on responsibilities in present history. Hope acts here and now, here and now it requires to be lived; in daily life, in fact, it becomes a sign and an instrument of liberation. In this context there come to mind the words of Paul at the end of his Letter to the Romans: 'May the God of hope fill you with all joy and peace in believing, so that by the power of the Holy Spirit you may abound in hope' (15:13). This passage from Paul is significant because it seems to define the name of God as 'God of hope'. The God who in Jesus made Himself fully known is the God who brings hope. Is this not perhaps a serious clue by which we can also define the believer as a 'man of faith'? The 'God of hope' has a dual meaning.[3] On the one hand, this phrase could indicate that the God who is professed is He who generates hope, not the author; on the other hand, it expresses the idea that God is the subject of our hope. In both cases, the nature of believing hoping is revealed: it directs our gaze directly to God. The title 'God of hope', however, opens the mind to a further possible analogical interpretation: is the God of hope also the God who hopes? In a certain sense it is a good thing to be able to verify this dimension. It says that God Himself awaits the fulfilment of His creation and 'hopes' that the salvation given in Christ and realised through the sacrificial death of the Son has the widest possible dissemination. If 'God hopes', then man, too, has the right to hope. If 'God hopes', the strength and possibilities specific to hope cannot be taken away from anyone for any reason.

H.E. Msgr. RINO FISICHELLA,
Auxiliary Bishop of Rome,
Rector of the Pontifical
Lateran University,
the Holy See.

Notes

[1] R. GUARDINI, *Le età della vita* (Milan, 1986), p. 11.
[2] Cf. *Ibidem*, p. 59.
[3] B. PASCAL, *Pensieri*, 168.
[4] Cf. J. GALOT, *Il mistero della speranza* (Assisi ,1971), pp. 39-43.

IGNACIO CARRASCO DE PAULA

2.4 Our Responsibilities Towards the Sick Elderly

1. Premise: the Problems and the Analytical Approach

Responsibility is a concept with strong juridical and moral contents. It pre-supposes two apparently contradictory elements. Indeed, on the one hand, a person is responsible when he or she has a duty or an obligation to perform, independently of whether the obligation has been taken on voluntarily or under constraint. The duty to use truthful words is an example of this. On the other hand, only an individual who does his or her duty should be seen as responsible because it is he or her who decides to act and how to act at a practical level: nobody else can put the words in his or her mouth that he or she speaks, whether they are true or false. For this reason, a responsible person is a person who must account for his or her words and his or her actions, and responsibility is nothing else but an awareness that one must account sooner or later for what one has done and/or what one has not done but should have done.

Duty and freedom, therefore, are two constituent elements of responsibility. They are thus the fundamental reading cypher if, when one speaks about responsibilities towards the sick elderly, one does not want to fall into a facile moralism, but, instead, wishes to understand the real anthropological density of the subject and its moral implications at an individual and social level.

To speak about the responsibilities that exist between health-care workers and the sick elderly means: 1) recognising the human identity of both of these categories because only a human being, a person, can claim a right that becomes the duty of another person; 2) admitting that between these two categories there is a relationship of need/dependence; 3) accepting that this relationship is not symmetrical – it is clearly weighted in favour of the dependent subject – it is the sick elderly who need medical doctors and not the other way around; 4) the future of the relationship will fall first and foremost on the health-care worker, on he or she who is really free, is able to choose, can act etc., whereas the elderly person is always limited and incapable of looking after himself or herself, and it is specifically for this reason that he or she needs help.

Let us now try to see how these observations apply in the fabric of the health-care professions, whether the responsibilities that constitute the core of current medical ethics as well derive from an excellent philanthropic predisposition, from a no less specific sense of solidarity, or rather, spring from something that is deeper, something that is more ontological, such as, for example, the very identity of the health-care profession, the encounter between duty and freedom, duty and freedom that are not in the least abstract but established in practical terms by the nature of the two subjects who effect them, namely the health-care operator and the patient.

Given that it is clear that the observations that I have made hitherto in this paper are applicable to all patients – illness necessarily creates a need and thus a dependence – we should be careful to place at the centre of things the singularity of the elderly person who is a patient or the patient who is an elderly person.

2. The Health-Care Professions and their Responsibilities

The health-care professions are increasingly called to attend to an elderly population that is increasingly growing, this is a phenomenon that is fostered – as many authoritative speakers at this international conference have made clear – by the reduction, compared with the past, of fatal acute events, improved conditions of life and health, etc. Increased life expectancy is accompanied at the same time by a greater recurrence of illness, an increased incidence of chronic pathologies, various levels of disability, and thus, overall, by an increased need for health care. For example, it is calculated that about a quarter of patients over the age of eighty-five will be affected by some form of dementia, by other chronic-degenerative illnesses, or by disabilities caused by brain haemorrhages, accidents (including ones at home), depression, etc.

To summarise: we have to get used to the idea that side by side with the move towards progress, towards greater prosperity, if radical solutions are not applied – and I hope that this never takes place – there will not fail to be a countertendency: that of a society with an increasing number of people who are dependent because of their age and because of illness. At the same time, the reasons to shoulder greater responsibility appear to be in clear decline because spontaneous ties – for example family ties – are becoming rarer and those that derive from individual choices – voluntary work, paid professional activity etc. – show themselves to be insufficient. Thus the only safe support for relationships with dependent individuals remains *humanity*, the awareness that we share a common nature, that we belong to each other.

It is undoubted that medical science will make further advances – perhaps the elderly people of tomorrow will be immune to diabetes and cancer – but it is not unreasonable to think that life will always have an end and that the more that end is shifted forwards the more we will experience new illnesses, new disabilities, that is to say other forms of dependence, other sick elderly people.

The problem of an ethical character that accompanies this prospect is specifically that of responsibility because it is in these terms that will be played out the future of the already not unusual attacks on personal dignity that elderly people, especially if they are ill or particularly vulnerable, can be subjected to in the current systems of care and help (hospitals, old people's homes, nursing homes…). It is responsibility that will decide in what way the present complaints about care for the elderly, in particular in structures that are specifically intended for them but which not rarely are inadequate from a point of view of respect for, and sensitivity towards, the condition of the elderly, will disappear or at least be reduced.

Indeed, the problems relating to dependent human beings – whether elderly or otherwise – can be addressed only in two alternative ways: with responsibility or with irresponsibility.

Responsibility: this exists when the following facts are absorbed: 1. you are like me; 2. but you cannot go on alone; 3. we met specifically for this reason; 4. I do not rebuke you for your dependence, indeed I freely embrace my task as you embrace yours.

Irresponsibility: this already takes place when there is the denial of only one of these facts that have just been referred to. However, it is advisable to pay attention to one phenomenon in particular – usually one begins with refusing that one has responsibility towards the other but with time one ends up by denying or ignoring that the other is another self. This is what frees us from all responsibility in a total way and apparently without leaving any traces.

In our case, that of the sick elderly person, the irresponsible response stops for the present at the third or fourth step – we do not have a real relationship of responsibility. With the newly-born child, the prematurely born child, and above all the foetus, our society has gone further, to the point of denying their human nature.

Specifically from the experience that comes from prenatal diagnosis we have ascertained that the irresponsible response to a dependent individual has two faces: one is soft – I ignore you, I do not know who you are; the other is hard – I exclude you or I eliminate you. Fortunately, with the sick elderly person the hard response is rejected with horror by the majority of people; unfortunately the soft response is not: to ignore, to abandon, to exclude, to marginalise, when referred to elderly people, are verbs that recur in the pages of our newspapers.

3. The Status of Geriatric Medicine Today

It seems to me almost useless to clarify that what has been said hitherto in this paper is compatible with the fact that failings at the level of care are usually to be traced back to the lack of 'qualified' personnel and a lack of economic resources employed in this field. These factors, especially when they are combined with each other, can easily lead to situations of care that are not able to respond in an adequate way even to the most basic needs such as, for example, good practice in alimentation, hygiene, and basic assistance in general, thereby causing those examples of mortification of the dignity of the elderly person that are increasingly complained about.

However difficult it may be to understand the importance of the phenomenon, assuring elderly people have adequate standards of care certainly today constitutes a global problem. However I believe that these kinds of daily problems should be traced back not so much to the responsibility of individuals or institutions, in the strong sense that I employed above, but, rather, to what one could call the problem of the status of geriatrics today.

Care for elderly people is an activity that is certainly complex and demanding, both from a medical point of view and from the care and ethical point of view. From a medical point of view, advanced age is characterised by physical and mental resources that are in general diminished compared to the age of young adults, by greater vulnerability to attacks by illnesses and by longer periods of convalescence. Diagnoses can be more difficult because the symptoms tend to express themselves in a vague way and very often situations involving more than one malady are present. In addition, the close link between age and clinical symptoms often makes it difficult to distinguish between the existence of a pathological alteration and changes that are linked physiologically to age. All of these factors put together involve difficulties in identifying what the adequate level of intervention should be in the case of individual patients.

The complexity of the medical problems of elderly people and consequently the high level of professionalism that is required in this field could lead one to think that medical science as applied to elderly people is held in high regard. Instead, it is the case that specialisations in geriatrics wrongly have very little prestige amongst medical doctors, differently, for example,

from heart surgery, transplants or neurology. This fact reflects, albeit indirectly, the way in which elderly people are seen by medical science, by the health-care services, and more in general by society.

At least some of the difficulty that care for the elderly experiences, and this is a point that should be emphasised, is a result of the low level of resources that are invested, and this further helps to distance medical doctors, nurses and health-care personnel as a whole, who are understandably attracted by other areas of medicine where professional gratification is more easily obtained, from this sector. To this we could add a cultural aspect of the medical profession, whose principal priority has always been to save people's lives, whereas any significant 'heroic' meaning to the 'mere' looking after a sick elderly person is today much less acknowledged. I do not know whether one day we will see a television series on these matters.

We may thus state that care for the sick elderly certainly does not constitute today a priority of medical science, despite the fact that these patients often clearly require specific medical care and treatment.

4. Constructing Responsibility towards the Sick Elderly

What, instead, is the responsibility that medical science has today towards sick elderly people? This question has already been posed and it will be posed again over the next three days of this international conference. We have listened to authoritative and pertinent answers. For this reason, in relation to the answers that I believe to be most relevant to the analysis that has been presented in the first part of my paper, I will confine myself to pointing out two, two responsibilities or two tasks for which medical doctors will have to give account to history. Allow me, however, to make a preliminary observation: it is not only the sick elderly who are dependent individuals – medical doctors are dependent individuals as well. A medical doctor is dependent on his or her teachers, he or she is dependent on society, he or she is dependent on the demonstrations and experience of responsibility that have met or have not met his or her needs. The law and morality ordinarily mean by responsibility a personal fact, probably out of respect for the freedom of the individual, but we know that there are many fine threads, invisible threads, that tie together this extraordinary and immense family of mankind.

The first responsibility can be none other than that of respect for the dignity and autonomy of the elderly patient, that is to say recognition of the first statement invoked above. Indeed, when faced with someone who is naked in his or her dependency, the immediate response should be: you are like me, always and in all situations you are a person, you deserve to be esteemed by me unconditionally.

Why this emphasis on the elderly patient? Certainly because it is in the condition of life of an elderly person – one may think here of dementia – that there is expressed a high level of dependency, *but even more* because we are faced with a human nature that has been upset by an irreversible process that first weakens and then cancels one after the other the signs of humanity that up to that moment protected the dignity of the person.

Dignity and independence are two aspects that are connected: a way of offending the dignity of a patient is certainly that if treating him or her as a non-autonomous individual; however the dignity of a patient is frequently attacked by violations of his or her privacy as well and, more in general, by a relationship that is not attentive to the real needs and wishes of the patient.

Frequently an elderly person experiences, even in the absence of illness, a progressive loss of his or her autonomy and independence which almost always, at least at the outset, causes in the individual who is involved (but not rarely also in the outlook of those who surround him or her) a threat to the perception of his or her dignity. In some cases, as for example in forms of dementia, the loss of autonomy and independence can involve a rapid progression, without leaving the person who is affected by it, or even his or her family relatives and acquaintances, the time to adapt to the new situation. Often because of the appearance of alterations of a mental kind, the person is seen, in people's attitudes if not at the level of words, as an individual who is no longer useful, who can no longer be relied upon, even as a person without self-control, and on a par with children.

The gravest loss is that of autonomy which, at the same time, is the principal source of dependence. The aphorism of medical ethics, 'yes to help no to replacement', applies more than ever before. The patient does not need a recognition by other people of his or her right to autonomy – that right by its nature cannot be cancelled, even though it can almost not be demonstrated at the level of facts. His or her autonomy, concealed by old age and infirmity, does not need to be ignored or replaced by the autonomy of another person but, rather, only accepted and helped. In this context of care, health-care workers must develop a strong sense of moral commitment to the needs of others and specifically on the basis of this taking on of responsibility they should from time to time support old and sick human beings who at that time depend on their care and treatment. It is said, and there some truth in this, that the outlook of the other can become the least objective and most pitiless mirror in the world. Instead, it is always true that when a sick person manages to fix his or her gaze on a medical doctor he or she does not see his or her face but, rather, his or her real 'value', that is to say if he or she is someone who still deserves esteem.

The second responsibility relates to an effective response to the need generated by the pathology involved and by ageing. In caring for an elderly person there is certainly the difficulty of identifying a clinical level that is suited to avoiding the excesses of treatment – which can reach the point of hindering a serene death – as there is that of an insufficient level of care – the forgoing of forms of treatment (above all specialist visits and rehabilitative initiatives) is indeed an approach that is rather frequent, being fostered both by a widespread pessimism on the part of medical doctors in relation to elderly people (today this is almost a stereotype of medicine) and, as has already been pointed out in this paper on a number of occasions, by the scarcity of the resources that are available in this field.

As regards medical decisions and the identification of the right level of care, the greatest difficulties relate to the decisions that have to be taken during the final stages of life when family relatives often call insistently for the application or removal of intensive measures – in this kind of situation it can turn out to be more difficult for the medical doctor to abstain from further measures in order to allow the patient to have a serene death, something that is at times requested by the patient himself or herself.

Perhaps more frequent is the risk that an elderly patient will be neglected or allowed to go too early. However, it is also possible that one will fall into the opposite excess of a form of treatment that is not longer reasonable and which condemns the poor patient to pass from the hands of one medical doctor to those of another without being able to obtain any real benefits. The identification of the right decision to be taken between an excessive prolongation of forms of treatment and an interruption of treatment that is too early, will, however, remain, an eternal conflict of medical science, above all as applied to the elderly.

It is obvious that amongst the objectives entrusted to my paper we do not find the question of the suspension or rejection of life support systems. For that matter, this is a question that is raised primarily in other contexts. Equally, I have avoided an approach that has by now become fashionable when reference is made to responsibility in the field of health and health care and which involves a one-directional process directed towards finding one or more guilty parties and, to put it better, deciding whether they can be made into satisfactory scapegoats. The responsibility of the structures, the institutions and even of the organisation of health care is a question that goes well beyond moral categories because they involve factors of an economic, social, cultural, political and even religious kind. However, here reference is made to responsibility that is in part conventional, in a certain sense arbitrary, which is said to require being treated not so much as a need of human nature but as a condition required by the common good in a specific place and moment in history

I will stop here and end my paper with a number of brief *additional observations*:

1). One problem that health-care workers are today called to address in an urgent way is that of raising the standard of care and treatment that is provided to elderly people. The quality of health care provided to the elderly should not be considered solely as a matter of structural factors – which are, nonetheless, important – but also as the responsibilities of individual health-care workers in the sense and relevance with which I think I have addressed the question in this paper.

2). The greatest challenge for health-care workers, today, more than the identification of the right level of care and treatment to be provided to sick elderly people, is that of upholding the importance of the elderly person as a subject of the human community to the full even though he or she appears only to receive and not to offer anything.

3). The recognition that the elderly person is a subject to the full and the quality of relationships with him or her are the key aspects of health care for the sick elderly that contemporary geriatrics has rediscovered and adopted.

4). The moral responsibility of health-care workers, differently from their juridical responsibility, is not measured so much by technical-professional capacities as by the condition of dependence of the sick elderly person, by the needs of a human being who has been struck down, perhaps irreversibly, by old age and illness.

5) Medical training and training in the field of care today are not sufficiently well grounded, from many points of view, to address the provision of care and treatment to sick elderly people, with obvious repercussions for the quality of health care and treatment that is provided. In addition, the hyper-specialisation of medical training increasingly distances future health-care workers from an ability to address and manage the complexities of clinical cases with multiple pathologies, which, indeed, are typical of elderly people. Greater attention in the field of professional training to the problems and characteristics of elderly people can only have a positive effect on the approach of health-care workers and heal that situation of marginalisation that today elderly people easily experience at a social, family and even medical level.

Msgr. IGNACIO
CARRASCO DE PAULA,
Chancellor of the Pontifical Council for Life,
Director of the Institute of Bioethics,
The Catholic University of the Sacred Heart,
Rome.

3. Inter-religious Dialogue on Sick Elderly People

ABRAMO ALBERTO PIATTELLI

3.1 The Jewish Perspective

To address the questions and issues connected with the condition of elderly people, above all during our epoch, means for a Rabbi, as well, to find oneself faced with a complexity of topics, each one of which would deserve a special analysis.

Indeed, we have problems that relate to the psychology of ageing and the prevalent tendency to marginalise the elderly from the social fabric, with contempt for experience, wisdom and the possibilities at the level of work for people of an advanced age. Once the age of retirement has been reached an elderly person is offered some presents because of the services that he or she has provided and those who have given such presents are no longer interested in that elderly person.

Loneliness, the possibility of filling the day with meetings with other people or finding something to do becomes a source of worry for the elderly person who in this way grows older every day.

The Jewish community, as well, in its activities involving care for its members has to face up to these problems. The invocation of the psalmist is full of contemporary relevance: 'Do not abandon me now that I am old, do not leave me now that my strength has gone'.

However, it remains to us to follow the fundamental lines of tradition so that these can bring out for us forms of behaviour and above all motivation for our conduct.

In the Jewish tradition the relationship with elderly people follows two directives: on the one hand, attention is paid to the respect that is due to elderly people; on the other, the forms of care that we are called to provide to these individuals is highlighted.

The fundamental Biblical text which shows us that every person is called upon to respect the elderly is the text that we find in the famous chapter on holiness in Leviticus: 'You shall rise up before the hoary beard, and honour the face of an old man' (19:32). And it adds by way of a seal: 'and you shall fear your God: I am the Lord' (*ibid.*).

It is interesting to observe how the figure to which the Biblical text refers is identified with the wise man, the sapient man. Through an anagrammatic exegesis, the *zaken* (the elderly man) becomes *ze shekanà chochmà*, that is to say he who has acquired wisdom. The *sevà*, the hoary beard, an honourable advanced age, according to Proverbs (16:31), 'is gained in a righteous life'. One is dealing here, therefore, with that maturity of wisdom that is acquired through the study and experience of life. We are called upon to give honour and respect to these people.

The most widespread defect to be found in elderly people is loss of memory. In Jewish ethics emphasis is laid in a very strong way on not ridiculing a teacher who by chance does not remember something relating to his studies or his research. One remembers, in fact, how inside the Holy Ark, of biblical memory, there were both the Tablets of the Law and the fragments of the first tablets received by Moses from the hands of God on Mount Sinai. The esteem and honour reserved to a wise old man must be accompanied by an attempt not to marginalise the elderly; indeed, they must be continued to be seen as an integral part both of their families and of the social fabric.

In a passage from Ecclesiastes where, after a certain fashion, old age is much praised, one reads the following: 'All this is observed while applying my mind to all that is done under the sun' (8:9). These words mean that wisdom acquired through experience of life is beneficially handed on to subsequent generations. But unfortunately old age is not always a pleasant condition. Most of the time it is synonymous with weakness, illness and physical and mental deterioration, We may remember the description of old age provided by Ecclesiastes: 'Remember also your Creator in the days of your youth, before the evil days come, and the years draw nigh, when you will

say, "I have no pleasure in them"; before the sun and the light and the moon and the stars are darkened and the clouds return after the rain; in the day when the keepers of the house tremble, and the strong men are bent, and the grinders cease because they are few, and those that look through the windows are dimmed, and the doors on the street are shut; when the sound of the grinding is low, and one rises up at the sound of a bird, and all the daughters of song are brought low; they are afraid also of what is high, and terrors are in the way; the almond tree blossoms, the grasshopper drags itself along, and desire fails' (12:1-5)

But great and tenacious should be the trust directed towards the elderly person. Simon, the son of Eleazar, repeated that if an elderly man tells you 'destroy', and a young person says 'build', you should destroy because the destruction of an elderly man is always construction and the opposite for an inexpert youth.

In the view of Scripture, the service of Levites at the Tabernacle was limited by age – until the age of fifty they performed this activity but after that age they were reabsorbed into family duties (see Numbers 8:25).

In Jewish society, ever since the time of antiquity, the elderly have been surrounded by special care and concern. A place of importance was attributed to them both within the family and within society. That 'council of elders' which frequently recurs in the Biblical texts and in subsequent traditions was certainly not a mere choreographic or honorific assembly. In the same way as role of an elderly person within the family was to be identified totally with the relationship to be maintained with parents.

The organisation of the Jewish community has always shouldered responsibility for the needs of the elderly; to them have been extended those forms of solidarity that were envisaged since Biblical times for widows, orphans and those in need in general.

It is interesting to observe how beginning from the high Middle Ages there were decisions taken by the organs of communities to help elderly people. The particular conditions of the diaspora of the Jews meant that the frequent persecutions led to the dissolution of the family unit because the first to suffer were specifically the elderly, the most prone to suffering and malaise. We are dealing here were ensuring the elderly help and above all the security of being able to continue their religious observance, to respect every form of Jewish life, and above all not to run the risk of being in an underhand way taken away from loyalty to the faith of their fathers. Thus it was that above all from the beginning of the eighteenth century we can witness the emergence of well-defined structures designed to give hospitality and assistance to elderly people in various Jewish communities in Europe.

In an epoch such as ours when generational ageing has become a major contemporary problem, in an epoch in which the marginalisation of every weak individual and the elderly in particular is a reality that can be seen by everyone, care for the elderly is a question that concerns each member of society and not only because everyone, thanks to the will of God, is destined to pass through this stage of life. Thus the Biblical words to the effect that 'You shall rise up before the hoary beard' impose the (not only moral) duty to care for the elderly and to organise every initiative possible to help them.

Prof. ABRAMO ALBERTO PIATTELLI,
Chief Rabbi of the Jewish Community of Rome.

MIGUEL ÁNGEL AYUSO GUIXOT

3.2 The Islamic Point of View

Introduction

For Muslims as well the world is not the outcome of chance or of need but of a wonderful project whose secret is known by God because He is its origin and its end. True Muslim believers thus have the duty to ensure that the world achieves and in the end perfectly corresponds to everything that God created it for. This, in fact, is a dynamic project in which God has decided, freely and with love, to turn to human cooperation.

It follows from this that the Muslim believer as a 'vicar' of God on earth, called to true submission to Him, is invited to defend and steward human dignity, and thus first and foremost there is the 'dignity of life' which has to be stewarded and preserved from birth until death.

Thus in his human adventure a Muslim feels himself especially responsible for his brothers in humanity at the level of the defence of their dignity. This, evidently enough, leads him to have the greatest care for sick people, with absolute respect for the biological functions of their bodies,[1] aware that illness is a part of human existence and as such is a part of the general economy of the universe which is seen in Islam as being extremely balanced.

For Muslims, God has envisaged a cure for every illness, as emerges from the statement of the Prophet Mohammed: 'God has never sent an illness without sending a remedy for it'.[2] Hence, also, careful care for elderly people.

1. The Foundations: Honouring Parents – Care for the Sick

In all cultural and religious traditions the invitation to honour the elderly is seen as a universal obligation. This extraordinary ethical value should be applied both to the elderly and to those who accompany, help and treat them.

Thus with respect to illness and the sunset of life Islam, too, proposes messages of God and the Prophet which are very fine and are concise as to how the Muslim believer should act. I will here give some illustrative and symbolic quotations from the two principal sources of Islam, namely the Koran and Islamic Tradition *(Sunna).*

In the Koran, the Holy book of the Muslims, God says: 'Your God has decreed that you should worship none but Him and that you should treat your parents well. If one of them, or both of them, reaches old age with you do not say to them 'Oh!', do not rebuke them, but give them words of sweetness. Bow before them the meek wing of submission and say: "Lord, have pity on them, as they had with me, bringing me up when I was little"'[3]

In Islamic Tradition, which contains the sayings and the deeds of the Prophet Mohammed, we can find a large number of traditions or *hadiths* in which explicit reference is made to the sick. One example alone: according to Abu Hurairah (may God be pleased with him), the Messenger of Peace (may peace and blessings be upon him) said: '"The rights of Muslims over Muslims are six in number". A man said to him "And what are they O Messenger of God?". He answered: "When you meet a Muslim greet him; when he invites you, accept his invitation; when he needs advice, give him advice; when he sneezes and praises God, say to him: may God have mercy on you; when he is sick, visit him; and when he dies go to his funeral"'[4]

It therefore appears clear that for the true Muslim believer taking care of one's parents, especially if they are elderly, like visiting and treating the sick, are true moral obligations, injunctions of God and the Prophet of Islam.

2. Some Approaches: Respect, Patience and the Acceptance of Suffering

The true Muslim believer is constantly called by God and Tradition to be concerned about those who are in need. Thus, visiting the sick is highly recommended by God who will bestow numerous blessings both upon the sick person and upon those who go to visit him. The approach of a believer to the mystery of human suffering must be based upon respect, patience and a serene acceptance of his situation.

Respect for life
and respect for the sick

First of all, respect for life. Indeed, the Prophet Mohammed manifested the high value that a

Muslim must give to life in line with the implementation of divine will. The Prophet said: 'Absolutely none of you should wish for death after an injury that has afflicted you. And if you cannot do otherwise then say: Lord, keep me alive as long as life is a good for me and let me die if death would be better for me'.[5]

Then respect for the sick through intercession and care. Indeed, a true Muslim believer when he goes to visit a sick brother or sister is invited to intercede with God for him or her. According to another *hadith,* during a visit to a sick member of his family, the Prophet (may peace and blessings be on him) touched the sick man with his right hand and said: '"O God! Lord of humanity! Make this malady disappear from him and heal him! You are the Great Healer. There is no healing other than by You"'[6]

There can be no doubt that Islam openly invites us to treat our parents and the sick elderly with dignity and respect. This dignity and

honour for advanced age is required by God who in the Koran points to our weak human nature: 'It is God who created you from a very weak thing and then gave strength, and then this strength followed by weakness and grey hairs. He creates what He wants, He is the Wise Possessor'. [7]

Patience

Secondly, patience. Another feature that marks out the Muslim believer is patience *(al-sabr)* which is to be linked to the term 'submission' *(islâm)*: one abandons oneself to God through submission and acceptance of His will. Thus patience/acceptance[8] leads the true believer to a state of peace and serenity and thus to virtue *(al-birr),* thereby learning to accept every situation, whether it is good or bad, to accept illness as a necessity, because to be patient is a gain and complaining is no use at all.

The serene acceptance of suffering

Lastly, acceptance of one's own situation of suffering. Suffering is in the heart of every human life and traditional reactions in affliction are concentrated on the patience/acceptance of the believer who will easily say: 'Praise be to God! He does as He wishes; I accept with patience what He orders; acceptance is the key to paradise. God is with the patient *(Allâh ma' al-sâbirîn)*; He must be praised in good and evil'. Perfection for a sensible Muslim lies, by accepting his suffering, in praising the God who makes him suffer, in recognising His divine omnipotence, and at the highest level of suffering in repeating: *al-hamdu lillah!* (God be praised!) [9]

In this way, in his acceptance at moments of affliction, the Muslim believer finds comfort because the patient bearing of his affliction expiates his failings and thus discharges his debts. Indeed, the Prophet experienced afflictions as a part of his religious experience and thus provided a positive vision of illness itself when he proclaimed: 'Yes, for all suffering undergone by a Muslim, God cancels his errors; they fall like leaves from a tree'.[10]

3. Witness

At this point it is appropriate to recall the experience of Sheik Mahmoud Hammâd Shuayda, the *imâm* of the Great Mosque of Rome who died in May 2006 at the Fatebenefratelli Hospital to which he had been admitted because of a grave illness. Testimony as to his serenity and patience when faced with suffering and death are notable, and the same may be said about the Muslim believers who accompanied him at his bedside. In addition, the sincerity and sincere sadness of Muslims, Jews and Christians at his death were an evident testimony to the importance that the believers of the various religious traditions give to life and to the acceptance of suffering and illness with serenity and patience.[11]

4. Some Virtues in Behaviour towards the Sick

A classic Muslim theologian, al-Ghazâlî, in his great Compendium on the religious sciences[12] devotes a whole chapter to the question of rights and duties in relation to one's family. Referring to a series of *hadiths* of the Prophet he argues, amongst other things, that the most excellent virtue is that of paying visits to one's family relatives even if they have neglected, forgotten or abandoned you: 'The best virtue is to pay a visit to those who have abandoned you, to give to those who have taken from you, and to forgive those who have done you an injustice'[13]

In another *hadith*, emphasis is given to the civil and moral excellence of those who respect and honour their parents, a virtue which is greatly exceeds that of the duties of worship. Indeed this *hadith* says that 'Honouring one's parents is greater than prayer, alms-giving, fasting, pilgrimage and *jihâd* on the way of God'. There is also a *hadith* that goes beyond this and advises honouring the memory of one's father by continuing to love

and pay visits to the friends that he had when he was alive: 'most excellent respect for one's father is continuing to visit the family of the friends of one's father after his death'[14]

5. Inter-religious Dialogue in Relation to Illness: a Common Value, a Shared Value

In order to live in a climate of esteem and friendship, Christians and Muslims must always search for common and shared values through inter-religious dialogue.

When faced with illness and suffering, Christians and Muslims are obliged to help all human beings without distinction, and each in his own most concrete singularity, because 'man on earth is the only creature that God willed for himself'.[15] And the best way of serving this dignity is through the defence of life. As a consequence, Christians and Muslims should be particularly concerned about those who are afflicted and they should demonstrate compassion, love, affection and devotion towards them. Through this shared respect for the body and the importance attributed to human life, Christians and Muslims also bear witness to their spiritual vision of man, gratitude for the gifts received from God and hope in 'resurrection on the last day'.[16]

Special emphasis should be laid on the cooperation between believers in active participation in the specific works of care that Christians and Muslims have developed in the world. Through these works, living witness is borne to service to suffering humanity. Reference should be made to cooperation at the level of hospitals and of health care that has been developed throughout the world, and in particular in places that are less favourable to dialogue and to cooperation at the service to life and against illness. We know of very many people, Christians and Muslims alike, who bear witness to this special devotion of care for the sick and the elderly, a devotion that makes us feel called by one God to service to a single humanity.

6. Conclusion

Thanks to advances in the field of medical care and nutrition, which were developed in particular during the twentieth century in order to improve quality of life, the number of elderly people has increased notably. This has led the United Nations to become interested in this question which, although, on the one hand, it is the outcome of achievements by humans, on the other, has required special policies which began in 1982 with the International Action Plan for the Elderly,[17] and continued thereafter with the principles of the United Nations for the Elderly.[18] We may also recall that 1999 was the International Year for the Elderly.

Muslim believers, for their part, have been very much interested in all these initiatives of the international community directed towards meeting what their religious traditions see as a moral obligation. I would like to describe this obligation by narrating a popular story, which reads as follows: 'An old man aged eighty was sitting on a sofa with his son who was forty-five years old, a man with a degree, when a crow perched on the window. The father asked the son "What is that?", "A crow", replied his son. The father then asked him once again "What is that?", and his son replied once again "A crow". Later the father asked his son once again "What is that?" His son, who by now was angry, replied 'Oh, a crow. Have you not yet understood?" After a few minutes the father went to his bedroom and came back to the living room with an old diary in his hand which he had kept ever since his son was born. He sat down, opened the diary, and asked his son to read from the page he had chosen. The son began to read it and found the following words: 'today my little boy aged three was sitting with me on the sofa when a crow perched on the window. My son asked me twenty-three times what it was and twenty-three times, without any irritation or difficulty but with great tenderness and patience, I told him that it was a crow'. The moral of the tale? If your parents grow old, do not reject them or think that they have become a burden for you but, instead, be affectionate and kind, meek and obedient, humble and generous with them; and do everything to keep them happy, loved, esteemed, and respected.[19]

I will end with a quotation from the Koran which every believer subjected to affliction should, it seems to me, adopt as his own: 'Give good news to the patient! When they fall into misfortune they say "in truth we are of God and to Him we will return!" They will have the blessings of their Lord and mercy: they are well directed on the Path'.[20]

Rev. MIGUEL ÁNGEL
AYUSO GUIXOT MCCJ,
Dean of the Pontifical Institute for Arab and Islamic Studies.

Notes

[1] See M. BORRMANS, *Orientamenti per un dialogo tra cristiani e musulmani* (Urbaniana University Press, Rome, 1991), p. 127.

[2] See V. VACCA, S. NOJA, AND M. VALLARO, *Detti e fatti del Profeta dell'Islam, raccolti da al-Bukhârî,* (UTET, Turin, 1982), p. 559, quoted by F. Zannini, *Ahmed, il mio vicino di casa, guida alla conoscenza dei musulmani* (ISCOS Marche Onlus, Ancona, 2002), p. 274.

[3] Koran 17, 23-24. Translation into Italian of the Koram by Alessandro Bausani, BUR, Milan, 2004.[15]

[4] Muslim, 39, 5. See *Sahîh Muslim,* Ed. 'Abd al-Bâqî, al-Qâhira 1955-56, vol. 4, p. 1705.

[5] See V. VACCA, S. NOJA, M. VALLARO, *op. cit.*, p. 557.

[6] AL-BUKHÂRÎ, 75, 1. See Sahîh al-Bukhârî, Ed. Ibn Ismâ'îl (Leiden, Brill, 1862), vol. 4, p. 49.

[7] Koran, 30, 54.

[8] See for example 'La patience-résignation du musulman', *Comprendre* saumon 33 (1960), p. 11.

[9] See JEAN DÉJEUX, 'Le musulmans et le mystère de la souffrance' *Comprendre* bleu 40 (1965), p. 4.

[10] See V. VACCA, S. NOJA, M. VALLARO, *op. cit.,* p. 557.

[11] See the article by PAOLO BROGI, *Corriere della Sera,* 22 May 2006.

[12] Cf. GHAZÂLÎ AL-, ABÛ HÂMID, *Ihyâ' 'ulûm al-dîn* (Dâr al-Fikr, Lubnân, 1999), volume 2, pp. 186-187.

[13] AHMAD B. HANBAL, *al-Musnad,* V, 309.

[14] Muslim, 45, 11-13.

[15] *Gaudium et Spes,* n. 24.

[16] See, M. BORRMANS, *op. cit.,* p. 127.

[17] See Resolution of the United Nations 37/51 of 3 December 1982.

[18] Annexe to resolution 46/91 of 16 December 1991.

[19] On popular thinking about suffering see ANDRÉ FERRÉ, 'Il problema del male e della sofferenza nell'Islam', in AA.VV., *Liberaci dal male. Male e vie di liberazione nelle religioni* (EMI, Bologna, 1983), pp. 62-65.

[20] Koran 2, 155-157.

SUKLA DEB KANANGO

3.3 Care of Elderly Sick People: the Hindu Ethos

Introduction

Hinduism is one of the oldest religions of the world. It is a religion and a way of life.[1] As a way of life 'every important event of Hindu life has to be sanctified through religious observance'. A Hindu is expected to perform certain tasks, fulfil certain responsibilities and duties towards himself as well as towards others, aspire for those goals in life which will ensure holistic welfare, and pursue these goals commensurate with the norms enunciated by the Hindu religion. Hindus believe in the rebirth or reincarnation of the soul and therefore they are expected to be conscious of the deeds in the present life which should enable them to enjoy the good results in the next life should they have to go through another one. As Hinduism is regarded as a way of life, service to the needy has never been thought of as a special effort to be made but the normal and natural duty of an individual. The history of this religion, therefore, reveals that there has never been what is called organised social service in Hindu religious practices. As service to the needy is regarded as a duty of every Hindu, the religion also enjoined upon kings the responsibility of protecting and looking after the needs of those who are without support in times of emergency. It was considered a moral duty of the king. If a king failed to do this, he was viewed as immoral and irreligious.

Significant Tenets of Hinduism

The phenomenon of service to society as a communitarian effort dictated by religious sentiment could be observed among the Hindus mainly towards the later part of nineteenth century and in the early twentieth century. It is also true that evidence of philanthropic work carried out by individuals prior to that period exist. In order to respond to the subject matter of this conference – care for sick elderly people – it would be essential here to refer to two significant tenets of Hinduism. These are the doctrines of '*Dharma*' and '*Chaturashram*', which merit some discussion here.

The Doctrine of Dharma

In common parlance '*dharma*' means religion – the observation of religious practices and duties such as worship and related matters. '*Dharma*' is also used in another sense – ethical principles or simply ethics. Hindu scriptures dwelt at length upon the code of ethics to be followed by a Hindu in the different spheres of life. There is a dictum in Hindu ethics which says, 'whatever you do, do it in a truthful and righteous manner'. It says, '*Dharma charh*' – your conduct should reflect that you are truly following *dharma*. In a significant provision *dharma* maintains discipline in society.[2] It is said that the society which does not observe ethical codes is not sustainable and perishes before long. Immorality becomes the foundation of such a society; it is devoid of morals and cannot hope to progress truly. As Axel Michaels mentioned 'Dharma is what holds the world together and supports it, the eternal (sanatan) look, the "order in consummation". The Dharma applies to humans and animals but also to elements; it includes natural and structural order, law and morals in the broadest sense'.[3] It may be mentioned here that in every sphere of human life how an individual should conduct himself has been laid down by Manu (a seer), the Law Giver of the Hindus. The scripture which contain these laws is known as '*Manusamhita*'. The two tenets mentioned here are explicitly noted in this scripture.

The Doctrine of Chaturashram

An important tenet of Hinduism is that life has to go through four stages and in each stage an individual's residence is different. The Hindu term of residence is '*Ashram*'. The responsibilities and duties that one has to perform also differ according to the stage one is passing through.

Ashrams in four different stages of life are called:

Brahmacharya – the first stage when an individual is required to reside in a teacher's residence and pursue knowledge under his guidance. This is a period of studentship.

Garhasthya – this is the stage of householder when an individual is expected to marry, raise his/her family and perform the duties of a householder such as bearing and rearing children, support and care for parents and other elderly and relations when residing together. In a sense, the nurture and taking care of those who are naturally dependent on the householder. Therefore, according to Hinduism elderly members are part of the family, it is their rightful place and it is the duty of young adults to take care of them whether they are able-bodied or suffer some disability – physical or otherwise.

Vanaprastha – this in the third stage of life, known as *Vanaprastha*, when the residence of the person is the forest. That means the leaving of home and hearth of an individual, either with or without his wife, leaving her in charge of his son(s), and abiding in the forest and leading an almost

ascetic life, withdrawn from the responsibilities of householder.

Sannyasa – this is the last stage (fourth stage) where the individual becomes a wanderer and an ascetic, the ultimate goal being the realisation of the self and salvation of the soul.

An important observation to be made here is that the Hindu religion extensively suggests how the elderly should lead their lives in old age. It is moving forward, looking ahead, and striving to discover how they can realise their selves, reaching that ultimate state of freedom from bondage of all kinds, and salvation. Not bothering at all about what or whom they have left behind in their previous stage of life, i.e. *garhasthya*. That is, to be completely detached from all that concerns family life.

The Place of the Elderly and Care for the Elderly in Hinduism

In order to understand the place and space an elderly person occupies in Hindu society one has to understand Hindu family life, which is what the second stage, *Garhasthya*, signifies rather than *Vanaprastha*, which is the stage when one is considered old and should retire from active life.

Manusamhita extensively and specifically laid down the duties and responsibilities of a householder (*Garhasthya*). In a sense this Hindu scripture is quite prescriptive as it mentions what ought to be done and what should not be done in a specific situation. Here also the householder has to follow the *Dharma* of a householder. '*Dharma*' is a relative term that always refers to special circumstances. 'This is righteous and that is unrighteous' (explains an old legal text).[4] Hence the householder has to be mindful in his action and behaviour, otherwise he will fall prey to unrighteous action whose consequences will not be desirable nor beneficial.

Worship and regular study of the Vedas, earning a livelihood through honest means, the bearing and rearing of children, honouring guests through proper hospitality, respecting elders and taking proper care of parents and other relatives who live with him, are among the many duties that a householder has to perform. In fact, nowhere in the ordinance of Manu (Manusamhita) no specific mention of care for the parents is found except when there is a reference to making gifts ('*dana*') to parents. This scripture gives details of who are fit persons to be given gifts and who are not. Parents are placed as the first; gifts to parents leads to rewards.[5] These rewards also imply the ultimate, the passage to heaven.

Observing this silence about care for parents one cannot help concluding that parents are an integral part of the family and therefore it goes without saying that they should be looked after and taken care of by the householder (Garhasthya). However, if we refer to the epic Mahabharata we do find mention of how, in their old age parents and elderly members of the extended families are to be looked after and taken care of by the householder (meaning the son/nephew etc. of the elderly). In an extensive account of the details of the duties of a householder towards his parents and other elders given in the epic Mahabhrata, the renowned Sanskrit Scholar, Sri Sukhomoy Bhattacharya Sastri Saptatirtha of Visva Bharati,[6] mentions that among all teachers (Gurus) parents are considered superior and are referred to as '*mahaguru*'. Just as parents rejoice at their children's achievements in life, so also the children's welfare ('*mangal*') is assured in this life and life afterwards if they serve their parents with all respect and humility. Mention also is made of other elderly people such as teachers, older brother(s) and older sister(s) who should be attended to and looked after; indeed, nursed if need arises.[6] Their satisfaction is the householder's reward. Children who do not provide for the day-to-day needs of the parents are sinners. They are fallen human beings who desert their parents without reason. Children are never to hurt the feelings of their parents. Mention here is made not only about the elder brother(s) but even his wife who should be looked upon as equal to one's mother in the same way as an elder brother should be seen as being equal to a father.

There is another reference made to widowed sisters in Mahabharata by the above scholar. A widowed sister without any support is to be provided for and she is to be well looked after wherever she lives by her brother(s). Pandava Yudhistira, the oldest of five brothers (as depicted in Mahabhrata) ,looked after not only his mother Kunti in her old age but also his paternal uncle and aunt, Dhritarashtra and Gandhari, as well as his great uncle Bhisma, until all of them opted for Vanaprastha (dwelling in the forest).

Hitherto my discussion of care for the elderly has focused principally on parents. This is because of the question of who should take care of parents when they become

old. Obviously care of the elderly has become an issue today as more and more elderly parents are seen to be without the care and support of their families as the extended family has given way to the nuclear family, thereby impinging on many vital spheres – the decreasing numerical strength of the family and consequently a decline in the resources that support and sustain the family. Manpower, material and financial resources, together with the vital life supporting elements of love and care – all are depleting and are rather depleted. Many elderly are deserted by their offspring and even when they remain within the family, the resources of the family are not sufficient to take care of elderly parents adequately. Hence society is concerned about providing for these elderly people and how to take care of them.

The Place of the Elderly in the Public Sphere

The discussion now should relate to the place of the elderly in society in the public sphere according to the Hindu Dharmasastra. Reference here again should be made to Manu's ordinance and Kautilya Arthasastra (Kautilya the Minister of the Emperor Ashoka's kingdom).

Manusanhita explains why a king should associate himself with elderly people who are well versed in Vedas and Religious Norms. Slokas 36, 37 and 38 specify that it is the duty of a king to serve such elderly people and follow their advice. A king who engages himself in the service of such learned elderly people, even if hostile enemies, will not receive any harm.. However well versed in Sastras and benevolent by nature a king may be, he should associate with the learned elderly to learn humility and conduct himself with all humility because a humble king is never destroyed whereas an arrogant one does (he loses his empire).[7] It is obvious that elderly people, because of their knowledge and wisdom, are a great support to a king who in turn should serve them with sincerity.

As king should lead his subjects and his behaviour should be example for them to follow. By caring for the elderly he sets an example for others. Thus in the Hindu tradition the elderly are given a respectable place.

Similar ideas are to be found in the *Arthasastra* by Kautilya. Dr. S.G.Moghe[8] observes: 'the topic of the association of a person particularly a kind with the Vrddhas has become a subject matter of the Kautiliya Arthasastra 1.5.11 and 1.5.16. Kautiliya specifically asserts that a prince should have constant association with elders in learning for the sake of improving his training, since the training has its roots in the association with elders in learning'.[8]

It is obvious that the above scriptures highlight the place of the learned elderly but are silent about those who are not so endowed with knowledge and wisdom. In spite of this, one may conclude that whether learned or not, an elderly person is to be taken care of by his family, and in particular his offspring.

The Present Scenario

In both industrialised countries and developing countries the same trends as regards the elderly population are to be observed: it is growing. Projections of the elderly population in India, as per the Census of India 1997, can be had from the table 1.

The influence of religion on the conduct of society has weakened over the ages and apparently religious norms regulating day-to-day interaction among young and elderly within a family are also rare except in the observance of certain rituals. However, in spite of this, the role of the family in the provision of security and care to the elderly was emphasised in the Indian National Policy on Aging. The family is still viewed as very important and is seen as a cherished institution in India; it is looked upon as the rightful place of the elderly. In spite of all this, it would be a travesty of truth not to acknowledge the other reality – the deprivation and abuse of the elderly, within the family as well as without. This is also increasing. Coupled with this is the situation of large populations of elderly people who are in rural areas and do not have equal access to services that are available in cities and towns. The family, on the other hand, is also constrained in caring for its elderly members. The economic hardship of the majority of the families is enormous. In addition to this there is the lack of manpower within families to look after the elderly because of the ever shrinking size of families. Nonetheless, society and the state value the family as the most favoured living context for the elderly.

Homes for the elderly are gradually gaining ground in care for the elderly but they are still not a favoured option for the majority of families. There is also another phenomenon – families suffer from social disapproval or are looked down upon if they fail to keep their elderly within the family fold. Thus when the elderly are disowned, families resort to deception to cover up the truth. Therefore, whether with respect and dignity or without it, the majority of the elderly are still part of their families in Hindu society and state support to supplement family resources is also gradually increasing though not proportionately or to the extent that is needed.

Table 1. Total Elderly Population in India (in millions) 1950-2025

Age group	1951	1991	2001	2021 (projected)
60+	20.10	60.50	81.40	177.50
Percentage of total population	5.62	7.31	8.44	14.45

Source: Sharma S.P. and Xenos, P., *Ageing in India: Demographic Background and Analysis* (Based on census Materials, Occasional papers, Census of India, 1997.[9]

Conclusion

The question of care for the elderly, the majority of whom develop some kind of disability or other as age advances, perturbs society. However, Hindu religious organisations cannot but view responsibility for taking care of the elderly, nursing the sick and making necessary provisions for them as belonging to the family. External support in terms of the provision of health-care (including treatment) and financial assistance to the families in times of need, are, however, welcome. Hospitals, clinics, charitable dispensaries etc. are regular features of many Hindu religious organisations today. The elderly sick are a growing concern of Hindu society and it is a struggle to meet their needs in the present economic scenario where there is plenty of money but at the same time no money. Added to this is the weakening social fabric as families are constrained in a myriad ways and thus cannot care for the elderly, particularly those who are sick, adequately, and to the extent desired.

Prof. SUKLA DEB KANANGO
Department of Social Work,
Visva Bharati, Santiniketan,
West Bengal, India.

Notes

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[9] KOPLAN, MATHEW AND CHADBA, N.K., 'Intergenerational Programmes and Practices: A Conceptual Framework and an India Context in Studies in Gerontology: International Perspectives', ed. by K.L.Sharma (Ravat Publications, Jaipur, India, 2007), p.1.

CHENG CHEN-HUANG

3.4 Nirvana as the Supreme Healing: a Buddhist Perspective on Medical Care for the Aged

1. Sickness as One of the Eight Most Concerned Sufferings

Sakyamuni Buddha, the founder of Buddhism, has been regarded as the Great King of Medicine.

The Buddha told his disciples that taking care of sick people is equal to taking care of the Buddha himself. There are three Gems in Buddhism: the Buddha as the physician, the *dharma* as medicine, and the *sangha* as nurse. There is even a scripture called "*Sutra of Buddha's Medical Science*". From the above, one may conclude that Buddhism is a religion of medical science, although its main concern is the therapy of psychological diseases which are the main reasons for physical diseases.

In his very first discourse of teaching after attaining enlightenment, the Buddha declared the Four Noble Truths. In fact, his teachings are nothing but the diagnosis and healing of sufferings or sickness in human life.

In the First Noble Truth of Sufferings, the Buddha warned that sufferings are inevitable for every living being. Sufferings are commonly classified into eight: birth, old age, sickness, death, departure from whom or what one loves, encountering whom or what one dislikes, inability to gain what one seeks and psycho-physical imbalance.

In the Second Noble Truth of Causes of Sufferings, the Buddha analyzed the main causes of sufferings as ignorance and karma, i.e. action, speech and thought.

In the Third Noble Truth of Cessation of Sufferings, the Buddha targeted Nirvana as the ultimate aim.

In the Fourth Noble Truth of Ways Leading to the Cessation of Sufferings, the Buddha specified the Eightfold Noble Ways: Right View, Right Thought, Right Speech, Right Livelihood, Right Action, Right Effort, Right Mindfulness, and Right Concentration.

If the Formula of Four Noble Truths is applied in medicine, we can induce the following table:

Four Noble Truths	Medicine
Noble Truth of Sufferings	Diagnosis of Symptoms
Noble Truth of Causes of Sufferings	Investigation of Causes of Diseases
Noble Truth of Cessation of Sufferings	Ideal Healthy Body
Noble Truth of Ways Leading to the Cessation of Suffering	Therapy

The Buddha, although an enlightened being, had much less vexation and diseases in his physical body than others but he could not be absolutely free from them. If the components of body become imbalanced, the illness will certainly occur.

2. Characteristics of Buddhist Medical Care

A *bodhisattva* is a great being working towards full enlightenment by means of benefiting oneself through helping others. The goal of Buddhist medical science is to transform the life of patients into that of a *bodhisattva.*

To help others, a BODHISATTVA should make Four Great Vows: 1. I vow to help the immeasurable living beings. 2. I vow to eradicate the boundless vexations. 3. I vow to learn the infinite knowledge. 4. I vow to attain the supreme Buddhahood.

In Buddhist medical science, to heal the illness, a medical professional, no matter whether he or she is a physician, a nurse, a pharmacist or else, should not only work with all efforts but also encourage his or her patients to work positively. A physician should act like a *bodhisattva,* and ask his or her patients to develop the ambition of a *bodhisattva.*

Through the interaction with the patients, a medical professional is not only a giver of medical treatment and psychological support to patients but also a receiver of knowledge and wisdom from the patients. This is exactly the growing process of a *bodhisattva,* to give what he or she has to the living beings and to receive reciprocity from the living beings so that he or she may continue to increase wisdom and compassion.

Vice versa, a patient is not only a receiver of medical treatment and psychological support but also a giver of life phenomena and medical experiments.

A medical professional and a patient are irreplaceable partners, aiming to transform the life of the partner intentionally or unintentionally

tionally. This parallels the interrelationship between a bodhisattva and the living beings.

The following chart exemplifies a medical professional as a *bodhisattva* and his or her patients as living beings:

	A medical professional as a bodhisattva with patients as living beings
1st vow	Give best medical treatment to patients regardless of their background.
2nd vow	Treat all diseases of the patients whether serious or not.
3rd vow	Master medicine science, Buddha dharma, and other knowledge.
4th vow	Be perfect in wisdom and compassion.

On other hand, a patient can also play the role of a *bodhisattva* and treat all medical professionals and those who are around him or her as living beings.

	A patient as a *bodhisattva* with medical professionals as living beings
1st vow	Show compassion, respect, gratitude, symptoms, tolerance, and diligence.
2nd vow	Cease all vexations, diseases, ignorance, and unwholesome minds.
3rd vow	Learn medical science, hygiene, information about health, etc.
4th vow	Be a healthy person and a *bodhisattva*.

3. Buddhist Therapy

Buddhist therapy aims to flow into the foundation of the universe through the moderation of individual life rhythm, ranging from taking drug, counting in-breath outbreath, regulating breathing, and observing the mind to integrating with life of the universe.

Master Chih Yi (538-597) illustrated the relationship between causes of illness and therapy in his *"Great Concentration and Insight Meditations":* "If the illness is caused by physical action, work, foods or drinks, it can be cured by taking drugs. If the illness is caused by the improper sitting meditation, it can be cured not by taking drugs, but by sitting meditation again and regulating breathing properly. If the illness is caused by spirits or devils, it can be cured only by deep contemplation and great mantra. If the illness is caused by karma, it can be cured only by contemplation inwardly and repentance outwardly. There are different ways of therapy. One should know them well. One should not hold knife and hurt oneself".

In Buddhism, all foods are regarded as drugs. The herbal drugs are applied only when foods and drinks are taken improperly. Drugs are important. However, besides drugs, the practice of concentration meditation, insight meditation, regulating breathing, contemplation, occultism, etc. are also much emphasized. Obviously, in Buddhist medical science, an imbalance mind is considered as the main cause of illness. The wholesome mind is the key to physical health. The practice of Buddha dharma is for attaining wholesome mind and finally nirvana or Buddhahood.

4. Twenty Five Skillful Means

Master Chih Yi, in his books "*Great Concentration and Insight Meditations*" and "*Small Concentration and Insight Meditation*", listed 25 skillful means of meditation which can be regarded as the Buddhist therapy. The 25 skillful means should be practiced by the patients themselves, and the medical professionals play only the role of an advisor.

Fulfill five conditions in order to protect individuals: 1) Observe precepts purely to live a normal life, 2) Prepare necessary clothes and foods with gratitude, 3) Live in quiet surroundings, 4) Keep away from secular affairs, 5) Learn with virtuous and knowledgeable teachers.

Be free from these five desires in order to create peaceful living condition: 6) Be free from desires for visible objects, 7) Be free from the desires for sound, 8) Be free from the desires for smells, 9) Be free from the desires for tastes, 10) Be free from the desires for gentle touch.

Break down five handicaps in order to warn against the afflictions springing out of the depth of mind: 11) Break down the handicap of cravings, 12) Break down the handicap of hatred, 13) Break down the handicap of drowsiness, 14) Break down the handicap of agitation, 15) Break down the handicap of doubt about oneself, teachers, and truth i.e. medical science.

Moderate five things in order to moderate the whole rhythm of life: 16) Moderate drink and food, 17) Moderate sleeping, 18) Moderate the body, 19) Moderate breathing, 20) Moderate the mind.

Do five things: 21) Strong desire to practice, 22) Effort, 23) Mindfulness, 24) Skillful intelligence, 25) Concentration.

5. Compassion and Wisdom: Antidotes to Karmic Sickness

According to Buddhism, there are three ways to liberate living beings from suffering: precepts, meditation, and wisdom. Precepts can liberate one from doing evil and thus the consequence of sufferings. Meditation can liberate one from psychological afflictions and thus attain happiness. Wisdom can liberate one from the rise and fall of the mind, and thus attain eternal peace spiritually. Nirvana means eternal peace and perfect freedom from suffering.

After attaining nirvana, one may take a further step to help others liberate themselves from suffering. This is the virtuous sentiment called compassion, the empathy to feel oneness with others.

Everybody has the same hope to have peace and no suffering. This is where a *bodhisattva* steps in. Out of the wisdom to know the inseparability of all and the enlightened mind to help others, a *bodhisattva* develops unconditioned love and compassion to work for living beings. All beings are subject to past experiences deep in the mind, the karmic sickness in Buddhist terms. Compassion and wisdom are the antidotes to karmic sickness, and thus the prerequisites to attaining the nirvana of all beings.

6. Nirvana: the Supreme Healing

Physical sickness and death is inescapable for all. But psychological sickness can be cured eventually through practice, and there will be certainly no death if there is no birth. Nirvana is the only answer in Buddhism.

Nirvana is not nihilism but the complete cessation of suffering which relies on the eternal peace of the mind. When one gets sick, one should analyze the causes of illness and be treated properly with best medical care. However, the supreme healing is nirvana. When one has an empty mind, one will accept all conditions regardless of sickness or even death.

Prof. CHENG, CHEN-HUANG
President of Amala Association, Taiwan

JÁN ĎAČOK

3.5 The Point of View of Post-Modernity

Introduction

At the international conferences on palliative care (2004), genetics (2005) and infectious diseases (2006), which were organised by the Pontifical Council for Health Care Workers, I had the opportunity to briefly present the complex question of post-modernity. In this paper I will confine myself to an extreme summary of post-modernity: the post-modern vision of human life is understood as being utilitarian, pragmatic, contract-based, nihilist and cynical. The value of human life is obscured and relativised. As we know, pain, suffering, the terminal stage of life, dying and death are a part of normal human life. Post-modernity, however, does not see pain, suffering, the terminal stage of life, dying or death, which accompany the illnesses of elderly people as well, as having any value. Instead, in the face of these realities post-modernity takes refuge in assisted suicide, suicide and euthanasia.

This paper will seek to describe the concrete positions of post-modernity in relation to sick elderly people. I will attempt to present what the post-modern position is through the positions of two principal representatives of post-modern bioethics, namely Hugo Tristram Engelhardt, Jr. (1941), an American philosopher of German origins, and Peter Singer (1946), an Australian philosopher.

H. T. Engelhardt

This thinker offers a clear perspective on the importance of bioethics[1] for the future. Of notable interest is his view on the mission of bioethicists whom he sees as the 'secular priests'[2] of our culture. On the other hand, some health-care workers, and precisely post-modern health-care workers, receive a specific appellation from him: he calls them 'cosmopolitans' and he defines them as 'men and women who can live in peace and procure health care in this world without fundamental moral conflicts. They are the contemporary expression of Nietzsche's 'superman'. They can contemplate the destruction of old traditions and prosper in the subtle area of post-modern times'.[3] In the approach of this author what can one predict for the future? When considering the ageing of the population in western societies Engelhardt proposes a summarising and 'prophetic' response: 'In the future… there will be an increasing risk not only of having to bear the weaknesses that are typical of old age but also of spending months, if not whole years, in institutions that provide complete nursing care. This risk can be avoided only by allowing individuals to allow themselves to be killed in a painless way where they find themselves in certain situations. This possibility will allow them to exorcise the fear of becoming so old that they are forced in live in an undignified way for themselves and in an extremely expensive way for others. Such a policy would remove these fears and free up resources which could be allocated to the defence of health and an increase in the pleasures of life when one can still live life in a truly gratifying way'.[4]

This position confirms that post-modern man feels fear when faced with old age, suffering and death. Faced with such strong pressures he strives, and will certainly strive in the future as well, to flee from it and move towards 'better solutions': suicide, assisted suicide and euthanasia. In the view of Engelhardt, the above solutions are options that can be morally accepted on the same level as prenatal diagnosis and voluntary abortion. One should not be surprised here: outside the context of substantial morality it is not possible to assess these choices as being morally wrong.[5]

However in his argument he reaches a position that is extremely utilitarian and inhuman when he states: 'Whether suicide and the killing of another person on request violate the principle of doing good depends on the hierarchy of rights and wrongs to which one refers. When the person to be killed is subject to unbearable pain, the secular argument that relies upon doing good could present an act designed to speed up death as a morally praiseworthy choice, if not an obligatory one… a very patriotic citizen with a debilitating terminal illness could take his own life for the purpose of not being a further burden on the national health service. To abstain from leaving instructions to others about the level of treatment that would be desired were one to be

afflicted by grave and irreversible dementia could constitute a form of moral and social negligence since such an omission exposes the family and society to forms of treatment that would not be desired. Those who do not judge killing to be immoral as such could even consider that it is their duty to arrange beforehand that in the presence of certain circumstances they should be killed'.[6]

Lastly, Engelhardt produces truly original proposals concerning religion, Christians, and moral theology as well. The cosmopolitan liberal ethos, in the name of self-determination, invites us both to a rupture with the traditional Christian past and to the acceptance of suicide and euthanasia. This secular culture, which is neo-pagan and also post-Christian, invites religion to engage in a reorientation of the obligations imposed on its own members. 'Religion should help health-care workers and family relatives to accept the choices of patients who want to engage in assisted suicide and voluntary active euthanasia'. Christians, because they love their neighbour, in the view of Engelhardt 'should encourage choices about death that protect the values, the freedom and the dignity of their neighbours'. He also makes a proposal for contemporary moral theology which should recognise that 'assisted suicide and voluntary active euthanasia can be accepted on the grounds of dignity and love'. And lastly, the same task also falls to post-traditional Christianity.[7]

P. Singer

This thinker in his views is certainly not distant from the views of Engelhardt. In the expression of one of his views he offers the following prophecy: 'in the United States of America, where stress always falls on individual rights... a change will probably come, as happened in Oregon, more in the form of the recognition of the right to assisted suicide than in the form of the legalisation of active voluntary suicide. But the most certain thing is that within the next decade, and perhaps before, the citizens of various countries, following the example of Holland, will manage to acquire the right to control their own lives'.[8]

In expressing another view Singer, with his cold logic, aware that few will agree and wanting to be provocative, argues as follows: 'When the right of patients to decide how to die is recognised in other countries, on a par with what happens in Holland and Oregon, the Hippocratic tradition will be subjected to a further transformation similar to that which has already occurred in the case of abortion. Gradually we will learn to think that in the case of the terminally or incurably ill, a correct exercise of the medical profession also understands the practice of euthanasia when the patient makes a free and well informed request to this effect. But are we really certain that the change will be limited to this?'[9]

How can one arrive at the legalisation of such practices so as to 'meet one's own wish to control one's death'? Singer already has an answer: 'if the right to assisted suicide does not come from courts and parliaments, in countries which allow their electors to express themselves directly on questions this could come about as a result of referendums'.[10] In other words 'new ethics' with 'new commandments' are required to meet this wish because traditional ethics will never be able to satisfy it. In his new moral approach to human life and human death he proposes 'five new commandments' which are clearly opposed to the 'old' commandments.[11] This approach expresses his 'rethinking' of traditional ethics and his 'rewriting' of the new ethical perspective.

Singer, as an atheist and non-cognitivist, develops his bioethics through dramatic and revolutionary case studies. From individual cases he draws unwarranted general conclusions that go against human dignity and against Catholic morality, which is labelled as being already 'old' or 'no longer useful'. He invites us to 'rewrite the commandments' and he is convinced that during the new century his ethics will be useful to us as a guide for decisions about life and death.

Conclusion

In short, these approaches leave no doubt about the fact that the ethics of Engelhardt and Singer display profound distrust in the dignity of man and the classical and Christian tradition. In their context there remains no space for old, sick, or handicapped person, or for a person who could be born deformed. They leave them no choice of being truly accepted and integrated, although the resources for the healthy and the young would be thereby reduced. Here they are convinced of their inferiority. The vision of man as being created in the 'image and likeness of God' (*Gen* 1:26) has been lost and with it also a sense of the absolute dignity of every man, and in a particular way when elderly and sick.

For the positions espoused by Engelhardt and Singer 'God is dead' in the sense that He is silent, inaccessible, inactive, or, even if He is perceived, He is rejected. This approach to bioethics is not ontologically based, it recognises no ontological hierarchy of values, no theory of inter-subjective good and no communitarian vision of moral action. As a result, their bioethics are in fact without any moral contents and as such take on the moral disorientation of con-

temporary society; indeed, it deepens that disorientation.

For the bioethics of Singer and Engelhardt, life as such has no meaning. The value of human life is relative, obscured, without a recognition of levels and ontological and axiological differences. The status of the human person is only conferred on those individuals who are self-aware and who can express their wishes.

What could be our answer here to post-modern trends?[12] To summarise: to accept life means to accept old age with its illnesses, and death too, as well. To be afraid of living, in the Gospel sense, means to be afraid of dying as well. Those who discover the beauty and the greatness of this life with Christ, embrace further that promised life which, however, passes by way of illnesses, pain, suffering, old age and death. Only in Christ, who is 'true light' (Jn 1:9), can one find the spring of light that illuminates the mystery of man during every period of his life.

P. JÁN ĎAČOK SJ
Lecturer in Moral and Ethical Theology, Faculty of Theology of the University of Trnava, Bratislava, Slovakia, Provincial of the Society of Jesuits in Slovakia.

Notes

[1] H.T. ENGELHARDT, *Bioethics and Secular Humanism. The Search for a Common Morality* (London/Philadelphia 1991), p. xv.

[2] H.T. ENGELHARDT, 'Bioethics in the Third Millennium: Some Critical Anticipations', *Kennedy Institute of Ethics Journal*, n. 3, 1999, pp. 235-236.

[3] H.T. ENGELHARDT, *Bioethics and Secular Humanism*, p. 39.

[4] H.T. ENGELHARDT, *Manuale di bioetica* (Milan, 1999^2) p. 384.

[5] Cf. H.T. ENGELHARDT, *Manuale di bioetica*, pp. 382-383.

[6] H.T. ENGELHARDT, *Manuale di bioetica*, pp. 381-382.

[7] Cf. H.T. ENGELHARDT, *The Foundations of Christian Bioethics* (Lisse/Abingdon/ Exton (PA)/Tokyo, 2000), p. 312.

[8] P. SINGER, *Ripensare la vita. La vecchia morale non serve più* (Milan, 1996), pp. 163-164. For the evolution of legislation on euthanasia in Australia see P. SINGER, 'The Legalisation of Voluntary Euthanasia in the Northern Territory', *Bioethics*, n. 5, 1995, pp. 419-424.

[9] P. SINGER, *Ripensare la vita*, p. 156.

[10] P. SINGER, *Ripensare la vita*, pp. 154-155.156.

[11] For a summary of both 'ancient' and 'modern' commandments see P. SINGER, *Ripensare la vita*, pp. 193-208.

[12] For a broader vision see J. ĎAČOK, *La postmodernità nel dibattito bioetico. Il caso delle questioni di fine vita* (Trnava, Slovakia, 2007).

Third Session

What Should Be Done?

1. The Pastoral Care of Sick Elderly People from the Religious Point of View

SERGIO PINTOR

1.1 Sick Elderly People: Formation and Maturity in the Faith

This subject, within the context of the various contributions made during this international conference, addresses the task, specific to a catechesis and education in the faith, of achieving more suitable care for elderly people who find themselves in conditions of illness and accompanying them in a more mature faith.

It is immediately clear that one cannot speak in a general way about a more mature faith. There exist and one encounters elderly people who are a) in conditions of illness that are very diversified (chronic illnesses due to old age or to the arrival of pathologies, invalidating physical or mental pathologies that make elderly people no longer self-sufficient, temporary illnesses etc.); b) and in religious, cultural, and social conditions that are notable different. In the same way, the diversity of the 'places' in which sick elderly people are to be found should also be borne in mind: at home with their family relatives or at home alone; in a structure where they are admitted for a while or where they live; or in a hospital or in a place where they stay for a long time. Yet without forgetting that each sick elderly person lives out his or her condition in an always specific way and can have an experience of faith of varying levels of development or one that is even non-existent (and thus in need of an initial proclamation of the Gospel).

As a result a catechesis and education in the faith in relation to sick elderly people must be thought about, and implemented in line with, two complementary directives: a) education whose direct and immediate recipients are the elderly themselves through forms of catechesis that are prevalently occasional or a matter of the situation that presents itself, always assuring an essential wholeness to the message that will help the elderly person to illuminate his or her own life with faith and open up that life to Christian hope; b) education in the faith that is after a certain fashion more systematic and referred to people who are called to look after sick elderly people and Christian communities themselves so that they will prepared to take responsibility for an accompanying in the faith of sick elderly people.

1. An Elderly Person, Especially when in a Situation of Illness, Needs Education and Necessary Support in the Faith

It is necessary to begin with the belief that every person of whatever age or situation needs education in the faith; indeed, they have a right to this. Indeed, 'every age of man has its own meaning in itself for the achievement of maturity'.[1] Indeed, the need for education in the faith appears to be especially justified in situations of life that are often decisive for the destiny of a person's faith, such as a situation in which one is called to understand and live situations of suffering, of illness and of old age with a Christian meaning.[2]

2. Some Emphases and Characteristics of a Catechesis and Education in the Faith for Sick Elderly People

A first and fundamental emphasis is to bear in mind the experience of faith that has at a practical

level been lived out by the sick elderly person. Indeed, 'an elderly person can reach his age with a solid and rich faith: in this case the catechesis leads after a certain fashion to fullness of the pathway that has been followed in an approach of thanksgiving and trusting expectation; others live a faith that is obscured to varying degrees and with weak Christian practice: in this case the catechesis become a moment of new light and religious experience; at times an elderly person reaches his days with profound wounds in his soul and his body: the catechesis helps him to live his situation in an approach of invocation, forgiveness, and inner peace'.[3]

Whatever the case, reference may be made to certain emphases and characteristics of education in the faith or a catechesis addressed to elderly people who are in situations of illness:

a. Catechesis or education in the faith embodied in the situation or condition of the elderly sick person

It is necessary first of all to listen to his or her questions and interpret his or her moods so as to identify the contents of faith that one wants to communicate and the forms of language that are most suitable to communicating them.

b. A catechesis or education in the faith for a Christian vision of life

The preparation and waiting for the final encounter with the Lord must not pass by way of fear of death but rather by way of an intense love of life.[4] A sick elderly person is called upon and subject to trial twice over as regards the meaning itself of life: by advanced age with its progressive biological deterioration and by the illness from which he or she suffers. In such a situation it is very easy 'to look back', to feel useless and a burden, and not to understand the gift and the meaning of life in the reality that he or she is experiencing. And yet in his encyclical *Evangelium Vitae* John Paul II stressed the need to proclaim and celebrate the Gospel of life in every situation, with the outlook of those who know how to see in life an always new gift and in every person the living image of the God of life. 'This outlook does not give in to discouragement when confronted by those who are sick, suffering, outcast or at death's door. Instead, in all these situations it feels challenged to find meaning, and precisely in these circumstances it is open to perceiving in the face of every person a call to encounter, dialogue and solidarity'.[5] Sick elderly people must be helped to recognise and welcome life as a gift that is always new and as a mystery of love in the situation that they are living.

c. A catechism or education in the faith on the meaning of old age, even when it is marked by illness

One may state that old age grows with us in our various conditions of life. It can thus be prepared for, helped and accompanied in order to understand its meaning and its value at both a human level and at the level of faith.

For this reason, it is necessary to help the sick elderly person to locate himself or herself in a design of God, who is love, living his or her own condition as a stage on the pathway by which the Lord leads us to the final encounter with him.

Only the light and force of faith opens to hope that does not disappoint (cf. Rom 5:5) and can allow us to live old age, even when it is marked by illness, as a gift and a mission.[6]

d. A catechesis or education in the faith about the sacrament of baptism

It is important to reawaken in the sick elderly person the gift of the sacrament of baptism as immersion in the mystery of the Easter of Jesus Christ and participation in his new life and as a foundation of his or her own dignity as a child who is loved in every situation and forever by God.

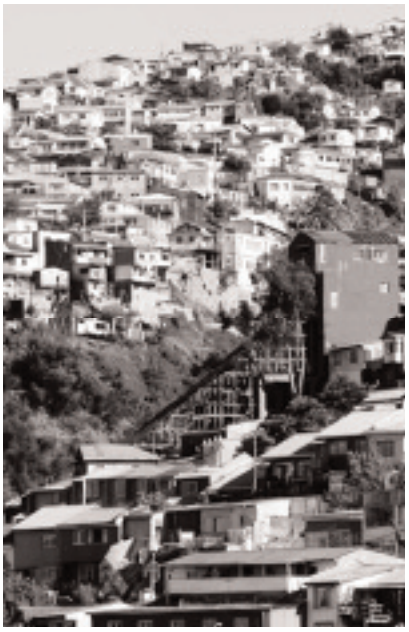
It is beginning with this awareness of the baptismal rebirth that the sick elderly person can best be helped to discover the meaning of his or her present and his or her future. Indeed, hope has its roots in faith in this presence of the Spirit of God, 'he who raised Jesus Christ from the dead' and will give life to our mortal bodies as well (cf. Jn 3:6).

e. A catechesis or education in the faith about illness and suffering

It is of fundamental importance to help the elderly man or woman to live his or her illnesses and suffering in the certainty that God is in communion with him or her. Just as Jesus at the moment of trial

abandoned himself with trust totally to the Father, so the elderly person must be guided to live and bear witness to his or her faith in a total self-entrusting to the love of the Father. But this requires a catechesis accompanied by signs of nearness and loving care which a Christian community is called upon to give. In care for the weakest, the suffering and the non-self-sufficient, the Christian community demonstrates in a very authentic way its own fatherhood. Pain and suffering, as well, have a meaning and a value when they are lived in close union with love that is received and given in full communion with Christ.[7]

Of particular importance, therefore, is a catechesis that knows how to communicate how even negative events and the experience of the human limits of life are in reality 'redeemed' by Christ and taken on by him as an instrument of redemption and salvation, supported by unlimited love.



f. A catechesis or education in the faith under in the sign of comforting

A sick elderly person must be helped to recognise, encounter and receive in faith the revelation of God the comforter through the proclaiming of the word accompanied by sacramental signs and the witness of loving nearness. Indeed, the category of God the comforter runs through the whole of Revelation from the Old to the New Testament and in reality characterises the whole of the salvific mission of the Messiah (cf. Is 61:1-3; Lk 4:16ss.). This is a proclaiming of faith that is especially important in fostering in the sick elderly person a more suitable rediscovery of the face and the mystery of God in the situations that the sick elderly person is experiencing. A catechesis on comforting cannot, therefore, involve a simple exhortation or a cold proclaiming but, rather, it must lead to discovering and experiencing that He who comforts is God Himself through His Son Jesus Christ and the Comforting Spirit.

'Comforting' is a real gift of God, it is the gift of the Paraclete Spirit who dwells in us. For this reason, it is important to educate the sick elderly person in prayer and invocation, in awareness that comforting must always lead to encounter and dialogue with God.

g. A catechesis or education in the faith as openness to hope

The education in the faith of a sick person must illuminate the pathway towards the final and beatifying encounter with God in the sign of comforting and hope. Beginning with the baptismal certainty of already being loved children, it is necessary to educate in total self-entrusting, to achieve what we are called to become (cf. Jn 3:1-2), to the God of love and life, being faithful to His promises. 'Death itself is anything but an event without hope. It is the door which opens wide on eternity and, for those who live in Christ, an experience of participation in the mystery of his Death and Resurrection'.[8] Educating in Christian hope means helping the sick elderly person to grow in 'the confident expectation of divine blessing and the beatific vision of God' (*CCC*, n. 2090; cf. also 1042 – 1050), when God Himself 'will wipe away every tear from their eyes, and death shall be no more, neither shall there be mourning nor crying nor pain anymore, for the former things have passed away' (Ap 21:4).

3. The Christian Community: an Agent of Education in the Faith of Sick Elderly People

The Christian community is a responsible agent for the education and accompanying in the faith of elderly sick people, with all its pastoral action and in particular with its action within the domain of service of the Word and overall care for health. This requires the constant commitment to construct itself as a 'healed' Christian community in order 'to heal', a community achieved by the 'words of comfort' to be communicated to everyone in their conditions of life. From this comes the need that in the transmission of faith – in its various forms and languages (teaching, catechesis, encounters of reflection and spirituality, preaching…) – there is developed, on the one hand, care and responsibility towards elderly sick people to achieve overall care for them that involves accompanying in the faith. On the other hand, it is important that the various pathways of catechesis contain, within education in the life of faith, the various questions and issues evoked for support in the faith of sick elderly people. This should be done to sensitise and prepare people as regards taking care of sick elderly people because they themselves, of various ages, can be helped to mature a faith that is open to future situations. In particular, one the one hand, theological reflection is required and, on the other, our Christian communities should study and identify: the conditions that are required for a more effective accompanying in faith of the sick elderly person in the various contexts, places and situations in which he or she find himself or herself; the most appropriate modalities and the most appropriate languages by which to communicate the proclaiming of the faith to the sick elderly person and to those who take care of him or her in the various communities of the local area (families, parishes), in the various socio-health care or hospital structures…; the most advisable modalities to place in the ordinary catechesis: education in the meaning of life, in unconditional love for life in every situa-

tion of existence and in every person: education to serve care for life and health in the most frail and needy sick people; the questions and issues that emerge from the world of health and health care, illness and suffering, above all with reference to the condition of sick elderly people, with the dynamics that concern the responsibilities and witness of the Christian community for an illumination

and a response in faith – questions about being born and dying, about human limits and human suffering, about deterioration during an advanced age, about service and love, about solidarity and justice, about the love and mercy of God, about the design and implementation of salvation by God…These are questions that no catechetic pathway should ignore given that they find an answer and light in the mystery of the Word made flesh and in the gift of a new life participated in by Christ through faith and baptism; the identification of certain pedagogic criteria and certain emphases of the Christian message with reference to an occasional catechesis with a sick elderly person in a family context or in that of an institution; and the pointing out of catechistic pathways that are of educational help for the various men and women workers in pastoral care in health, including extraordinary ministers of communion.[9]

One is certainly not dealing with 'planning' around a table rigid certain catechetical courses for sick elderly people. Instead this is a matter of placing ourselves both individually and as Christian communities in the 'school' of sick elderly people in order to see them not as 'objects' of care but as subjects of a communication that calls upon our faith, inviting us to share that faith. This is a matter of having – and asking for – the gift of a heart rich in God and humanity, and of living the dynamic of 'giving and receiving' that is specific to faith.

To end this paper I would like to pose a number of questions by way of a healthy provocation: what real commitment exists on the part of many of our structures for elderly people managed in the name of the Church to a real welcoming of sick elderly people, above all when they are not self-sufficient? How much is there care and real concern about providing them with suitable accompanying in the faith?

In a certain kind of culture which often sees sick elderly people as the 'object' of a socio-health care market, we must all feel committed to defining the service of our structures and the service of local areas by our Christian communities as overall care for the person, inspired and sustained by a faith that is lived and shared and thus 'prophecy' of a welcoming of the elderly sick and taking care of them, with them finding in the faith the heart of a renewed therapeutic relationship which is more authentically and more profoundly human.

With great certainty: faith and education in the faith certainly do not remove the discomforts and the sufferings of old age accompanied by illness, but they are light, strength and grace which help to live and to look after this human reality of ours, which in a certain sense is always mysterious, with more serenity and a strong hope in the belief that every limit of ours is transformed, freed and redeemed in participation in the paschal mystery of Jesus Christ and sustained by the constant care of God marked by every tenderness and every comfort.

H.E. Msgr. SERGIO PINTOR,
Bishop of Ozieri,
Italy,
Consultor to the Pontifical Council for
Health Care Workers,
the Holy See.

Notes

[1] CEI, *Il rinnovamento della catechesi*, n. 134.
[2] *Ibid*., n. 130.
[3] CONGREGAZIONE PER IL CLERO, *Direttorio generale per la catechesi*, LEV, 1997, n. 187.
[4] Cf. COMISION EPISCOPAL DE ENSEÑANZA Y Catequesis, *La Catequesis de la comunidad* (EDICE, Madrid, 1983) n. 251.
[5] JOHN PAUL II, *Evangelium vitae*, 1995, EV/14, 2443.
[6] cf. PONTIFICIO CONSIGLIO PER I LAICI, *La dignità dell'anziano e la sua missione nella Chiesa e nel mondo*, 1 Oct. 1998, EV/17, 1481.
[7] Cf. JOHN PAUL II, *Evangelium vitae*, EV/14, 2488 – 2491
[8] *Ibid.*, *EV*, n. 97
[9] Cf. ANGELO BRUSCO AND SERGIO PINTOR, *Sulle orme di Cristo medico* (EDB, Bologna 1999) pp. 86-87.

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JOHN PAUL II, encyclical letter *Evangelium vitae*, 25 March 1995, EV/14, 2167 – 2517.
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VICTORINO GIRARDI STELLIN

1.2 Sacraments for Sick Elderly People. Pastoral Care for Sick Elderly People

1. What one learns through suffering, one learns better

I heard this saying during years of missionary service in Africa. This is one of the very many ways of expressing what comes to us from the word of God. 'Before I was afflicted I went astray; but now I keep thy word… It is good for me that I was afflicted, that I might learn thy statutes' (Ps 119:67-71).

The phenomenon of old age and illness has the same complexity as the life of a man. The two things are 'connatural' in human beings, and to such an extent that we may state that every man is 'a sick person' whose condition becomes worse with age. Both of these realities, that is to say illness and old age, belong to, and overlap, in the life of a man as a fact which is at one and the same time both natural and obligatory, as well as being extraneous to the human experience, but imposed contemporaneously as an unwanted burden.

This is phenomenon beyond will or human decisions, whether one's own or those taken elsewhere, and in this sense it provokes in man a question concerning the influence of higher forces or powers, the unknown causes that intervene in his life.[1]

The tendency to explain illness and misfortune by referring to a moral fault of the sick person himself or his family relatives has been a constant in religious culture. Christ reacted forcefully against this approach which, indeed, contains a false idea of God as one who punishes; an idea, , furthermore, which is 'unjust' because, hypothetically, it applies punishment to innocent family relatives. To the question of his disciples about the man born blind, "Rabbi, who sinned, the man or his parents, that he was born blind?", Jesus replied "It was not that this man sinned, or his parents, but that the works of God might be made manifest in him" (Jn 9:2-3). Since then Jesus has invited us to discover the signs of the Kingdom, that is to say his salvific action, in human sufferings.

Whatever the case, illnesses always and severely place man in front of his own limits and obliges him to adopt a stance which may be one of understanding and acceptance or one of rejection, submission or rebellion, or it can be simply one of ambiguity. The famous anthropologist Laín Entralgo wrote: 'For man, illness, which is sometimes positive and sometimes negative, whether in the form of acceptance or rejection, is always the subject of personal appropriation'.[2]

Illness is an experience that obliges human beings to enter the radical character of their own existence, to become aware of the fact that they do not possess principal or fundamental things, which, indeed, essentially depend on someone or something that they cannot control or dominate. There can be no doubt that suffering is the best school of life. And it is this in the most effective way in the cases of the suffering and illnesses that accompany old age. These make us understand and experience, at the end, that we are 'mortal'. The radical experience of human life comes with the drawing near and the experience of death.

In this context of old age and illness, when the person feels driven to ask fundamental questions about the *meaning* and what we could call the *basis of reality*, the salvific action of God intervenes. God makes Himself present where the human being is located and reaches him with His grace in the concrete circumstances of his life. He does this because He wants to save man. 'But Jesus answered them, "My Father is working still, and I am working"' (Jn 5:17). This is not only a matter of divine 'work' in the constant governance of all of the creation, but, rather, of His redemptive action, which is the expression of His universal salvific will, as is revealed in 1 Tim 2:4: 'God wants all men to be saved'

When the Church, through her pastoral workers, draws near in the specific spirit of the ministry of Visitation to our sick elderly people, she draws near to a 'sacred human area' – so to speak – in which God, with His freely-given action, intervenes to 'respond' to the worries and questions of a sick person, to illuminate sufferings with meaning, and to infuse that strength that is needed to overcome dears and makes hope shine forth in what remains of the earthly journey and is rapidly drawing near to eternal Life…Our pastoral workers are only humble cooperators in the merciful action of God for the benefit of His children

2. The place of sick elderly people in parishes

Every Christian 'vocation' is a 'con-vocation'. The very personal 'Yes' of the response to the call of God is located within a community, and what constitutes in fundamental terms the Christian community is to live the charity and mission of Christ in a communion of faith. The more perfect a Christian community is, the more it lives and achieves 'in common' this dual task, without excluding anyone, since everyone is a part of the community not because of what they have or do but because they are in Christ.

Sick elderly people who live within the boundaries of a parish form an integral part of the parish community. They belong to it with a full entitlement, indeed because of a special entitlement. They are the suffering members of the community which extends in time and in their persons,

in a mysterious way, the passion of Christ, 'In bringing about the Redemption through suffering', observed John Paul II, 'Christ *has also raised human suffering to the level of the Redemption*. Thus each man, in his suffering, can also become a sharer in the redemptive suffering of Christ'[3] and complete, as St. Paul says, in his body the suffering by which Christ redeemed the world, for the good of the Church (cf. Col. 1,24).

In suffering and through suffering, our sick elderly people acquire their 'own dignity' and their 'own mission', which defines them as privileged and as worthy of veneration. 'And for this reason suffering also has a special value in the eyes of the Church. It is something good, before which the Church bows down in reverence with all the depth of her faith in the Redemption. She likewise bows down with all the depth of that faith with which she embraces within herself the inexpressible mystery of the Body of Christ'.[4]

One more observation: the Church, which was born from the mystery of redemption worked on the cross by Christ, necessarily feels driven to look for encounter with man, and in a special way through the pathway of suffering, that pathway, that is to say, trodden by Christ to reach humanity at its deepest part whither sin and death have led it. The Church is called to follow the same pathway and in this way 'suffering man' becomes the 'way of the Church'. The Servant of God John Paul II stated this with emphasis: 'the Church has *to try to meet* man in a special way on the path of his suffering. In this meeting man "becomes the way for the Church", and this way is one of the most important ones.[5]

In our ecclesial communities sick elderly people, in addition to being an 'inescapable way' for pastoral work, are a *sacrament* of Christ, a specific sign of his presence: 'I was sick and you visited me' (Mt 25:40). They show and represent the most surprising face of Christ, that of God who suffers, sharing in human pain to the ultimate consequences, in order to achieve, through Christ, salvation.

It is the duty of every Christian to honour and worship Christ who gives himself to us in the mystery of the Eucharist and continues to be present in the tabernacles of our churches, without, however, underestimating his *presence* in the sick of the community, indeed in all of them, the true 'icons' of God.

3. "Today salvation has come to this house" (Lk 19:9)

The observations that have been made hitherto in this paper stimulate us to a pastoral work for our sick elderly people that has priority importance and is constant. We are not allowed to 'pass by' with indifference; we must, rather, 'halt' at their side. And this halting has nothing to do with watching because of curiosity but, rather, is an expression of ourselves and of our readiness to help. 'The world of human suffering unceasingly calls for, so to speak, another world: the world of human love; and in a certain sense man owes to suffering that unselfish love which stirs in his heart and actions'.[6]

The pastoral care that the Church provides to sick elderly people is specifically the action of the Good Samaritan who 'moved by compassion' does everything he can to help his suffering neighbour. 'Illuminated by Christ, suffering and the cross call on us', the bishops who gathered together at Aparecida, Brazil, declared, 'to live as a Samaritan Church (cf. Lk 10:25-37)'.[7]

The special concern of Jesus for the sick, to whom he reserved the most human gestures of his goodness, and the most surprising miracles of his divine power and the hope of a special place in his Kingdom – "Blessed are those who mourn, for they shall be comforted" (Mt 5:4) – represent for every Christian community the model to be followed in caring for sick elderly people.

If the sick and the afflicted are the favourites of Christ, the privileged people of his salvific mission (cf. Mt 4:16-19), this must be also the case for every parish community that seeks to be faithful to Christ himself. In addition to the affectionate care of the Church for those who suffer, and which she has demonstrated during her history, this without doubt constitutes a rule of behaviour for every Christian community, and at the same time a privileged place for its pastoral care. *Pastoral care in health*, therefore, must be placed at the centre of parish activities; it cannot be seen as an optional activity but as an ineluctable task of the being and doing of a community. Although for years reference has been made in ecclesiastical language to the 'preferential option for the poor' or to 'poor being at the centre', we know that often in parishes sick elderly people are the poorest of the poor.

It is obvious that the option for these poor is implemented through a pastoral care for the sick that is suited to the times, incarnated in history and made effective in a specific place, in its geographical and social context. It must be located with

parish, diocesan and also national planning in line with the orientation of the pastors involved, although all pastoral care becomes real and concrete only to the extent to which it is received, thought about and implemented within the context of the parish community. The territorial character of the parish creates neighbourliness, knowledge about each other, and living amongst one another which facilitates encounter.

In particular, the world of terminally ill elderly people, who live in their own homes or in the homes of their family relatives, requires preferential pastoral care on the part of the parish community because, as a result of the deep difficulties that they feel as regards trust in life, they also enter into a state of crisis at the level of faith in God and love for the Father. In addition, their situation is very painful because of various causes:

– the state of social abandonment in which they live because of the low level of interest in them on the part of the state and society;

– economic, housing and welfare (etc.) difficulties;

– the physical and moral marginalisation that afflicts them because they are seen – and they themselves see themselves as such – as being useless and a burden for their families.

The Church does not forget the example of Jesus and his teaching when he sent them out to evangelise: "heal the sick… and say to them "the kingdom of God has come near to you"' (Lk 10:9).

Just as Jesus entered the home of Peter, the home of Simon the leper, the home of Jairus, the home of Martha and Mary, the home of the chief of the Pharisees, Zaccheus (and always to offer mercy, hope, friendship, and salvation), so the Church, though her pastoral workers, allows Jesus to return to 'visit' his favourite ones, sick elderly people, to console them, to illuminate the meaning of their sufferings, and to animate their hope in the life that has no end.

4. Capable of transmitting reasons for living and hoping

In the Pastoral Constitution *Gaudium et Spes* of the Second Vatican Council, we read an inspired prophetic statement: 'We can justly consider that the future of humanity lies in the hands of those who are strong enough to provide coming generations with reasons for living and hoping'.[8] This is a mission in which both the sick elderly people and the pastoral workers who care for them cooperate, each in their own way. They are committed to making present the salvific action of Christ in an overall way by embracing the sick elderly in all their being and in all their dimensions with the intention of freeing them from what oppresses them. At a concrete level, pastoral care for the sick cannot be confined to proclaiming the Word of God and the administration of the sacrament, although these two finalities remain the primary objectives and the 'support' of every form of pastoral care in health. This must arrive first and foremost from a concern to bring *love* to sick elderly people, expressing such love in a concrete way to the extent that the recipient can perceive it. God asks us above all else to love sick people with profound respect for what they are, what they think, and what they suffer. It is necessary with special care to avoid that sick people 'perceive' that our primary purpose is not to visit them and accompany them, in the free-giving spirit of love, but, rather, to achieve the implementation of a pastoral and sacramental project, however noble that project may be. Accompanying a sick person must never be a means – it should always be an end: he or she is the recipient of our loving service.

In his context of visiting that is freely given, friendly, constant and respectful of the spiritual state of sick elderly people, and of their religious situation, I will now try to bring out the specific *functions* of pastoral care in health, namely:

A. *Offering sick elderly people help so that they can live their own situations*: their 'status' constitutes – as I have already stressed – a propitious terrain for pastoral action. One therefore tries to 'guide them' towards understanding the reality and the meaning of pain in the light of the crucified Christ and the Gospel.

– Making them 'discover' that God is the companion of their lives of suffering and of apparent uselessness and through his loving presence to give salvific value to their pain and their loneliness.

– Helping them to accept their painful situation.

– Accompanying them so that they can recognise the human and religious meaning of illness.

– Giving emphasis to their contribution to spiritual, moral and religious values to help and the community and the… world.

Accompanying them through the power of prayer and the grace of the sacraments.

B. *Developing a work of healthcare and moral education* within the perspective of the absolute and sacred value of life so as to generate in their life spheres an authentic 'culture of life' from conception until natural death.

C. *Implementing clear witness to solidarity and service* towards sick people with concrete gestures of spiritual and economic care, and care through presence, to avoid

them running the danger of profound depression.

D. *Fostering the 'redeeming'* of those who can recover a condition of health, even though it may be precarious, so that they can dedicate themselves, as far as this is possible, to something that is useful.

E. *Contributing through the use of all instruments to the humanity* of the social-health care structures, institutions and services of the local area so as to direct them towards achieving the practical overall welfare of sick elderly people.

It is necessary to give a 'soul' to our health-care structures. In this field it is necessary to go beyond the easy temptation to separate and almost oppose the two dimensions of pastoral care for our sick elderly people. Indeed, social-charitable activity, as a human or 'natural' action, is not opposed to specifically 'pastoral' activity. This is because this last is of a moral order (Blessed Teresa of Calcutta engaged in 'pastoral care for the sick' even though in her homes she received elderly people to whom she could not speak of Jesus). We cannot oppose the 'natural' and the 'supernatural', just as there is no separation between God the Creator and Christ the Saviour. Everything that human activity engages in for the liberation and the salvation of man – from the specific action of the most advanced technology to the simplest gesture of help – is participation in the creative and salvific work of God who wants for our sick elderly people an atmosphere in which is felt love, light and hope.

5. 'Is any among you sick? Let him call for the elders of the church, and let them pray over him, annointing him with oil in the name of the Lord' (Jm 5:14)

This famous text from the letter of James enables us to understand that one is dealing with a practice that was already known about by the early Christian community. In this anointing carried out in the name of the Lord, accompanied by prayers said by the 'presbyters', in order to alleviate a sick person and to remit sins, the Church has seen an initial form of 'anointing of the sick'.

We know that gradually there was a shift from the 'anointing of the sick' to the 'anointing of the dying' or 'extreme unction'. Thanks to the reform of the Second Vatican Council, this sacrament has returned to its early character[9] and has contributed to making pastoral care for sick people seen as an activity that is not limited to certain *auxiliaries* but one which, rather, takes into account the complex and permanent reality of sick people, and particular sick elderly people, who are in need of constant human and spiritual care that fills their lives and nourishes their hope.

In addition, it is necessary to bear in mind that hospital organisation, especially in industrialised countries, has progressively touched upon a greater number of people who, during varying periods of hospitalisation, experience illness. This requires religious assistance to make a greater effort to offer a suitable response to the human, moral and spiritual needs of the sick who have rights recognised by society. In this context illness, and in particular the illness of elderly people, cannot be seen as a general limit situation but, rather, must be seen by taking into account the diversifications and complexity of human beings. Nor can it be seen as simple situations involving a transit to the life beyond, although it constitutes a human reality that can subsist in a much more prolonged form.

Although pastoral care in health is not limited, as indeed I have emphasised in this paper, to offering the sacraments to our sick elderly people, we are aware of the fact that assuring that they have a suitable sacramental life is the best service that we can provide them with. To this end it may be suggested that certain instruments should be used and certain opportunities should be created to foster the practice of the sacraments. I will now give some examples of this:

– Periodic days for sick elderly people in parishes, hospital centres or old people's homes.

– The monthly celebration of the Eucharist for sick elderly people.

– Taking advantage of this for the strong moments of Advent and Lent.

Knowing, in addition, that anointing of the sick is normally preceded by the sacrament of reconciliation and followed by the administration of the Eucharist, its celebration constitutes an moment of extraordinary importance in the life of sick elderly people. As the *Catechism of the Catholic Church* testifies, there is available a sacrament 'especially intended to strengthen those who are being tried by illness'.[10] 'In it, through an anointing accompanied by the prayer of the priests, the Church commends the sick to the suffering and glorified Lord, so that he may give them relied and salvation'.[11] These statements recall the prayer that the Church uses for the blessing of oil: 'Effuse your holy blessing so that those who receive the anointing of this oil obtain comfort, in their body, their soul and their spirit, and are free from all pain, all weakness, and all suffering'.[12]

The Church asks for health for her infirm in faithfulness to the mandate of the Lord when he sent out his disciples: 'heal the sick' (Mt 10:8). She believes in the vivifying present of Christ, the physician of souls and bodies, and believes that this presence is particularly at work in the sacraments.[13]

The Church, however, admits that neither the sacraments nor the most fervent and full prayers with faith obtain a cure for all illnesses and thus holds addressed to herself the words that that the Lord spoke to Paul "My grace is sufficient for you, for my power is made perfect in weakness' (2 Cor 12:9). Anyway, the principal grace of the sacrament of anointing of the sick is a grace of comfort, peace and courage to overcome the specific difficulties of a condition of serious illness or the frailty of old age. 'This grace is a gift of the Holy Spirit, who renews trust and faith in God and strengthens against the temptation of the evil one, the temptation of discouragement and anguish in the face of death (cf. Heb 2:15)'.[14]

'By the grace of this sacrament the sick person receives the strength and the gift of uniting himself more closely to Christ's Passion: in a certain way he is *consecrated* to bear fruit by configuration to the Saviour's redemptive passion'.[15] In this sense there is an 'exchange' of mutual help: 'the sick who receive this sacrament, 'by freely uniting them-

selves to the Passion and death of Christ' contribute to the 'good of the people of God' (Second Vatican Council, *Lumen gentium*, n. 11). By celebrating this sacrament, the Church, in the communion of saints, intercedes for the benefit of the sick person and he, for his part, through the grace of this sacrament, contributes to the sanctification of the Church and the good of all men for whom the Church suffers and offers herself through Christ to God the Father'.[16]

The sacrament of the anointing of the sick is followed – where this is possible – by the administration of the most holy Eucharist. Although it is not always possible to establish the most suitable moment for this, it is advisable that in some occasions this is administered in the form of Viaticum. 'Communion in the body and the blood of Christ, received at this moment of 'passing over' to the Father, has a particular significance and importance. It is the seed of eternal life and the power of resurrection, according to the words of the Lord: "He who eats my flesh and drinks my blood has eternal life, and I will raise him up at the last day" (Jn 6:54). The sacrament of Christ once dead and now risen, the Eucharist is here the sacrament of passing over from death to life, from this world to the Father (cf. Jn 13:1)'.[17]

Conclusion

This brief paper has sought to show that our sick elderly people, in addition to being the privilege recipients of the pastoral care of the Church, are an extraordinary gift for the Church because they are a 'sacrament of Christ', his icon, and participants in his redemptive suffering.

The problems of sick elderly people remain with all their complex questions but our pastoral care and sacramental life help them to have experiences of understanding, moments of serenity, and feelings of authentic self-esteem and real usefulness for their families and for the whole of the Christian community. To care for an elderly person means, to summarise, *to give hope*, that is to say to infuse that dynamic and vital strength which is characterised by confidence that one will be able to reach a better future which is really possible and personally meaningful. And this not only after the final passing over from this world to eternity but also as regards what is connected with the *meaning* of old age and illness.

To care for a sick elderly person means to be an instrument of the presence and the action of the Church to offer the light and the grace of the Lord, the 'sacrificed and living lamb', who died and rose again, to those who suffer and those who care for them.

To care for a sick elderly person is, and I make the point again, 'to see' through faith and to communicate with Christ who is present in him; it is to mysteriously extend the experience of the Eucharist to the point when we can see him 'face to face', when he will say to us 'Come O blessed of my Father, inherit the kingdom prepared for you from the foundation of the world; I was sick and you visited me' (Mt. 25: 34-36)

H.E. Msgr. VICTORINO GIRARDI STELLIN MCCJ,
Bishop of Tilarán, Costa Rica.

Notes

[1] FLORES GONZALO, *Penitencia y unción de los enfermos* (BAC, Madrid, 1997), pp. 355-358.
[2] ENTRALGO L., *El estado de la enfermedad* (Madrid, 1968), p. 43; Cf. also his *Mysterium Doloris, Hacia una teología cristianade la enfermedad* (Madrid, 1955).
[3] JOHN PAUL II, *Salvifici Doloris, n.* 19.
[4] *SD*, n. 24
[5] *SD*, n. 3
[6] *SD*, n. 29
[7] V CONFERENZA GENERALE DEL CELAM (Bogotá, 2007), n. 26.
[8] *Gaudium et spes* (GS), n. 31.
[9] *Sacrosantum Concilium* (SC), n. 73.
[10] *Catechism of the Catholic Church* (CCC), n. 1511
[11] RITUALE ROMANUM, *Ordo Unctionis Infirmorum*, n. 5.
[12] Congregation for the Doctrine of the Faith, *Instruction on Prayers to Obtain Healing from God*.
[13] *CCC*, n. 1509.
[14] *CCC*, n. 1520.
[15] *CCC*, nn. 1520-1521.
[16] *CCC*, nn. 1522.
[17] *CCC*, n. 1524.

BONIFACIO HONINGS

1.3 Pastoral Aspects Connected with Psychology: the Rediscovery of the Religious Meaning of Health and Salvation

Because of the importance of the subject matter I have to address, in it I will refer first of all to the change in the demographic situation of elderly people. This paper is then organised into three sections: 1. the holistic aspect of pastoral care in health in the light of the Gospel; 2. the psychology of elderly people who are sick; 3. the rediscovery of the religious space in contemporary culture.

The Overall Demographic Situation of the Elderly

The Second World Assembly on Ageing was held in Madrid on 8-12 April 2002. The aim was to adopt an international action plan on the subject. Given that matters proceeded well, the assembly provided a response to the problems raised by the elderly part of the population and offered the promotion of development within a society for all ages. During the second half of the twenty-first century, and this point should be made, the number of people over sixty will grow from 600 million in 2000 to 2,000 million in 2005. The elderly, therefore, will move up from 8% to 19% of the population, whereas births will decrease from 33% to 22%. Such an overall demographic situation clearly involves profound consequences for every aspect of individual, community, national and international life. Every social, economic, political, cultural, psychological, spiritual and, obviously, pastoral aspect, must be able to develop in conformity with this trend. The process involving the advance of overall ageing must be integrated into a process involving increasingly large-scale humanising and socialising development. There should be, first of all, the promotion and protection of all the fundamental human rights of the elderly and the upholding of the freedoms required by their dignity as human persons.[1] It is essential to recognise the ability and the capacity of all elderly people to go on contributing to social life as a whole. As regards Christian elderly people, in general, and sick Christian elderly people in particular, I would like to emphasise their ability and capacity to contribute in their own way to the life and the mission of the Church.

1. The Theology of Holistic Pastoral Care in Health in the Light of the Gospel

Pastoral care in health, as a mission of the Church, is nothing else but the continuation of that pastoral care exercised by Christ. When sending out his disciples his words were unequivocal: 'And preach as you go, saying, 'The kingdom of heaven is at hand'. Heal the sick, raise the dead, cleanse lepers, cast out demons. You received without pay, give without pay' (Mt, 10:7-8). At a general level we can say that the pastoral care in health of Jesus expressed the benevolent presence of God amongst His creatures, the tenderness of God towards suffering humanity, and His initiative for the total recovery of man. The healings meant for Jesus the beginning of his messianic time. Indeed, he said to the disciples of John the Baptist 'Go and tell John what you hear and see: the blind receive their sight and the lame walk, lepers are cleansed and the deaf hear, and the dead are raised up and the poor have good news preached to them (Mt 11:2-3). However, and it is very important to stress this point, the healings carried out by Christ were not ends in themselves but the pathway, the beginning, of a healing that had to take place in the innermost part of the sick person. Jesus said to the paralysed man of Capharnus 'your sins have been

forgiven' and to the only leper who came back to thank him for healing his body Jesus expanded the perspective of healing by saying to him 'your faith has saved you'. The therapeutic activity of Jesus reveals in a very significant way the action of salvation that God was engaging in through the power of love of Jesus himself. Pastoral care in health, therefore, should not only be an expression of the tenderness of God towards suffering humanity but also an accompanying of suffering humanity towards salvation, that is to say towards man's full natural

and supernatural fulfilment. And a sick person of advanced age finds himself in exactly such a condition.[2]

At this point it is important to make clear that at the time of John of God, Camillus de Lellis and Vincent de Paul, pastoral care in health involved religious assistance, 'caring for souls'. The manuals of pastoral theology tried to train priests in a practical way[3] and later in a more theological way in 'caring for souls'.[4] The classic manual of Ignaz Schuch, which was more in the style of Rautenstrauch, became the classic text of pastoral care in health. [5] The Second Vatican Council taught that pastoral activity must be realistic, that is to say that it must take into consideration its divine and human dimension, i.e. that it should rest completely and at the same time within revelation and historical reality. [6] The Bishops' Conference of Italy saw pastoral care in health 'as the presence and the action of the Church to bring the light and grace of the Lord to those who suffer and to those who take care of them'. In other words, pastoral care in health has the task of integrating all forces around the sick person in order to raise him up morally and help him to accept and appreciate his situation of suffering – accompanying him with prayer and the grace of the sacraments as well in order to respond to his vocation as a man and as a baptised person.[7] What has just been said stresses that the features of pastoral care in health are to do with the holistic approach to the sick person: soma, psyche, pneuma.

2. The Psychology of Elderly People who are Sick

We cannot and we should not hide from ourselves the fact that illness constitutes, for the religious world as well, a psychological and spiritual challenge. Indeed, in illness, and especially grave illness, fear of death and worries about the patient's personal situation and the situation of his relatives can subject his religiosity, even if he is a believer, to a severe trial. To begin with God could appear to him to be directly responsible for his suffering or as someone who is indifferent to the suffering of His creature. 'Illness and suffering', observes the *Catechism of the Catholic Church*, 'have always been among the gravest problems confronted in human life. In illness, man experiences his powerlessness, his limitations and his finitude. Every illness can make us glimpse death'.[8] 'Illness can lead to anguish, self-absorption, sometimes even despair and revolt against God. It can also make a person more mature, helping him to discern in his life what is not essential so that he can turn toward that which is. Very often illness provokes search for God and a return to him'.[9] It is important, therefore, for the pastoral pastor to discern who the patient is that he has before him, and above all when that sick person is elderly. This is because that sick elderly person is drawing ever nearer to the ultimate destiny of his life. John Paul II, of venerable memory, observed that the world of health and illness, in which the fundamental human events of existence take place, appear as an emblematic 'place' to perceive or grasp certain expressions or clues with regard to the psychological and spiritual condition of a sick person, above all, as is the case here, if that patient is an elderly person.[10]

Science and technology, which are increasingly near to the ultimate secrets of life, have relativised or at least weakened the religious value of human life. Instead of salvation, contemporary man wants health of increasing quality. In the place of forgiveness and sacramental reconciliation, the sedatives of an immense market are looked for or the resources offered by the behavioural sciences are sought. Experience of pastoral care in the world of health tells us that religion has lost a great deal of space in the human soul and that the spiritual experience, which is increasingly subjective, more intimate or concealed, often goes unobserved. The psychology of the elderly sick is not alien to this religious loss. They experience a profound sense of loneliness and live in a state of mind which involved feeling that they are a heavy burden for their family and social context. By now they feel that they are a ruin that has to be got rid of *quam primum*.

3. The Rediscovery of Religious Space in Contemporary Culture

It is precisely here that religious and spiritual practice and experience can have the effects of health and above all else of salvation. This is a somatic, mental and pneumatic dimension, specific to the human person, which, above all in the psychology of an elderly patient, are profoundly interactive. Here we open up a field of research into the pastoral aspects that can help us to read and to propose a vision of the Gospel of life, of suffering and of death. Pastoral care in health can find in elderly patients, even though not always in an explicit way, an integral vision of their human and Christian being. Not only this: it can also and above all encounter the active interaction of all their dimensions in the psycho-physical and religious-spiritual process of their illness. Here, however, it is important to point out two risks: the first is the reduction of pastoral care to the psychological condition of the individual with the exclusion of the religious dimension; the second is that possible needs and wishes of a religious character may become irrelevant in the process that involves the overcoming of a profound feeling of loneliness and a state of mind that involves feeling that one is a heavy burden for one's family and a burden of a socio-economic character.[11] The first risk arises with pastoral care that is too disembodied, provided from on high, and not very sensitive to the human individual and social fulfilment of man in time and space. The second risk arises with pastoral care that is too embodied, horizontal, wand which has an ambiguous openness to transcendence and is exposed to religious subjectivism and ethical relativism, and thus without contents.

Conclusion

With regard to pastoral matters it is important for the experience of illness, suffering and death to bring out the fundamental structure of the person. Such experience points to the true identity of the human and Christian being, that is to say it points out not what happens but

what in essential terms each one of us is. It places man in front of choices guided by values, that is to say it forces him to pronounce on what is essential in his life and, above all if he is elderly and sick, on what illness and death mean for him. The certainty of the Apostle allows of no doubt on the matter: 'I consider that the sufferings of this present time are not worth comparing with the glory that is to be revealed to us' (Rom 8:18). With respect to the psychology of every man, but I would say first of all and above all else with respect to the psychology of every elderly person who is sick, St. Augustine demonstrates that the human person realises his existence beginning with a radical tension. 'You Lord made us for You and our hearts will always be troubled until You rest in us'. With death man definitively overcomes man. This is the originality of every human being, created and conserved through love by God, redeemed by the blood of the Son, sanctified by the grace of the Holy Spirit, to rest eternally in the love of the Father, of the Son, and of the Holy Spirit.[12]

Rev. BONIFACIO HONINGS, O.C.D.
Professor Emeritus of Moral Theology, The Pontifical Lateran and Urbanian Universities, Consultor to the Pontifical Council for Health Care Workers, the Holy See.

Note

[1] See *International Plan of Action on Ageing 2002,* Introduction, n. 2 and n. 5.
[2] Cf. Di Menna Renato, 'Pastorale sanitaria. Storia, concetti, ambiti', in *Dizionario di Theologia Pastorale*, pp. 830-832
[3] Cf. Stefano Ratensctrauch OSB.
[4] Cf, Michael Sailer and Anton Graf.
[5] It was duplicated for the first time in 1865 and had various editions of which the last came out in 1924.
[6] Cf. Seveso B., 'Teologia pastorale' in *Dizionario Teologico Interdisciplinare* (1977), p. 94.
[7] Cf. Di Menna Renato, *op. cit.*, p, 835.
[8] *CCC*, n. 1500.
[9] *CCC*, m. 1501.
[10] Cf. *Dolentium hominum*, 3.
[11] Cf, Francisco Àlvarez, 'La dimensione spirituale della persona. Per un accompagnamento salutare nella malattia', *Camillianum* 19, 2007, pp. 72-73, (see above all note 7), but see also Zucchi-Honings, various studies in *Dolentium Hominum*.
[12] Cf. *CCC*, n. 27.

2. The Pastoral Care of Sick Elderly People from the Biomedical Point of View

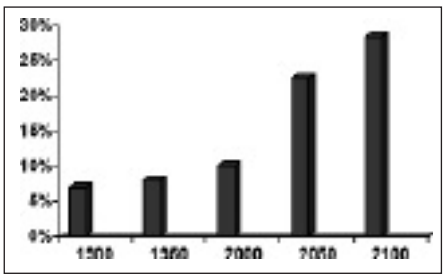
GIUSEPPE RECCHIA, PAOLO RIZZINI

2.1 Biomedical Research and Pharmacology for Sick Elderly People

Introduction

The modification of the social structure that is under way, with the significant increase in the number of elderly people both above the age of sixty (see fig.1) and above the age of eighty, as a result of the increase in life expectancy, constitutes an important and profound demographic revolution whose impact could be greater, according to the forecasts of the United Nations, than that caused by the industrial revolution.(1,2)

Fig. 1. Percentage of the world's population with an age equal to or greater than 60 during the last century and projections for the present century(2)



The picture becomes even more dramatic if we confine ourselves to the so-called developed countries: over the last hundred years average life expectancy for humans has practically doubled and at the present time in Europe and America about 20% of the population is made up of people over the age of sixty and it is calculated that by the year 2100 this percentage will be 45-50%.

Ageing is certainly a universal process that can be easily recognised in all animal species because its manifestations are familiar, evident and well-defined. Despite this, there is no completely accepted definition of what it is and the mechanisms that underlie it have not been clarified and are often elusive and difficult to research. Ageing has been defined as a progressive diminution of the capacity to function, accompanied by a loss of a capacity to reproduce and an increase in mortality and disability.(3) To this should be added the effects of age on responses to therapies, whether they are pharmacological, surgical or rehabilitative. Lastly, during advanced age the prevalence of illness markers increases, as well as that of attested illness and functional deficits caused by various pathologies. Old age is thus seen in developed countries as the principal risk factor as regards the majority of pathologies and in the United States of America individuals over the age of seventy make up 58% of people with osteo-articular pathologies, 45% of those with hypertension, 21% of those with heart disease, 19% of those with cancer, 12% of those with diabetes, and 9% of those with stroke.(4)

Although the process of the ageing of the population is seen as an important potential factor of crisis for the economy and the health-care services,(5, 6) it should be recognised that the potential capacity exists to achieve an excellent state of health in advanced age, thereby allowing elderly people to make a positive contribution to society.(1) The decrease in illnesses and mortality, for example cardiovascular disease, together with an increase in the functional condition of the geriatric part of the population, means that it is at the least confusing to extrapolate the contemporary levels of prevalence of illness and disability onto future generations of elderly people.

Basic biomedical research, in particular genetic basic research, the clinical experimentation of therapies for the elderly and health-care research will be fundamental in the next years in defining more effectively a new paradigm of ageing and its medical and health-care management. In this paper we will discuss the opportunities and problems linked to the studies on the elderly part of the population in relation to these three sectors of research.

Biomedical Research and the Genetics of Ageing

'Elderly people' represent that part of our population which is growing at the fastest rhythm. This could lead to a significant if not dramatic potential increase in the prevalence of pathologies correlated with ageing, such as cardiovascular and cerebrovascular illnesses, arteroscelerosis, type 2 diabetes, tumours, cataract, Alzheimer's disease, osteoporosis and arthritis, to list only a few.(7) Improvements in therapeutic capacity and efficacy as regards these and other important

pathologies could push average life expectancy to eight-five and over, with a substantial 'compression' of geriatric illness in the last period of life. A further increase in life expectancy could in reality be achieved in the future only through intervention at the level of the basic biological mechanisms (molecules and cells) of ageing. The ability to achieve a notable or extraordinary longevity in good health is probably the result of a combination of many factors: lifestyle, alimentation, and the 'good luck' to have a (genetic) constitution (genotype) that is 'favourable', that is to say a lack of genes with a predisposition to illness, disability and premature death, and the presence of genetic variants that favour longevity.

But what is ageing? And is ageing an illness or not? Some 'experts' (that is to say the gerontologists) clearly make a distinction between the terms 'ageing' and 'senescence', where they mean by senescence all those structural and functional modifications that manifest themselves towards the end of a person's life (we can refer to the life of a cell, of a tissue, of an organ, or of an entire organism), and which are associated with the more or less imminent death of the tissue or organism. In evolutionistic terms, it is possible to assume that the mechanisms of cellular senescence have evolved as anti-tumour mechanisms in order to impede injuries to the DNA, the uncontrolled growth of cancers, and other phenomena that are typical of transformation into cancer.(8) In opposed fashion, the term 'ageing' is used to define any structural and/or functional change that takes place during a person's life . In other words, active ageing begins during prenatal life given that certain cells die because of apoptosis as a part of the process of the development of the embryo/foetus which is established by the genetic programme. Thus ageing can be defined as that set of changes which make a human being progressively 'nearer' in a probabilistic sense to death.

Studies in the field of evolutionistic biology have provided us with a robust theory (even though it does not lend itself to immediate and easy comprehension) about *why* we age. In very summarising terms, we grow old because the 'senescent' phenotypes escape the power of natural selection and ageing is a non-adaptive process. However, much less is known about *how* we age, that is to say in large measure the molecular mechanisms of ageing which constitute a field of study that is extremely complex. For example, it is not clear if this process is due to a relatively low number of universal molecular processes or if the ageing of each organism, organ or tissue takes place with unique and specific mechanisms. Some of the problems that exist in the study of the molecular causes of ageing are to be identified, for example, with individual tissue heterogeneousness, the differences between animal species, and the role of intrinsic cell factors in relation to general modifications of homeostasis. In other words, the cell and tissue molecular changes associated with ageing are the net result of many other concurrent events which can thus obscure the primary cause of ageing itself.(9)

From the point of view of genetic research, an increase in our knowledge in these spheres can be obtained principally through two strategies, namely 1) the identification (employing mapping and subsequent cloning) of the genes responsible for the important chronic-degenerative pathologies that are typical of elderly people (for example Alzheimer's dementia), tumours, arteroscelerosis, etc.); and 2) the study of the genetic bases of human longevity. A simple but important theoretical assumption for the attributing of a non-secondary role to our genes in the complex processes correlated with ageing is represented by the fact that the scale and speed of ageing and the maximum life span vary between various species of animals. Thus these processes must at least in part be subjected to controls of a genetic type. For example, in some important experimental animal models employed for the study of ageing (the nematode *C.elegans*, the fly *D.melanogaster*, and mouse), specific mutations in specific genes induce an increase in life span that is even sixfold, apparently slowing down the processes of ageing. And the same kinds of genes that act in one species have the same effect in other species as well. This is a very important fact because, given that most of the bio-metabolic pathways are conserved by evolution in the most varied of animal species, and given that almost all these genes are present in homologous form in our genome as well, their analysis could certainly help us to further understand the mechanisms of human ageing. In addition, the identification of the genetic determinants that govern human longevity suggest that there is the possibility of identifying potential therapeutic targets, as we describe below.

The 'Gerontogenes'

One path that can be followed, therefore, is that of discovering the genes that are responsible for the processes of ageing (for example in fruit flies the genes that hinder the accumulation of energy) and then deactivating them. There are over fifty genes that *seem* to be involved in the process of ageing (the gerontogenes). The first to be discovered was the daf-2 gene which causes ageing in the filarial: when it is deactivated these worms double their life span. In 1998 the Matusalem gene was identified and this allows an increase in the life span of the species of 35%.(11) It is interesting to note how the functions of these genes are correlated with the energy-metabolism cells and this sup-

ports the idea that there is a close connection between metabolism and ageing. Another interesting gene, which was baptised p66shc, when suppressed and deactivated in mouse doubles the life span of this animal.(12) This gene, which codifies through a transductor of the cytoplasmatic signal involved in the transmission of mitogenic stimuli by specific receptors activated with the Ras oncogene is probably involved in the regulation of the apoptotic responses involved in stress and in the regulation of the life span of mammals. In December 2000 the discovery of Indy (an acronym of 'I'm not dead yet') was announced. Its mutation doubles the life span of fruit flies, creating a metabolic cellular situation that stimulates a state of calorie restriction. (13) In 2001 an Italo-American team announced the generation of transgenic mice whose muscles do not age and thus do not lose strength with age. This was made possible by transferring into embryos the gene for a protein (Igf1, insulin-like growth factor) that is able to block the degeneration of muscles typical of ageing.(14). The taking of Igf1 as an anti-ageing search has probably allowed the identification of a gene involved in the regulation of calorie intake, associated with longevity in metazoas.(15) This is *Sir2* which codifies through a histonic deacetilasis (but other proteins can be modified, for example the p53). A significant increase in the expression of this gene has been observed in long-living mutants as well as in long-living wild-type drosophilia subject to calorie restriction. The idea is that Sir2 is directly involved in molecular and biochemical pathways deputed with the regulation of calorie restriction associated with life span.

Cromosome 4, Ageing and Lipid Ageing

Chromosome 4 seems to offer some hope as regards the genetics of ageing. In 2001 a group of researchers in Boston identified, through the familial analyses of genetic linkage, a region of chromosome 4 that contains one or more genes that can be associated with longevity, studying 137 families for the most part of European origins with family members who have

hormonal therapy has been known about for some time but the collateral effects (the development of tumours) have blocked its use. The advantage of inserting it into embryos is that its action is limited only to involuntary muscles. Obviously enough, this is research which if applied to man could improve quality of life in an advanced age but it does not improve longevity given that it works only on a portion of the organism. To return to the fruit fly, very recent re-

lived to over the age of a hundred – 308 individuals in all. It was discovered that these individuals had in common a region of chromosome 4 containing at least 50 genes.(16) In 2003 the same authors (led by the Italian Annibale Puca) identified a probable 'candidate' gene in this region involved and/or associated with the length of life span in man.(17) This gene codifies for a microsomal transport protein (MTP) involved in lipoprotein biosynthesis (packaging of the ApoB and the triglycerides). These studies also opened up other interesting medical and pharmaceutical scenarios. Indeed, the MTP constitutes a fascinating therapeutic target for next generation anti-lipid pharmaceuticals in the treatment of hyper-lipemias and obesity. In addition, the action of the MTP in lipid metabolism provides rational evidence to suspect that it plays a role in human longevity. It is known to everyone that alterations in the lipid profile (together with other genetic and environmental factors) constitute an important risk factor for vascular (cardiac, cerebral, periphery) illnesses, which are, indeed, amongst the primary causes of mortality. Genetic variants associated with the lipid function should also have some effect on life span. For example, the children of centenarians have more 'favourable' lipid profiles (an increase in HDL-cholesterol and a reduction on LDL-cholesterol) compared to members of control groups and as a result they display a significant reduction in cardiac and cerebrovascular risk. In addition, these studies demonstrate the practicability and utility of utilising individuals and families of centenarians or near centenarians as a study model for human longevity and resistance to chronic-degenerative illnesses.

In Italy research into the genetic aspect of ageing has recently been launched as well. In May 2004 in Bologna the European project 'GEHA – Genetics of Healthy Aging' was presented. This is an integrated project of scientific research financed by the European Union headed by the University of Bologna. It is a five-year project and its task is the identification of 2,800 over-ninety siblings in seventeen geographical areas covering eleven European countries, as well as Israel and China. This project has the goal of identifying genes that play a role in healthy ageing and allow the attainment of an advanced age in good conditions of physical and cognitive activity: sons, grandsons but also husbands and wives will be used to identify how much the environment in which an individual has lived may have contributed to his or her good health. The CIG, the Galvani Interdepartmental Centre for the inte-

grated study of bio-informatics, biophysics and biocomplexity of the University of Bologna, will coordinate the research of the twenty-six project partners, chosen from amongst the most advanced centres for the study of geriatrics, genetics, bio-informatics and demography. Professor Caludio Franceschi will be the head of this project. He is the director of the National Institute for the Treatment of Elderly People of Ancona (INRCA). The aim is to achieve a genetic mapping through a scansion of the entire genome. From this preliminary scansion an attempt will be made to reduce the analysis to the zones that tell us about the state of health of elderly people. On these regions will be concentrated research into the genes that may have brought about this good state of health.

Telomeres and Telomerasis

Telomeres are portions of the short sequence of repeat DNA located at the extremities of the chromosomes. Their task is to protect the chromosomes during cell division; this task tears them and every time that the cell divides they are shortened. At a certain point their length is no longer able to protect a cell that reproduces in an incorrect way and this generates ageing. The telomeres constitute, therefore, a kind of cellular biological clock which tells the cell when the moment to go into 'apoptosis' has arrived. Apoptosis is a difficult term which refers to programmed cell death. The shortening of the telomeres probably derives from a lack of activity on the part of the telomerase enzyme (a rather complex ribonucleoprotein for the enzyme activity that builds the telomeres) in the majority of somatic cells. The so-termed theory of telomeres, therefore, postulates that cell ageing is due to the inability of the cell to divide itself. In 1996 the cloning of the sheep Dolly generated alarm in scientists who were looking for the elixir of eternal youth – the sheep was born 'old', being similar to her mother from whom she was cloned ('old' in a biological sense, in the sense that is to say that the length of the telomeres in the newly-born lamb corresponded to the length of telomeres in an adult sheep). What are the limits of the theory of telomeres? The fact that telomeres could not be the true neck of the bottle of the ageing process. In other words, even with telomeres of an infinite length other factors may intervene that drastically reduce longevity. Telomeres were brought to the attention of the general public when they began to be associated with the ageing process. It should be noted here that often the mass media tend to transform interesting scientific hypotheses into spectacular and sensational news. Many newspaper headlines, referring to these studies on telomeres or telomerasis, triumphantly proclaimed 'the immortality gene has been discovered!' Further comment is superfluous here.

Progeria (Hutchinson-Gilford's Disease)

A new theory, on the other hand, posits that cells continue to divide even in an advanced age but because of a genetic defect they do so badly. For example, children affected by a form of progeria (Hutchinson-Gilford's disease), a rare and grave genetic disease that causes very precocious and ageing, have fibroblasts which in vitro rather than dividing about fifty times before dying divide only ten to thirty time, thereby displaying very early signs of cellular senescence. Mutation is seen in the LMNA gene which contains basic information for the construction and maintenance of two proteins that are strongly involved in the growth and maturation processes of cells (lamin A and C). (18) This is a very important discovery for the early diagnosis of this disease and opens up a new pathway for the understanding of the phenomena that in general regulate the lives of tissues.

Altmann's Granules

It is known that mitochondrial DNA, without effective repair systems such as those possessed by nuclear DNA, accumulates mutations over time, damaging itself progressively and in a constant way, probably because of oxygen reactive radicals produced in the respiratory chain.(19) The mutations in the Altmann's granules can be involved in the development of certain ageing pathologies such as osteoporosis, heart disease and anaemia linked to old age. For example, experimental mice with genes that have been modified to increase the number of mutations in the Altmann's granules age three times faster than is normal. For that matter, genetically modified mice suffer from fur loss, osteoporosis, weight loss and heart problems much earlier than is the case with normal mice and live for a third of the time of their non-genetically modified fellows.(20) In addition to acting as energy converters in cells, Altamann's granules produce oxidising agents that can injure cells and their DNA. Because of their proximity to these oxidisers or free radicals, Altmann's granules are particularly vulnerable. Scientists have been studying the connection between mutations in Altmann's granules and illnesses connected with ageing since the 1950s. These mutations are not simply a sub-product of ageing. They are one of its principal causes, even though the mystery connected with them has not been completely solved.

Calorie Restriction

In order to attempt to answer the question that was posed at the beginning of this paper, namely 'is ageing an illness?', one possible strategy is that of comparing animals that age normally with animals that live for a long time (or have long lives). It is known that mice subject to low calorie diets are good models at the level of 'health'. If ageing is an illness, then these long-living animals are without it. The only certain and known thing that delays ageing (at least in rodents) is calorie restriction, However, these data that link calorie input to length of life in rodent animal models have still not been reproduced in non-human primates. Thus this, too, constitutes a research pathway to be explored with studies in comparative physiology and genetics.

The Future Prospects for Research

The study of human ageing is an extraordinary challenge. This phe-

nomenon is made even more complex by the fact that it is practically impossible to study it directly in humans in vitro. Thus this research has to be, and will have to be based, upon indirect strategies such as models and extrapolations. Very new and promising research opportunities in relation to the genetic aspects of the physiology and physiopathology of human ageing will come from the new technologies that are offered by genomics, by post-genomics and by proteomics, for example through the creation of broad genetic and protein data bases containing information derived from studies on animal models (genes, metabolic pathways, and mutations known to modify ageing), integrated into functional networks. A data base appropriately called GenAge has been recently established and it is able to provide a kind of genomic and proteomic map of human ageing.(21) Side by side with these astonishing developments, bioinformatics, comparative genomics and multiple gene analysis through DNA chips (DNA microarrays) for the reconstruction of the genetic networks involved in the causative and regulatory processes of ageing will certainly find space and play a fundamental role.(22)

We can at this point pose certain questions: will we live to the age of a hundred and twenty? Or perhaps even longer? Many theories hold the field in this debate. We would like to cite three from those that are most accredited at the present time. *The genetic theory*: genes are said to exist that command, survey and regulate by certain pathways the process of ageing. This theory grants little space to the defences that the individual can activate against his or her biological clock and thus against the 'environment'. Only genetic engineering, it is said, could thus in the future alter things. *The theory of free radicals*: in 1954 the Nobel prize winner D. Harman advanced the thesis that the cause of senescence was the free radicals produced during the metabolic processes. Free radicals are very active and can react with DNA, proteins, and the fatty acids present in the cell membrane. *The hormone theory*: this is one of the most interesting theories on ageing. With age some hormones decrease and provoke many of the problems normally associated with old age. In reality, it is probable that these causes may coexist (together with others) and that in removing some of them one could actually reach that limit of a hundred years of age which is at the present time the goal of researchers. The recent discovery of the p66shc gene, which controls a protein that governs the cell response to oxidative stress, seems to confirm the possible coexistence advanced by these various theories. Ageing is a complex phenomenon that involves the degeneration of the vital capacities of the organism which, even in the absence of illnesses, leads to death. One should, therefore, observe that despite certain commonplaces and prejudices, ageing is not necessarily associated with illness or various degrees of incapacitating pathologies. This is because its effects, in terms of diminished psycho-physical performance, are also to be observed in perfectly healthy individuals. The enormous steps forward that genetics is making have generated perhaps unjustifiable enthusiasm in the study of anti-ageing strategies. Indeed, the results of research in this field have not yet been consolidated. This means that of the hundred of research projects that have been carried out throughout the world and whose results have appeared in specialist reviews only some have become fundamental, that is to say they will be translated into practical results. Many others will be reduced in importance or contradicted by greater understanding of the processes of ageing. It is necessary to distinguish between experiments on animals and experiments on humans. The general application of results to humans is by no means something that can be taken for granted. One has to distinguish between partial results (on one part of an organism) and total results. Prolonging the efficiency of an organ does not necessarily mean increasing the longevity of that organism, in the same way as cell immortality does not mean the immortality of man. A majority of the research on experimental animals relates to animals which have a relatively short life span where the discovery of the genes responsible for ageing is thus facilitated by the rapid succession of generations and the rapid passing of the lives of individual members of that species. The prospects for this pathway of research are very good because a possible discovery about man could actually be translated into anti-ageing products (for example pharmaceuticals that deactivate the substances whose synthesis is set in motion by bad genes). Will it be possible one day to control the expression of the genes responsible for ageing? Even though the answer to this question is probably in the affirmative, these genes will have to be first of all identified and only subsequently will it be possible to study and modify their expression. In a slightly less distant future it is possible that once the molecular mechanisms of ageing have been understood it will be possible to offer targeted anti-ageing therapies. But how much time will be needed to answer all our questions? Given the present state of knowledge it is not possible to make easy predictions and the facile scientific popularisers who answer this question do not do so on the basis of correct forecasting data.

Genes and the Pathologies of Advanced Age

The role of genetic factors in the development of illnesses is by now unquestioned. Francis Collins, the co-ordinator of the Human Genome Project, has illustrated the relationship between genes and illnesses with the phrase 'we can say that all illnesses, apart perhaps from traumas, have a genetic component'. Every illness is the result of an interaction between genetic factors and environmental factors. In rare genetic illnesses (these are also called Mendelian or monogenic illnesses), the weight of the genetic component is largely prevalent. In multi-factor illnesses (also called complex illnesses or shared illnesses), both genetic and environmental factors play an important role and thus the development of a pathology is the result of a complex interaction of more than one gene with other genes and environmental factors. This category includes many pathologies con-

nected with advanced age, such as, for example, cardiovascular and cerebrovascular pathologies, diabetes, certain tumours, and Alzheimer's disease.

It is thought that each individual has at least four or five genes that strongly predispose him or her to certain illnesses and another ten or so genes that confer on him or her a moderate risk – here one speaks therefore of 'susceptibility genes'.(23) On average a man has a genetic make-up that allows him a life span of about eighty-five years with morbidity compressed into his final years. This make-up, together with a 'healthy' lifestyle, should allow the twenty-five years after the age of sixty to be passed in good health, with the emergence of grave pathologies being postponed to the last years of a person's life. The fact that often such is not the case is said to be attributable to an incorrect lifestyle, a hypothesis that is absolutely credible if one considers the percentage of people who are overweight, smoke, do not engage in physical exercise, or are subject to strong environmental pollution, stress etc. These environmental factors ensure that life expectancy is lowered by about ten years with more years of disability than our genes would allow us.(24)

What is it that Allows Centenarians to be Healthy?

In many species, including man, the mortality rate, which increases exponentially with age, begins to de-accelerate in very advanced age, and this suggests that a different factor is at work.(25) Some evidence, and in particular that relating to studies on centenarians, demonstrate that this factor is genetic and not environmental. The parents of centenarians on the whole survive longer than the rest of the population and the children of centenarians as well have an increased probability of living for a long time. Their wives do not display this advantage.(26, 27). In addition, this advantage does not appear to decrease with age as it should were it attributable to environmental factors. The hypothesis, therefore, is that genes with a susceptibility to lethal pathologies operate a demographic selection, as a result of which the most susceptible individuals die, leaving behind them a cohort of long-survivors with a different genetic make-up, a phenomenon that modifies the incidence of the mortality rate.(24) The consequence of this theory is the 'compression of morbidity', by which, with the increase in average life span, the emergence and length of lethal pathologies correlated with age are said to be compressed into the last stage of life.(28) The studies on centenarians indicate that most centenarians live in good or relatively good conditions of health and have not had important pathologies during their lives. For example, in one study 90% of centenarians were self-sufficient at the age of ninety.(29) To reach this age an individual must of necessity have been healthy for the major part of his or her life and escape or delay the emergence of the pathologies that are normally associated with growing old.

To go beyond the age of eighty-five it is necessary to have a 'genetic advantage', that is to say the absence of genes with a susceptibility to important pathologies together with the presence of genes that foster longevity. Individuals who reach a very advanced age probably do not have those genetic variants that increase risks of premature death because of lethal pathologies both related and not related to age.(24) To support this theory there are certain observed facts, for example the marked decrease in the frequency of the allele APOE e4 which increases the risks of developing Alzheimer's disease in advanced old age. People in their nineties with their cognitive functions in tact owe this advantage to an increased genetic resistance to Alzheimer's disease.(30, 31). Individuals that reach an advanced old age have a slower ageing process, as is demonstrated, for example, by the high percentage of children born to women over the age of forty who then live for a very long time.(32) To reach this age it is necessary to have genes that slow down ageing and not to have genes that predispose a person to important pathologies. To reach a very advanced old age in good health, to summarise, it is important to have the 'right' alleles and it is essential not to have the 'wrong' ones.

With respect to the effect of environmental factors (diet, lifestyle, economic level, schooling, etc.), these have a strong influence on life expectancy and morbidity in individuals that do not live beyond the age of eighty-five. In centenarians, instead, so far no significant correlation has been found between the possibility of surviving for so long and environmental factors, a fact that supports the thesis of the influence of genetic factors.(33)

The study of centenarians appears to be a very useful instrument by which both to uncover which genetic variants are associated with greater survival and to identify the genes with a susceptibility to the most important pathologies. In addition, because centenarians have a morbidity that is compressed towards the ends of their lives they constitute an excellent model to study ageing 'without illness'. These studies have the real capacity to throw light on these aspects because, although the genetic polymorphisms that can have a positive or negative effect on survival are thousands in number, the polymorphisms that exercise an important effect on the speed of ageing and predisposition to illnesses correlated with age are relatively few in number, as is demonstrated by the studies on lower organisms and centenarians.

Predictive Medicine and the Prevention of the Pathologies of Advanced Age

The assumption on which is based a new approach to medicine, predictive medicine, is that one can prevent illness at an individual level through the identification of the susceptibility genes.(34) This approach envisages that through an analysis of the DNA of an individual one can uncover the susceptibility genes that it possesses and thus implement early on lifestyles or therapies that are most suited to reducing the risk that the person involved will develop the illness concerned. For example, an individual who undergoes a check-up for his or her susceptibility genes could discover that his or her risk of having prostrate cancer or Alzheimer's disease is lower than average in relation to the population, whereas he or she could discover that his or her risk of developing coronary disease, colon cancer and lung cancer is higher.(35) For him or her there could thus be drawn up a programme directed towards reducing the risk that the pathologies to which he or she is susceptible will actually develop. This model can still not be implemented on a broad front because robust and clinically significant correlations have not been established between DNA variants and the emergence of illness, but it is to be predicted that in a not too distant future it will be implemented at least for the most relevant illnesses. The application of this approach early on in an individual's life could lead to a reduction of the presence of pathologies above all in advanced age and under the age of eighty-five – that age band when the influence of environmental factors on the development of pathologies to which an individual is predisposed is notable. Some argue that knowing that one is genetically predisposed to a certain illness gives a greater incentive to the adoption of suitable lifestyles than would be the case were there knowledge of a general risk.

Genetics and Therapy in the Case of Elderly People

As has already been observed in this paper, the treatment of elderly people involves various factors of complexity. The administration of combined therapies and for different concomitant pathologies increases the risk of unforeseen pharmacological interactions and ones that are not even known about or which have an altered bio-disposition as regards concomitant pathologies. Help in improving the treatment of elderly people could come from pharmacogenetics. Not only is there a genetic component, of varying degrees of importance, in all illnesses, but the individual response to drugs and medicines is also influenced by genetic factors. The model is similar to that of multi-factor illnesses: there are a number of genes which cause a predisposition to non-response or a side effects in the case of a specific pharmaceutical. The effect that is observed depends on the interaction of these factors with environmental factors such as the dose that is administered, the working of the kidneys, etc.

Pharmacogenetics is that branch of genetics that studies those genes that influence responses to pharmaceuticals.(36) The genes that influence responses to pharmaceuticals are those involved in the absorption, metabolism, distribution and elimination of the pharmaceutical or those correlated with the biological target that the pharmaceutical attacks to carry out its effect (for example a receptor). Genes belonging to other categories can be involved, for example the HLA genes are involved in the side effects of certain pharmaceuticals. A person who is genetically predisposed has more likelihood of developing, for example, a side effect, in particular if factors of an environmental character are at work, for example reduced functioning of the liver.

Pharmacogenetics has the final aim of developing pharmacogenetic tests, that is to say tests which, through an analysis of DNA, provide an *estimate* of the risk that an individual patient runs of not responding to a certain pharmaceutical and/or of developing a specific side effect. Genes involved in the metabolism of pharmaceuticals have been extensively studied, in particular those such as CYP2D6 and CYP2C9 which metabolise those pharmaceuticals which are most commonly prescribed or which are very polymorphous. For example, the gene CYP2C9 is associated with the daily maintenance dose for anti-coagulant treatment with warfarin. Individuals which have the *2 and *3 of the gene require a lower dose and are more exposed to the risks of grave complications involving haemorrhaging.(37) The pharmacogenetic effects of many classes of pharmaceuticals have been described and although the scientific evidence is often discordant many experts agree in thinking that not a great deal of time will pass before pharmacogenetics enters clinical medicine.(38)

A deep knowledge of these genetic risk factors and their relationship to the response to pharmaceuticals has a particular importance in the case of elderly people and could provide useful instruments by which to improve treatment. For example, knowing about the polymorphisms of the genes responsible for the metabolism of pharmaceuticals could be especially useful in identifying and preventing possible interactions between pharmaceuticals.

In elderly people, environmental factors can increase the effect of genetic polymorphisms giving rise, for example, to side effects. For example, a polymorphism in a metabolism gene may not generate any evident effect if the functioning of the liver is normal. The deterioration of the working of the liver in elderly people could make evident the effect of a polymorphism which is always present, giving rise to side effects. The application of pharmacogenetics to elderly people thus offers important possibilities of reducing the difficulties of a therapy and the low predictability of its effects. In opposite fashion, the complexity of a treatment, the high influence and variability of environmental factors as compared to genetic factors, could reduce the predictive power and thus the clinical utility of pharmacogenetic tests in elderly people.

Genomics and the Discovery of New Therapies

Despite the high number of pharmaceuticals on the market and the

undeniable enormous improvements in therapies over recent decades, there are still pathologies which do not have suitable therapies and many of these are pathologies that are typical of old age, for example psychiatric illnesses. Genomics could make an important contribution to increasing therapeutic possibilities for elderly people. Pharmacogenomics is the study of the variability of the expression of the genes (RNA and proteins) of an individual correlated both to susceptibility to illnesses and to response to pharmaceuticals. Pharmacogenomics could allow the discovery of new pharmaceuticals and above all innovative pharmaceuticals.(39)

It begins with the identification of a gene involving a susceptibility to a certain illness through studies on human genetics, studies on transgenic animals, and studies on differential or proteomic genetic expression. Once this gene has been discovered an attempt is made to find the codified proteins and their function in order to understand the role they play in the illness being studied. An understanding of this mechanism allows an identification of targets, that is to say those molecules which, if hit by the right pharmaceutical, can stop or slow down the advance of the illness. Pharmacogenomics could, therefore, contribute to the discovery of new pharmaceuticals for pathologies to which we still do not have an adequate response.

Stem Cells

Research on stem cells is advancing very rapidly and already there are examples of an effective use of this technique in the clinical sphere as well.(40) These advances are of extreme relevance to the pathologies suffered by elderly people because stem cells are seen as the most promising therapy there is for all the advanced neurodegenerative pathologies, such as Parkinson's disease, cerebral ischemia and Alzheimer's disease. Hopes about defeating these pathologies are in large part placed in the regenerative medicine that will be made possible by stem cells.

Pharmacological Clinical Research and Elderly People

It is estimated that in 2000-2030 the proportion of the population over the age of sixty-five will increase from 6.9% to 12% at a world level, from 12.6% to 20.3% in North America, and from 15.5% to 24.3 % in Europe.(41) In some regions of Italy, France and Germany the proportion of the population over the age of eighty will constitute 7-9% of the total population, compared to 3.9% in 1995. The growth will be greatest specifically in this age band, with a numerical increase of 62% over the next twenty-five years. In Italy in 2025 one in fourteen individuals (7.1%) will be over the age of eighty. Similar growth trends will be seen in Germany, Denmark, Sweden and Ireland. (42)

After the age of sixty it is estimated that about three-quarters of the population have a chronic pathology and that a half of this age band has two or more illnesses. This state of affairs involves the frequent use of therapies, often combined therapies, and often for different concomitant pathologies. An American study has shown that more than 40% of individuals over the age of sixty-five who are not in institutions use five or more different pharmaceuticals every week and that 12% use more than ten.(43) The use of therapies is even more marked in institutionalised elderly people and elderly people who are in conditions of home assistance.(44,45).

Although there is concern about the excessive use of pharmaceuticals in the case of elderly patients, where these are often prescribed in an independent and not integrated way by different specialists for different pathologies,(46), it has also been shown how there is a substantial level of under-treatment in elderly patients using categories of pharmaceuticals whose therapeutic value in diminishing morbidity has been established by adequate clinical studies.(47) In this study reference is made in particular to the low use of ACE inhibitors in cardiac failings, anti-thrombosis treatment, and beta blockers in patients with myocardial heart attacks, antithrombosis treatment and anti-coagulants in patients with stroke, and therapies for osteoporosis in individuals who run the risk of bone fracture.

It is thus evident that the elderly part of the population is more exposed to the risk of the excessive use of pharmaceuticals used at the same time, with unforeseen and not even known potential pharmaceutical interactions, as well as an altered bio-disposition to concomitant pathologies. Elderly people are also exposed to the risk of the underuse of appropriate therapies that could reduce illness and the acute consequences of chronic pathologies that are present.

One of the principal problems to be found at the base of the empirical approach and low level of knowledge in the treatment of elderly people is the scarcity of scientific evidence able to provide reliable and final answers on the benefits and risks of many pharmacological therapies. This problem is connected with an approach in studies that excludes the possibility of assessing therapies in conditions of polytherapy and/or polypathology, and also with the historical absence of a significant number of elderly patients in clinical trials.(48-50). Indeed, a descriptive analysis has shown that about a third of the

studies published in the principal scientific reviews excluded, without an adequate explanation, elderly people from the cases treated in clinical trials.(51). In 2000 only 3.45% of the 8,945 randomised clinical studies and 1.2% of the 706 meta-analytical studies were specifically directed towards the part of the population over the age of sixty-five.(52) It is often the case that great clinical trials for the study of pathologies specific to the elderly part of the population recruit select cases that are not representative of this part of the population. In the study of systolic hypertension in the elderly, 'Systolic Hypertension in the Elderly Program Study', better known as SHEP, only 2% of the randomised patients came from the general population.(53) As a consequence, therapeutic practice in geriatrics is often reduced to being anecdotal or at the best to referring to the generalisation of data that come from younger patients or 'healthy' elderly patients.

All of this finds little justification if one considers that in the year 2000 about seven hundred new pharmaceuticals being developed in the pipeline by the pharmaceutical industry were intended for illnesses of the elderly, such as heart disease, stroke, cancer, diabetes, depression, Alzheimer's disease, arthritis, osteoporosis and Parkinson's disease.(54) However, few pharmaceuticals amongst those that are used today largely in the geriatric sphere have undergone a clinical development that takes into account the problems and issues connected with ageing, and few are able to meet in a specific and complete way the therapeutic needs of the elderly. The causes of this situation lie in two principal areas: on the one hand, many factors connected with ageing create difficulties as regards the inclusion of these patients in clinical studies; on the other hand, most of the pharmaceuticals used in geriatrics belong to therapeutic classes in which the development and above all else the clinical development of new molecules has aspects that are especially critical. If we analyse the first of these two areas of difficulty certain elements emerge that make the inclusion of patients of a geriatric age in clinical trials, the consequent representativeness of the sample chosen, and the assessment and extrapolation of data to the general elderly population much more difficult:

– Elderly people constitute an especially heterogeneous group in which individuals under the age of seventy have physiological and psycho-social characteristics that can be profoundly different from patients who are over the age of eighty, with evident repercussion for the outcome of treatment. In addition, in the very elderly there are also differences within this age band. Clinical studies should, therefore, provide a precise characterisation by sub-groups of the patients to be treated and they should group them by individuals who are of determining importance for the outcome of the pathology that has been subjected for study. The results should be presented not only as averages but also with reference to the events of each individual, an approach that would better allow the individualisation of therapeutic decisions in clinical practice.(55-57)

– The already described co-presence of a number of illnesses in elderly people, with consequent polytherapy, predisposes to adverse events and leads to scarce compliance with the methodologies requested by the study, as well as to a potential confusion of the results themselves. A paradigmatic example is the association between mortality and low pressure levels found in individuals over the age of eighty which disappeared when the mortality levels were adjusted for the variables linked to the different pathological condition such as physical function, cognitive capacity, albuminemia and the presence of various levels of heart disease.(58) In order to reduce the variables of confusion linked to the various present and concomitant pathological situations, and thus to assure an internal validity as regards the data, researchers tend to design studies with very stringent inclusion criteria, limiting, however, the ability to generalise from the results, which, as has already been observed in this paper, is one of the principal causes of the insufficient availability of an adequate literature in the field of geriatrics.

– The problem of a scarce adherence to therapy is of extreme importance in clinical studies with elderly people, especially if they are carried out in a non-institutionalised clinical context where the lack of self-sufficiency and problems with sight, memory and movement can make it difficult for an elderly person to manage the requirements of the trial, especially if they are complex, as happens with forms of treatment for pathologies that are typical of old age.

– Many of the illnesses typical of elderly people are difficult to place in diagnostic terms. Pneumonia can be easily detected with radiological criteria but pathologies of the locomotive or neurological apparatus, for example Alzheimer's disease or post-stroke functional recovery, are very difficult and complex to define and/or establish. This means that one must pay particular attention to the risk of an erroneous classification of the cases included in the study, and one should ascertain whether the measuring of outcomes was done through the correct use of validated scales and instruments, a situation that necessarily requires the organisation of careful quality control on an at least sample basis.

– Comparative clinical studies involving elderly people involve special problems when the comparison involves a placebo, as is often required by the regulating authorities, at least during the first stages

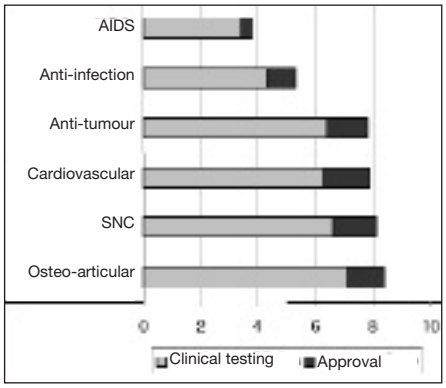
of the clinical development of pharmaceuticals – for example in research studies into effective and tolerated doses. For this reason, appropriate doses are often identified in young patients and there is only a verification of bio-equivalence in a few selected elderly subjects. Then at times clinical trials of effectiveness and tolerability of doses have been identified in equality studies with active pharmacological comparisons. At times, instead, active interventions are compared to the practice of current management which in elderly people is at times lacking, thereby creating situations in which positive results are more easily obtained but which do not necessarily represent the best approach to treatment.

– Age is a factor that influences the risk of an event and it is necessary to pay attention to this fact when the event is the end point assessed in the study. The relative risk decreases with an increase in age (through a decrease in the number of elderly people predisposed to that event because those who are most sensitive have already had it or have died, modifications in the biological risk of illness or the event at different ages, and the competing of other concomitant risk factors), whereas the absolute risk can increase. One can, therefore, overestimate an effect in the geriatric population on the basis of relative risk and it is thus extremely important to consider not only the statistical meaningfulness but also the clinical meaningfulness involved. It also becomes of fundamental importance to estimate – when this is possible the absolute risk – and even more the number needed to treat (NNT). Indeed, if we consider the treatment of hypertension in elderly people, it is evident that one obtains the reduction of mortality in all age bands: the reduction of the relative risk is similar in all the groups but the absolute benefit is greater in elderly people, given that the NNT to prevent cardiovascular mortality and illness is at least two times higher in young and adult individuals than in elderly people.(59)

It is thus undoubted, and this for some time has been pointed out, that the inclusion of elderly patients in clinical studies is particularly difficult for the reasons outlined above, to which should be added the low readiness of elderly people to take part in such studies. Indeed, participation is at a level of 97% in children, 75% in people between the ages of twenty-one and sixty-five, and less than 60% in the very elderly.(60). Various suggestions have been made as to how to foster the participation of the geriatric population in experimental studies, for example the creation of connections between clinical and academic research structures and institutes that treat and care for elderly people or the establishment of major clinical trials that would include a more heterogeneous population with multiple co-morbidity and differences in the advance of pathologies and which would allow the assessment of specific sub-groups. Of importance also are practical aspects such as the involvement of families or volunteers in the explanation of informed consent, helping with transport, clinical visits carried out when this is possible at home, and the printing of forms for informed consent in large letters.(53, 60, 61). Another important element that should be borne in mind in designing future studies on the elderly is that the principal clinical end points that are assessed should be carefully considered and probably modified as well. This is because in this part of the population outcomes as functional levels and independence are certainly as important, if not more important, than mortality.(53)

When we consider the second area of complexity as regards the development of molecules for the elderly, that is to say the difficulties of research, it should be stressed that most of the pharmaceuticals that are used in geriatrics are indicated for pathologies in which clinical experimentation is particularly complex and requires a period of time to be studied that can be very long, with an extremely significant impact on the costs and length in terms of time of development. Figure 2 refers to average periods of time required for the clinical development and authorisation for sale on the market by the Food and Drug Administration (FDA), the regulating agency of the United States of America, between 1995 and 1999, of pharmaceuticals that belong to different therapeutic classes. One can see how for molecules with relatively simple end-points, such as pharmaceuticals for the treatment of AIDS or other anti-infection drugs, the process of clinical development and approval by the regulating authority are relatively short whereas medicinal products that are usually more used by elderly people, such as those for illnesses of the central nervous system or of the cardiovascular apparatus, for osteo-articular pathologies, or for tumours, require significantly longer periods of time. (60, 61).

Fig. 2 – Average time periods for the clinical testing and approval of new molecules by the FDA, by therapeutic class (1995-1999) (60, 61).



To this should be added that the development of new molecules in these therapeutic sectors has a high level of failure, a factor which, associated with the long periods required for their development, increases the research costs for pharmaceuticals that come to be put on the market. Indeed, table 1 shows how anti-infection pharmaceuticals receive a 30% approval rate at stage I as regards being put on the market, 39% at stage II, and 77% at the clinical research stage III. This percentage decreases significantly in a sector with indications characteristics of the geriatric age, for example the sector of neurology: only 20% of pharmaceuticals in stage I, 23% in stage II, and 51% in stage III are put on the market. The costs of clinical development in these sectors are very high, varying from seventy-seven million dollars for the anti-infection sector to a hun-

dred and eight and a hundred and thirteen million dollars respectively for the cardiovascular sector and the neurological sector.(62)

Tab. 1 – Probability of success (of being placed on the market) at the various stages of clinical development for molecules of various therapeutic categories.(62)

Clinical development stages	Anti-infection	Cardiovascular	Neurological
Stage I	30%	26%	20%
Stage II	39%	41%	23%
Stage III	77%	72%	51%

From what has been said hitherto in this paper, it emerges that the clinical development of pharmaceuticals used in elderly people, for the various reasons described above, does not in reality provide sufficient data to extend their use in clinical practice for the general geriatric population, and also that this development specifically for these pharmaceuticals is very onerous in terms of time employed and costs borne.

The discussion outlined above on the use of pharmaceuticals with people of a geriatric age and the modifications correlated to age of pharmacokinetics and pharmacodynamics, and consequently of the efficacy and tolerability of the various doses of pharmaceuticals and their interaction, provides us with a knowledge base to consider the suitability or otherwise of the various regulatory guidelines for the development of new molecules with a potential geriatric use as outlined in table 2.

In addition to these guidelines, there exists a group of 'therapeutic' guidelines that provide indications and recommendations on the clinical studies to be carried out in specific pathological areas of special relevance for elderly people. They relate, for example, to osteo-arthritis, schizophrenia, depression, antiblastics, Parkinson's disease and Alzheimer's disease, cardiac failings, and urinary incontinence.

It is clear that in all of them a prevalent focusing on, and concern about, the effect that pharmacokinetic variations can have on dosage is due to genetic and non-genetic influences. Various guidelines of the European Committee for Proprietary Medicinal Products (CPMP) recommend the study of the impact of genetic factors on the relationship between dose and response in new pharmaceuticals.

The CPMP has always adopted a guideline on the interaction between pharmaceuticals which recommends the carrying out of studies on the interaction of new molecules on the basis of their physical-chemical, pharmacokinetic and pharmacodynamic properties, as well on the basis of the probability that two pharmaceuticals can be administered at the same time. An interaction is defined as being clinically relevant when the therapeutic activity or the toxicity of a pharmaceutical can change when the concomitant use of two pharmaceuticals can be easily advised as a therapeutic recommendation.

However, two guidelines are of especial interest. The ICH guideline connected with information on the relationship between dose and response in order to support registration (n. 2 of table 2) requires that in 'using information on dose-response it is important to define the factors that lead to pharmacokinetic differences between individuals, including demographic factors (age, sex, race), other illnesses (liver or kidney insufficiency), diet, concomitant therapies or individual characteristics (weight, corporeal morphology, other pharmaceuticals, and metabolic differences)'.

The ICH Note for Guidance on Studies in Support of Special Populations: Pharmacokinetics in Renally or Hepatic Impaired Patients', in particular geriatric populations (n. 4 in table 2), envisages that 'the complete database of the dossier should be examined to assess possible differences connected with age, for example in the incidence of adverse events, efficacy and dose-response. If this relatively preliminary overall analysis shows important differences, further and deeper assessments are necessary'. The ICH note for guidance on clinical studies in the geriatric population specifies certain points that we think it is important to emphasise: 1) 'the pharmaceuticals should be studied in all the groups of geriatric age for whom there is a presumable effective use and utility; 2) 'the guidelines refer in particular to: new molecules that have a potential use in the elderly because the indication envisaged is a pathology characteristic of old age (for example Alzheimer's disease) or is present in a high number of elderly people (for example arterial hypertension); and new pre-established formulations or associations of pharmaceuticals already used in elderly people when it is thought that they could lead to altered responses in elderly patients'. 'It is important

Tab. 2 – General regulatory guidelines of the Committee for Proprietary Medicinal Products (CPMP) and the International Conference on Harmonization (ICH) relevant to the development of pharmaceuticals in the elderly part of the population (bibliographical references n. 63 for n. 1; n. 64 for nn. 2-8).

1. CPMP Guidance on Pharmacokinetic Studies in man
2. ICH Note for Guidance on Dose Response Information to Support Drug registration
3. CPMP Note for Guidance on the Investigations of Drug Interations
4. ICH Note for Guidance on Studies in Support of Special Population: Geriatrics
5. ICH Note for Guidance on Studies in Support of Special Population: Pharmacokinetics in renally or hepatic impaired patients
6. CPMP Note for Guidance on the Evaluation of the Pharmacokinetics of Medicinal Products in Patient with impaired Renal Function
7. CPMP Note for Guidance on the Evaluation of the Pharmacokinetics of Medicinal Products in Patient with impaired Hepatic Function
8. Statistical Principles for Clinical Trias, CPMP/ICH/363/96

to include in these studies patients of the most advanced age band (those of more than seventy-five years of age) and patients with concomitant pathologies in order to identify interactions between the pharmaceuticals and illnesses'. 'One should include a significant number of geriatric patients in stage III (and at times also in stage II) of the development of pharmaceuticals. The geriatric population must be represented in sufficient numbers in order to allow a comparison of pharmacological responses with the younger group. With respect to pharmaceuticals being studied for illnesses that are also present in elderly people, a minimum of a hundred assessable patients should be sufficient to allow the study of clinically relevant differences. With respect to pharmaceuticals that are developed for pathologies typical of the geriatric age, elderly people should constitute a majority of the patients studied'. 'The differences between young and elderly individuals in clinical studies are in the majority of cases due to pharmacokinetic differences connected with different levels of liver and kidney function and to pharmacological interactions. It is important to establish possible pharmacokinetic differences between young and elderly individuals, just as it is important to characterise what an alteration in the excretory function (liver and kidney), which is frequent in elderly patients, also involves'. 'Dose-response or specific pharmacodynamics in elderly people are recommended in the following situations: sedative or hypnotic molecules and other psychotropic pharmaceuticals or pharmaceuticals that have relevant effects at the level of the central nervous system (for example anti-stamines); when during stages II and III of clinical development clinically relevant data correlated with age connected with the efficacy or tolerability of the molecule being studied that cannot be attributed to pharmacokinetic differences between young and old people'. 'The interactions between different pharmaceuticals, which are particularly relevant in elderly people, must be studied when the therapeutic interval (that is to say the interval between the effective does and the toxic dose) of the molecule that is studied or pharmaceuticals that are taken at the same time is noted, and the probability of a concomitant therapy is high. In particular, the pharmacological interactions and some aspects of enzyme metabolism should be studied in certain cases: interactions between oral anti-coagulants and digoxin, because many pharmaceuticals change the plasmatic of these active elements which are very much used with elderly patients and with a narrow therapeutic interval; new molecules with important hepatic metabolisation, which should be studied with inducers (for example phenobarbital) and inhibitors (for example cimetidin) of hepatic metabolism; new metabolised molecules of cytochrome P450, studied for inhibitor effects with chinidine (for cytochrome P450 2D6) and ketoconazalo or macrolids (for cytochrome P450 3A4); and interactions with other pharmaceuticals that could be taken together with the molecule being studied'.

It should also be remembered that a third group of guidelines of a bio-statistical kind exist which provide indications on the choice of the design of the study, its statistical power, the choice of comparisons and the analysis of results. One of these is of interest for studies in geriatrics, namely 'Statistical Principles for Clinical Trials, CPMP/ICH/363/96', because it recommends that the planning of the analysis should take into account the influence of the covariates and the effect of the sub-groups, in particular the age of the sample.

From an analysis of the recommendations of the regulatory authorities there emerges, however, an important concept that should be borne in mind: age in itself is not associated with significant modifications of pharmacokinetics but is accompanied by factors that can alter it significantly, such as reduced hepatic and renal function of both a metabolic and excretory character; the co-administration of other pharmaceuticals; and qualitative and quantitative diet differences that alter the absorption of pharmaceuticals. Another factor to be borne in mind is pharmacogenetics which is not correlated to age but in elderly people when associated with the other elements indicated can be more relevant because of the additional effect. All of these factors can, however, be predicted and assessed with specific studies, thereby allowing a possible adjustment of the dose.

From a psycho-dynamic point of view, apart from specific pharmacological targets correlated with the effects of anti-coagulant, psychotropic or cardiovascular pharmaceuticals which are known about and thus should be assessed with specific studies, there is no clear evidence that most of the pharmacological targets have a sensitivity to pharmaceuticals in elderly people that is altered.(65) Anyway it is to be hoped that in very elderly patients at least one randomised and controlled study is carried out that correlates plasmatic concentration with pharmacodynamics. This would provide sufficient data to verify if there exist variations in pharmacodynamic sensitivity correlated with physiological modifications typical of advanced ageing and would also help to design subsequent specific studies on the elderly part of the population and thus improve the therapeutic use of the pharmaceutical once it had been placed on the market.

Pharmacokinetics is usually studied in 'healthy' elderly populations

and the regulatory guidelines do not give different indications from this. It should, however, be emphasised that a solid rational reason exists for studying it in 'frail' elderly individuals to ascertain in this sub-population what the interaction is between pharmaceuticals, alimentation and nutritional status. At the present time this is not done. A recent study has demonstrated that in 50.9% of hospitalised frail elderly patients, therapies with incorrect dosages are prescribed, in 47.1% the length of the therapy is inappropriate, in 20.4% a pharmaceutical/pathology interaction is not taken into account, and in 6.3% attention is not paid to interactions between pharmaceuticals.(66) It should also be taken into account that frail elderly people in particular run the risk of interactions between pharmaceuticals and food because they have different predisposing factors, such as malnutrition, alcoholism, anorexia, and chronic illness which involve an altered alimentary absorption, in addition to the need to take many pharmaceuticals. Despite this, clinical and pharmacological research has never paid any attention to this especially critical and expanding epidemiological area of gerontology.

Very elderly patients should be more represented in the future in the programmes for the clinical development of pharmaceuticals and the assessment of the effects of their frailty on the risk-benefit relationship of pharmaceuticals must envisage specific studies in populations of frail elderly patients, taking into account that this condition is independent of the level of age and thus constitutes a further category on its own which should be taken into account in studies involving clinical trials with new molecules that receive therapeutic application in this geriatric sub-population.

As we have already seen, since the 1990s regulatory authorities have been entrusted with the responsibility of obviating, through the issuing of more indicative guidelines and revision of existing ones, the bias of the low representation of the elderly population at the level of its heterogeneous make-up in studies involving the clinical trials of pharmaceuticals. But the results of this initiative are not clearly visible. A meta-analysis of clinical studies of chronic syndromes carried out in 1996 and 2000 showed that out of the 593 trials selected the number of studies involving the evident exclusion of age was lower when comparing the period prior to 1990 (58%) with the period 1990-2000 (40%) and the number of elderly people at least seventy-five years old increased from 2% to 9%.(50). However, this percentage is far lower than the percentage of those of the same age suffering from myocardial infarct.(37%)

This study demonstrates that although advances have been made to ensure that elderly people are represented more in studies, a great deal still remains to be done. The decision of the FDA to include a 'geriatric use' section in medicinal specialities, with the obligation to insert information on their specific use in elderly patients (Federal Register 27/8/97 – 62FR45313), supplemented in 2001 by 'guidance for industry on the content and format of geriatric labelling', has not lead to great benefits in this direction because it is limited to indicating how information on pharmaceuticals for geriatric use should be provided and it does not compel the carrying out of supplementary studies on elderly people. This objective, however, could be achieved if the equivalent of the 'paediatric rule' applied in the United States of America to pharmaceuticals for paediatric use were applied to geriatrics as well, with an analogous extension of exclusive market use (six months for paediatrics) to pharmaceuticals for geriatric use which have undergone specific development in this part of the population.

Lastly, greater attention should be paid to the value of so-termed incremental innovation or marginal innovation for pharmaceuticals of geriatric use, given that the availability of more individualised therapies is particularly useful in a heterogeneous population, which the elderly population certainly is.(69) Small changes in molecules with characteristics of radical innovation could lead to molecules that are more tolerated, to new indications that are useful in the geriatric age, or to new formulations (for example controlled release) of molecules that are already in use, which allow a better system of dosage or easier ingestion or administration by the elderly themselves, who may have problems with swallowing, sight, memory or movement, thereby assuring greater compliance and independence in the patient. These pharmaceuticals or new formulations should be studied in particular in the elderly part of the population where their incremental value can be more easily determined, a value that should then be acknowledged by the regulating authority.

Given the practical difficulties that exist in the literature and in the study of elderly people with randomised clinical studies, other types of approach should also be considered to determine the relationship of risks to benefits of pharmaceuticals in geriatrics. For example it is possible to use the Markov model of analytical decision-taking in order to balance the benefits of pharmacological therapy ascertained in controlled trials with the adverse effects assessed during observational and case-control studies. This model has been used recently to assess the benefit of warfarin in preventing stroke in elderly patients with arterial fibrillation: evidence of its clinical efficacy was evident from six studies (reduction in stroke by 625) but a systematic review demonstrated an increase in gastro-intestinal bleeding in the most elderly subjects, with an inci-

dence that increased with age. An analysis like that suggested above demonstrated, lastly, that therapy with warfarin is associated with 12.1 QALY (quality adjusted life years) for each subject compared to 10.1 without therapy.(70)

Another approach should be carefully considered given the bias in selection reported as regards clinical trials. This approach is the use of case-control studies in the geriatric population. A study of this kind in hyper-tense patients over the age of eighty in old people's homes allowed it to be demonstrated that anti-hypertension therapy is not associated with hypertension events connected with posture and falls.(71)

Lastly, there should also be an increase in the observational and pharmacoepidemiological research carried out after the placing on the market of pharmaceuticals, especially in the geriatric population. This is the subject of the next section.

Health-care Research, the Measurement of Health Needs and the Assessment of the Quality of Treatment Applied to the Promotion of Health and Health-care in Elderly Patients

The Justification for, and Definition of, Health-care Research

The concept of health, defined by the World Health Organisation as a state of physical, social and psychological wellbeing and not only absence of illness, is applied without distinction of age to the elderly as it is also applied to the young and the adult.(72)

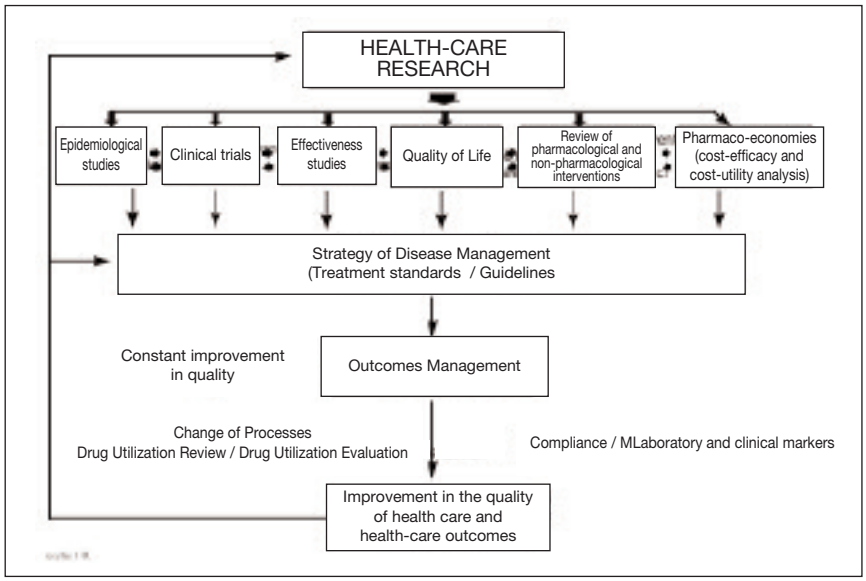
Health constitutes an individual good and a collective good and thus the systems for the promotion of health and health care must be directed towards assuring the meeting of the needs of the health of individuals and communities, independently of age, in line with the indications of priority established on the basis of people's values and expectations and the economic resources that are available.

The measurement of the level of health of a population and the quality of the health care that is provided presents a series of difficulties both as regards the methods that are used and the sources of information available.

Traditionally, the quality of health care is analysed on the basis of *structure, process and outcome* indicators. Most of the assessments carried out in Italy, however, are limited to structures and processes because it is difficult, and often impossible, to acquire data and information on health-care outcomes, thereby making the assessment of many initiatives limited and partial.

Health-care research is the set of both experimental and observational research techniques that allow an assessment of health-care needs and the state of health of patients both through the measurement of the characteristics of illnesses and of the outcomes of their treatment. It can thus allow an assessment of the quality of care and the attribution of a value to the various health-care, pharmacological or otherwise initiatives that are taken (figure 3).(73)

Figure 3: The instruments of health-care research



The definition of outcome

An outcome can be defined as any event of relevance for the patient and for the health-care system looking after him or her that arises from a health-care action. Health-care outcomes are the effect on the patient of an illness and its treatment and can be sub-divided into *clinical, humanistic and economic* outcomes (table 3)

Table 3: Outcomes of health care

- **Objective or Clinical**
  - death
  - hospitalisation
  - access to emergency care
  - absence from school/work
  - complications
  - others
- **Subjective or Humanistic**
  - quality of life
  - satisfaction of the patient
  - preferences of the patient
- **Economic**

Clinical outcomes are substantially observable and objective events, both of a clinical nature (i.e. death) or of health-care character (for example the number and length of hospitalisations or examinations at emergency care, the number of surgical operations), or social events, such as absence from school or work.

Humanistic outcomes are the perception by the patient of his or her own state of health, which is assessed through the measurement of quality of life or by the judgement of the patient on the service that he or she has received (satisfaction) or his or her preferences as regards alternative courses of action.

The clinical and humanistic outcomes can be subsequently assessed through techniques of economic assessment in order to obtain the economic outcomes.

The information that is required to assess the value and quality of health-care applied to the elderly can be obtained from studies carried out on the general population in order to: 1. measure needs at the level of health care specific to the elderly (measurement of the epidemiological dimensions of the prevalence and incidence of illnesses and their impact on the state of health of the population; 2. assess the quality of health care through the measurement of the clinical and humanistic outcomes produced by pharmacological therapies and other health-care measures.

Some examples of such studies now follow:

The Measurement of Health-care Needs in the Elderly Population: the ILSA Study

A correct policy of health-care planning requires an assessment of epidemiological data connected with the prevalence and incidence of those pathologies that are most frequent in elderly people and knowledge about the percentage of disabled individuals in the various age bands and the percentage of those who age in good conditions of health. Such information appears to be essential in an assessment of the health-care burden and to improve the distribution of the resources that are available.

In Italy, data on the pathologies of elderly people are rather short on the ground and they are often based on inquiries that use interviews where a medical diagnosis of the pathologies under examination does not exist – only a self-assessment by the individual concerned. The use of these questionnaires has notable limitations that are due above all else to the low reliability of the data that are obtained.

The ILSA (Italian Longitudinal Study on Ageing) is the first Italian epidemiological study, carried out on a randomised sample of the elderly population, to ascertain the presence of the most important invalidating pathologies through a specialist clinical assessment.(74,75)

The chronic pathologies that were investigated are relevant not because of their high illness and death rates but also because they are amongst the principal causes of the condition of being an invalid and their risk factors in the elderly part of the population are still controversial today. One of the principal characteristics of the ILSA is the fact that it allows an assessment of the impact of pathologies of the functional status of elderly people. The study of the natural history of these pathologies also allows an exploration of the relationship between illness and disability and to understand specific aspects of the physiopathology of disability. These results could have notable importance in the sector of public health and could be fundamental in the planning of care, prevention and rehabilitation services.

As an example of some of the results that were obtained from the ILSA study, we here present the percentage prevalence of the internist pathologies that were investigated, by sex and age (table 4):

Table 4 –Prevalence in percentages of the surveyed internist pathologies by sex and age band.

PATHOLOGY	Males					Females					Total				
	Age (years)					Age (years)					Age (years)				
	65-69	*70-74*	*75-79*	*80-84*	*Total*	*65-69*	*70-74*	*75-79*	*80-84*	*Total*	*65-69*	*70-74*	*75-79*	*80-84*	*Total*
Internist pathologies															
Angina pectoris	8.6	7.4	7.7	6.1	7.8	4.0	9.1	8.1	8.5	6.9	6.1	8.3	8.0	7.6	7.3
Myocardial infarct	8.4	12.6	12.1	11.3	10.7	3.9	5.6	5.4	5.2	4.8	5.9	8.7	8.2	7.4	7.3
Arrhythmia	20.6	23.8	31.7	30.8	25.1	16.7	20.7	22.9	24.3	20.3	18.4	22.1	26.5	26.7	22.4
Arterial hypertension	57.0	62.9	62.1	55.8	59.4	62.4	70.9	69.6	69.7	67.3	60.0	67.4	66.6	64.7	64.0
Congestion cardiac failure	3.8	5.0	6.5	9.4	5.4	3.7	7.8	8.5	13.2	7.3	3.7	6.5	7.7	11.8	6.5
Diabetes	13.2	13.7	13.4	9.7	12.9	10.6	17.0	14.6	13.2	13.4	11.7	15.5	14.1	11.9	13.2
- Type I	0.3	0.5	0.2	0.2	0.3	0.2	0.2	0.2	0.4	0.2	0.3	0.3	0.2	0.3	0.3
- Type II	12.0	13.0	12.9	9.5	12.1	10.0	16.8	13.8	12.5	12.9	10.9	15.1	13.4	11.4	12.6
- Secondary	0.3	0.2	0.0	0.0	0.2	0.0	0.0	0.2	0.2	0.1	0.2	0.1	0.1	0.1	0.1
Reduced tolerance to carbohydrates	6.9	7.2	4.2	2.9	5.9	5.1	6.7	4.1	6.3	5.4	5.9	6.9	4.1	5.1	5.6
Osteo-arthrosis	51.1	48.2	53.5	49.3	50.7	70.8	69.1	66.5	66.7	68.7	61.7	59.8	61.1	60.2	60.9
Chronic broncopneumopatia	26.6	27.2	32.4	32.1	28.7	13.1	13.9	18.1	16.8	15.1	19.1	19.9	24.0	22.5	20.9
Peripheral arteriopathy	4.1	8.7	5.8	8.6	8.1	2.5	2.1	6.1	6.6	5.2	4.8	7.0	7.9	8.7	6.5

(*) The data are standardised for the Italian population: census of 1991.

Amongst the results that were obtained, reference should be made to the high prevalence of arterial hypertension which is present in about 60% of elderly Italians. These levels of prevalence are comparable with those obtained in similar studies (NHANES III) carried out in the United States of America. Arterial hypertension is one of the most important risk factors as regards vascular pathologies, which, indeed, are the principal cause of death and amongst the primary causes of disability on Western countries. Careful control of it and the creation of suitable prevention programmes could lead to a reduction of morbidity and of the costs connected with such pathologies. The prevalence of osteoarthrosis is also high and this ranges from 50.7% in males to 68.7% in females. The prevalence of ischemic heart disease is, instead, lower than that reported in similar studies carried out in other Anglo-Saxon countries and this confirms the fact that this pathology is less frequent in Mediterranean countries.

The data on stroke show a high prevalence for this pathology which is higher than that reported in similar population studies. Indeed, the data available indicate levels that oscillate between 3% and 5% for men and between 1.5% and 3.5% for women, whereas in our sample the total level was 7.4% in men and 5.9% in women, with points around 10% in some age groups. Even though some methodological differences could in part explain this greater frequency, our data seem to suggest a higher incidence of this pathology in Italy, and the levels reported in some studies carried out in Japan, a country with a high level of cerebrovascular illnesses, are comparable.

The prevalence of dementia is 5.3% in men and 7.2% in women, with points around 20% in the most elderly. These data are in line with what has been reported in similar research carried out in Europe and indicate a high frequency, in Italy as well, of this pathology, which has very high costs at a social and health-care level.

An epidemiological fact on which at an international level as well we have little information available is the prevalence of distal brain disease of the lower limbs which, according to the data of the ILSA, affect about 6.5% of elderly people, with a greater frequency in the most elderly age bands. This pathology is often accompanied, in addition to a series of subjective disturbances, by important problems at the level of walking linked to a decrease in personal strength and alterations in deep sensitivity. Brain diseases, in fact, occupy a primary position as causes of disturbance in the walking of elderly people and can be the causes of falls and femur fracture, which is one of the principal causes of disability in elderly people.

The ILSA data demonstrate that about 16% of women and 17% of men are or have been smokers. Of these, about 16% of the women and 41% of the men smoke/smoked more than twenty cigarettes as day. Over 85% of smokers have been or were smokers for a period of more than ten years.

About 66% of women and 89% of men drink wine every day. Of these wine-drinkers, however, only about 3% of women and 24% of men declare that they drink more than 50 gr. of alcohol a day (half a litre of wine). With respect to diet, we have so far assessed only the consumption of fruit and green vegetables and a very small percentage, namely about 15% of women and 14% of men, consume at least two portions of fruit and/or green vegetables every day.

The index of excess weight used in this analysis is the body mass index (BMI), that is to say the relationship between weight (in kilograms) and height (in metres). Our data demonstrate that average BMI in both males and females tends to be higher than normal levels (20-25 Kg/m^2). About 33.6% of males and 26.9% of females are overweight and 15% and 28% respectively are obese, according to the WHO classification (BMI from 25 to 29.9 in males and from 23.9 to 28.6 in females indicates overweight, whereas a BMI higher than 30 and 28.6 respectively indicates manifest obesity).

The prevalence data of the ILSA study describe the characteristics of the elderly part of the population measured over a specific period of time. The interpretation of these data must be carried out with caution because the cohort effect cannot be eliminated in a prevalence study and because, given the presence of illness at the same time there is an identification of the presence of a risk factor, obviously enough one cannot establish a temporal nexus of causality. The ILSA study, which, it should be observed, envisages a follow-up study of the participants, will be able to provide estimates of the causal effect of all these risk factors in the ascertainment of illness, disability and death in the elderly part of the population.

To end this paper we may observe that ageing is a direct or indirect cause of many disabilities, illnesses, and deaths in the civilised world. The strong hope is that gerontology, together with many other disciplines (physiology, genetics, molecular biology, genomics, proteomics, bio-informatics, and clinical pharmacology) will manage to prevent chronic geriatric pathologies, maintaining the best possible state of health for elderly people, and effectively prolonging their lives. Naturally enough, this is a major challenge that is not only scientific and technological but also human and social.

Dr. GIUSEPPE RECCHIA
The Smith Kline Foundation Study Centre, Verona, Italy

Dr. PAOLO RIZZINI,
Vice-President and Secretary General of the Smith Kline Foundation, Rome, Italy.

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OTTAVIO BOSELLO

2.2 Ageing between Lifestyle and Nutrition

Average life spans have become greatly extended in a very significant way since the 1950s. Demographers argue that one of the most sensitive indicators of life spans is life expectancy at the age of sixty-five. Figure 1 presents the development of life expectancy from 1900 to 1980. A progressive extension is evident that is well beyond the projections of demographers which were drawn up on the basis of previous trends. Figure 2, on the other hand, has important surprises because since 1980 life expectancy at the age of sixty-five has undergone a levelling and after the year 2000 there has even been an inflection.(1)

If these data are confirmed, it may happen that those who are born at the present time will be the first generation of humans to have a lower life expectancy than those that went before them – this is an unexpected and dramatic event from a social and health-care point of view.

Figure 3 outlines the causes of morality that the Center for Disease Control and Prevention (CDC) of Atlanta see as being modifiable.(2) In particular, the modifications that took place between 1990 and 2000 are assessed. Smoking is still the first risk factor of mortality and it has also increased since 1990. The second risk factor, which, however, has undergone a notable increase, is obesity, and to such an extent that it is now reaching the levels of smoking. Then there is alcohol, which, if associated with road accidents which, as is known, are often linked to alcohol, also becomes an important factor in mortality.

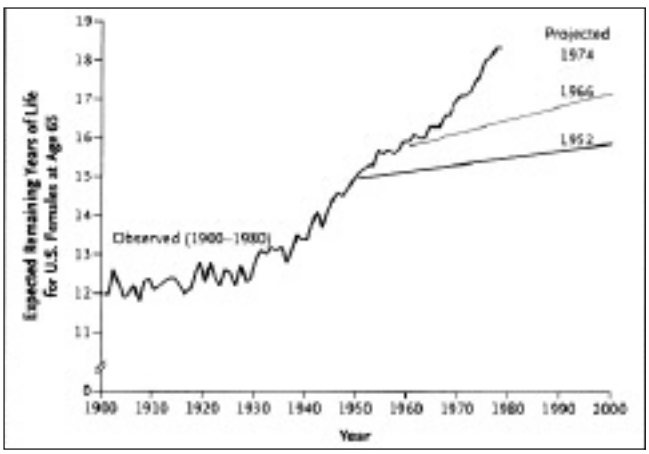
So to sum up, the principal modifiable causes of mortality at the current time are smoking, being overweight and obesity (that is to say hyper-caloric diets and a sedentary life) and alcohol. Just one reference to smoking to recall that this is a battle still to be joined because smoking is still extremely widespread in the world. We know that smoking is subject to forms of prohibition in very few regions of the world: a large part of Canada and Australia, some States of the USA, Great Britain and Iran. The rest of the world smokes freely, with the exception of a number of nations, amongst which Italy, where smoking is banned in public places.

Of special interest is the problem of excessive weight which is becoming one of the aspects of greatest social-health care importance. In Italy this affects above all the advanced age bands, with a peak between the ages of 55 and 75 (table 1), for both males and females and as regards excess weight and obesity.(3, 4)

Obesity is one of the most important risk factors in morality because of the association of multiple cardiovascular risk factors which go from hypertension to dyslipidemies, and from diabetes to tumours, with physiopathological aspects of an inflammatory kind which affect the cardiovascular system. It is perhaps less well known that obesity is an important factor of disability, above all in the advanced age bands. It has been observed that a state of obesity involves a risk of disability that appears five years earlier than is the case with subjects of normal weight.(5)

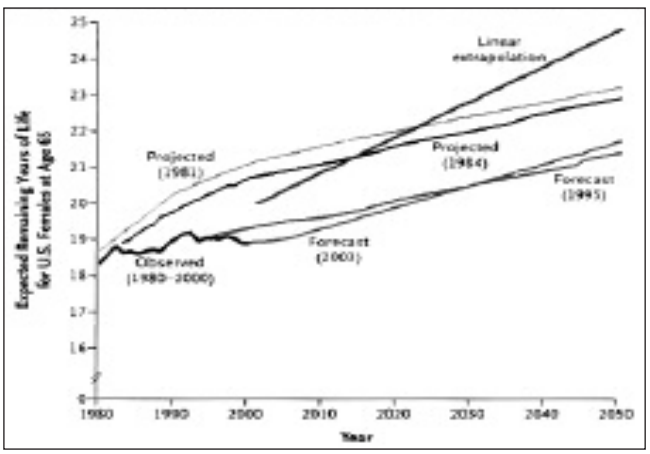
The nation most affected by excess weight is the United States of America where at the present time over two-thirds of the population have weight levels higher than those that are suitable for a good state of health. In the USA there is a system for weight control and control of eating habits – the so-named National Health and Nutrition Ex-

Fig. 1. Life expentancy in women at 65: observation and projection 1900-200



Da Olshansky et al, 2005, mod.

Fig. 2. Life expectancy in women at 65: observation and projection 1980-2050



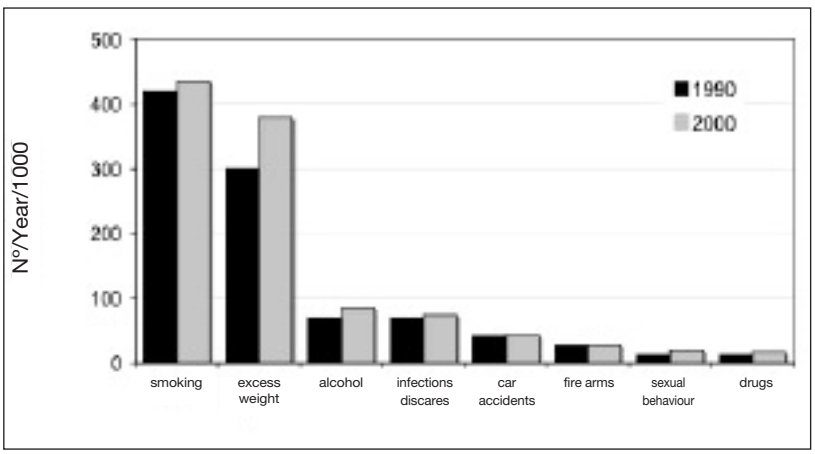
Da Olshansky et al, 2005, mod.

amination Surveys, which since 1970 have watched over such phenomena with care and have demonstrated a dramatic and progressive increase in obesity.(6) Not unexpectedly, the trend towards excess weight is associated with a progressive increase in average caloric intake. Particularly suggestive is the discovery that weight increase is also associated with a progressive increase in the energetic density of food – this means that the food consumed by Americans is increasingly rich in calories and therefore very rich in fats. It has also been observed that the fast-food habit, the consumption of red meats and soft drinks, that is to say sweetened fizzy drinks, involves a very high risk of body weight increase.(7)

Taking into account all these factors, it is evident that in order to address this problem of excess weight with success it is necessary to have recourse to changes in lifestyles and nutrition. It is first of all necessary to address the problem of people's nutritional habits. Certain questions spontaneously come to mind. Is the observation of the reduction or levelling off in life expectancy that has been emerging recently really linked to a progressive increase in excess weight? If one acts on eating habits and corrects weight will there really be a benefit in terms of life expectancy? The answers are neither easy nor simple. However, for many years the results of certain useful experimental studies with these precise conclusions have been known about. Almost a century has passed since the first observations that small rodents in research laboratories demonstrate a progressive extension of life span following a reduction in their caloric intake.(8) Laboratory animals, when they are fed ad *libitum*, tend progressively to increase their weight with the passing of time. In them the control of diet has obviously was shown to be useful in weight control and surprisingly efficient in extending life spans. Over subsequent years these experiments were repeated on a number of occasions in many laboratories on many types of small animals and all gave the same result – caloric restriction extends life span.(9, 10).

Given that these results were obtained on small animals (mostly rodents), it has been objected that man is not a little mouse and that the genetic difference is too great to be able translate these observations into a hypothesis for the human species. A few years ago at the laboratories of the National Institute of Aging of Bethesda a study was begun on a species of anthropomorphic primates, a monkey belonging to the rhesus monkey group – this kind of monkey has a genetic overlap with the human species of about 98%. When they are left to free alimentation in a laboratory these non-human primates tend to progressively increase their body weight, following modalities similar to those to be found in humans. In this study a certain number of monkeys were sub-divided into two subgroups: one continued the alimentation typical of laboratories and the other, after the period of sexual development, was subjected to a control of alimentation such as to allow constant weight over time. After twelve years of study (it should be remembered that to have valid data on life expectancy an inquiry has to last at least twenty-five years), as was programmed there was a significant difference in body weight of the two groups of animals – the first group weighed about one and a half times the second. But the result that most surprised the researchers was the percentage of deaths which in the animals with an alimentation regime that kept their body weight constant was half that of the group of animals under a regime of free alimentation. In addition to this phenomenon, which is already very significant, other data are also indicative: amongst these, those relating to certain bio-humoral indicators. In particular, body temperature was lower in the animals subject to weight control, the haematic concentration of insulin was lower in the animals of the same group, and the concentration of DHEAS was higher in the animals subject to calorie intake control.(11) It should be remembered that ageing is associated with a progressive reduction in DHEAS, a phenomenon that has generated many speculations of a therapeutic kind. These discoveries were compared with the results of an observational longitudinal study on human subjects, namely the Baltimore Longitudinal Study of Aging. It emerged that the group of human subjects with greatest life spans are characterised by a low body temperature, less concentrations of insulin, and higher levels of DHEAS.(12) The close association between the experimental results on

Fig. 3 - Modificable causes of death (CDC - Atlanta)



Da Mokdad *et al.* 2004, mod.

Tab. 1. Distributon of BMI in Italy by sex and age

AGE	BMI			
	Under weight	Normal weight	Over weight	Obese
Men				
18-24	3.3	76.4	18.5	1.7
25-34	1.0	61.8	32.8	4.4
35-44	0.3	45.6	45.1	9.0
45-54	0.3	35.4	51.2	13.0
55-64	0.4	33.5	51.4	14.8
65-74	0.6	34.4	51.8	13.2
75+	2.3	44.0	45.5	8.1
Total	**1.0**	**47.4**	**42.4**	**9.2**
Women				
18-24	18.2	72.6	7.7	1.6
25-34	10.3	74.8	12.0	2.9
35-44	4.4	69.9	20.2	5.4
45-54	2.4	55.4	30.4	11.7
55-64	2.2	45.6	38.0	14.1
65-74	2.1	43.1	39.8	15.0
75+	5.7	46.6	36.0	11.7
Total	**6.0**	**59.2**	**26.0**	**8.8**

monkeys and those on humans with greater life spans is an element that lends great value to a policy of controlling alimentation.

Given that in the human species it is realistically difficult to manage to obey an alimentary regime directed at weight control over a period of years, the pharmaceutical industry has been trying to identify substances that are able to produce the same endocrinal-metabolic effects as caloric restriction without having to intervene directly on a person's diet. These substances are called caloric restriction mimetics (CRM) and are one of the targets of the pharmaceutical future.(13)

Nutrition plays a crucial role in lifestyle and its inseparable partner is physical activity. There is by now convincing proof that a sedentary lifestyle is a greater risk factor as regards many states of illness such as obesity, diabetes, dyslipidemies, and as a result cardiovascular pathology, in addition to many tumours. There are also significant studies that show that a sedentary lifestyle is a mortality risk in itself.(14)

Many experimental and clinical studies have demonstrated that people who engage in significant physical activity and achieve a satisfactory level of fitness have a far less likelihood to die early than sedentary subjects.(15, 16) These observations represent an important stimulus to change lifestyles and to engage in an, albeit moderate, level of constant physical exercise. We cannot deny that in contemporary Western society there are many obstacles to physical exercise; current environmental conditions make it very difficult to achieve an adequate state of fitness, above all from a cardiovascular point of view. However, many studies have shown that it is not necessary to be athletes to reduce the risk of death connected with a sedentary lifestyle and that modest physical exercise is sufficient to increase the likelihood of survival over time.(17)

Having the telephone on one's writing desk or in the next room and having to move from one room to the other to answer the telephone means an estimated journey of a hundred kilometres every year. This journey has an energy cost of about 10,000 calories which are equivalent to 1.5kg of adipose tissue and thus 2.5kg of body weight. An apparent insignificant physical activity over a long period can involve the putting on or taking off of significant weight. Observations on the natural history of obesity demonstrate that levels of one or 2 kilos a year of progressive weight increase are sufficient to produce over time a higher adipose burden of 20-30 kilos compared to weights during a person's youth.(18)

Physical weight is fundamental for body weight, for consequences for the cardiovascular apparatus and also for the prevention of tumours. Less known are the other effects on organs and apparatuses. There are many indicative studies that show that good physical exercise is able to act upon one of the most worrying aspects of ageing, namely the loss of cognitive functions. It has been demonstrated with imaging studies that six months of regular physical exercise are able to prevent the loss of encephalic volume that is observed in ageing and in many cases to also bring about an increase in the cerebral volume of elderly subjects. (19)

These results, therefore, suggest strong ideological bases for the role of physical and aerobic activity in maintaining and improving the health of the central nervous system and the cognitive functions in elderly subjects.

In conclusion, we must listen to the words of Wolfgang Goethe, who proclaimed that 'to know is not enough; it is necessary to act as well. To want is not enough; we must also do'.

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Department of Biomedical and Surgical Sciences,
Chair of Geriatrics and Gerontology,
University of Verona,
Italy.

Notes

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MASSIMO PETRINI

2.3 Care, Accompanying and Institutions

A person aged sixty-five, who is at a period of life, that is to say, of 'administrative' old age – the period of retirement and the accentuation of that process of ageing that began at the moment of conception – has to address certain existential questions and issues. For example:

– The acceptance of the reality of ageing, something that is not easy given the youth-centred culture of the present time and the personal sensation of always being the same person over time.

– The search for new ways of expressing oneself after leaving the world of work.

– The acceptance of the limits that biological ageing can involve and which become more stressed with the passing of time.

– Addressing the inner belief in one's immortality as compared with an awareness of death.

– Learning to face up to the loneliness that can come from the losses that characterise this period of life.

– Acceptance of the possible dependence that can arise from varying levels of non-self-sufficiency, something that is in contrast with the desire for autonomy and independence which from childhood onwards motivates the development of a person.

– The acceptance that one will have to be helped, with regard to one's physical hygiene as well, by family relatives or 'outsiders', something that is in contrast with one's feelings of personal modesty.

– Adaptation to new ways of living when one is forced, because of problems connected with pathologies, to be admitted to a geriatric structure.

Naturally, not all these questions and issues characterise life after the age of sixty-five. They are, rather, possibilities that can emerge during the course of time and this means that many of the myths that are connected with people's approach to ageing become contradicted. The years of old age are not tranquil years, no peace is achieved, and people are not even wise if during their lives they have not sought wisdom and have tried to learn from their experiences. Life is a challenge involving adaptation during old age as well.

The first clarification one should make is that the elderly population is not a homogenous group. The state of life called old age involves at least three separate generations of people, and thus one can speak about the 'young elderly', who are between the ages of sixty-five and seventy-four; the 'old elderly', who are over the age of seventy-five; and the 'very old', those who are over the age of eighty-five. These are three generations that naturally have different needs (including pastoral needs) and perhaps needs that involve special pastoral methodologies, taking into account different behavioural characteristics as well (the duration of the provision of care, etc.). And from the point of view of providing care, in more advanced ages one is of necessity referring to a population that is proportionately made up of more women given that women live longer than men.

Now, if one wants to consider needs at the level of care, given that the subject of my paper is sick elderly people, one can first of all state that therapeutic attention should not be directed exclusively to the physical aspects of a person and to pathologies. Rather it should also be paid to the psychological aspects of a person, that is to say to the inner reality of the person, to his or her thoughts, and to his or her feelings. But also to his or her social self, his or her self in relation to other people, and to his or her spiritual and religious aspects, that is to say to the person's relationship with something that is greater than him or her – the Transcendent. And also from another point of view, that is to say health in a more overall sense, which is certainly conditioned by physical and psychological pain, by disability, but which is also conditioned by spirituality and religiosity, which means that life has sense, meaning, purpose, and hope.

Naturally, with regard to the provision of care, it is also important to ascertain the scale of the problem that is involved. In Italy the number of people over the age of sixty-five is twelve million, that is to say about 20% of the total national population. Physical disability that involves difficulties as regards common daily activities (washing, dressing, eating etc.) is principally due to the additional presence of morbidity and this afflicts about 25% of males and 34% of women over the age of sixty-five. By now it is well known that disability increases with the advance of age and

in the over-eighty group about 6% of males and 8% of females are totally non-self-sufficient.

As regards care, one cannot but remember that the pathology of dementia, which in at least half of cases is caused by Alzheimer's disease, provokes particular problems at the level of care which involve the health-care sector, the social sector and the family. The diffusion of this pathology is correlated with increase in age. In Italy, the cases that exist at the present time number about 800,000 and it is estimated that there are about 97,000 new cases every year. The incidence of dementia, as I have already pointed out, increases with age, and in particular it triples about every five years: the percentages pass from an incidence of 1.2% in the group of people between the ages of sixty-five and sixty-nine to 21.1% in people between the age of eighty and the age of eighty-four.[1]

It is undoubted that the family remains the centre of a balanced system of care and thus the family must be placed in a condition to be able to really choose how it cares for its elderly relatives. This is also what geriatrics, the medical specialisation that deals with elderly patients, says when it states that it is healthy for an elderly person to remain for as long as possible in his or her familiar life context, but this is a statement that must be realistically contextualised. Today, in fact, at least for reasons of work, families can move more easily than was the case in the past, although they conserve frequent relationships of affection by using the telephone. In addition, children can be at a geriatric age. Moreover, the low number of the members of a nuclear family conditions the care possibilities given that the two marriage partners, who themselves are often only children and who often, today, both work, find themselves responsible for four parents and two grandmothers.

It is precisely in the context of providing help to families that in recent years the figure of the *badante*, or to use a better phrase the 'family assistant', generally a male or female citizen from a country outside the European Union, who works with family relatives in providing care to an elderly relative, has emerged. In other cases day centres are of help and these provide care to an elderly relative at least during the working day. The same may be said of integrated home care. Naturally, the form of care that is most suitable depends what actual needs at the level of care are.

It is specifically on the basis of these needs that many disabled elderly people and their families have to find alternative solutions when the pathology and the family situation do not allow the right form of care or when home care is no longer thought to be adequate. These geriatric institutions (nursing homes; centres and institutes for functional rehabilitation; hospitals, naturally for acute patients; and hospices for patients at the terminal stage of their illnesses) can at one and the same time constitute places of refuge and relief for a family that is stressed by the care burden and represent an opportunity for adequate care for an elderly person.

One thing, however, is certain: these institutions at a general level are not well regarded, both by elderly people, who often see them as a 'place where people go to die', and by families, who may have to face up to the pain and the stigma of the 'institutionalisation' of their relative. One should realise that this is the first time in history that elderly people with families can experience a pathology and run the risk of ending their lives on earth in a context of care which in historical terms was reserved to poor people who were alone and without families. Today, elderly people experience this trauma by thinking of their parents who experienced their illnesses and their deaths within the context of their own families.

In addition, it is common knowledge that geriatric nursing homes carry out the 'simple service of looking after' elderly people who are waiting to die. Naturally, this statement should be considered in general terms but there can be no doubt that in many cases these institutions should see elderly people not so much as a 'patient' as a 'guest'. This is not a simple playing around with words but constitutes the need for a change in the philosophy of care. A good quality of life is present if the guest is objectively satisfied with the structure and the care that he or she receives, just as the indicators of the quality of the institution are the administration of suitable care, the approach of the staff, cleanliness, a family atmosphere, respect for the privacy and the rights of the guests, and the opportunity to have religious assistance.

To summarise: 'ethics of care' that spring from the primary need to provide a therapeutic support but also from the need to pay attention to the psychological and spiritual quality of life of an elderly person. An example of these needs may be seen in the following clinical case

which is emblematic of the complexity of geriatric care: 'An elderly lady without relatives and afflicted by a serious form of arthritis. She had been a piano teacher for generations of children in a small rural community, as well as a choir conductor in various schools, and since time immemorial she had been the pianist and organist of the church of her local community. Now her condition has got worse and her deformed hands no longer allow her to play. During a routine visit her medical doctor, observing the advance of her illness, told her that we was aware of the pain that was associated with her pathology and told her that he would do everything he could to make it bearable. However the answer of this lady had a profound emotional impact on the medical doctor: 'Doctor you do not understand – it is not the pain that is the problem; the problem is that I no longer know who I am'.

Adequate care thus means finding possibilities by which this elderly person can still express her knowledge of music because the ultimate enemy is not pain, illness or disability. What she cannot bear is the absence of meaning. What is terrible for men and women is the belief that they are no longer needed, that they can no longer make a contribution, that they are living a meaningless life. And this can be the situation of elderly people who live in geriatric institutions.

Thus a geriatric institution should strive to become a community of life where the interaction between the professional workers and the elderly guests allows the structures to be transformed from being contexts where the elderly are looked after into therapeutic contexts, in the broadest sense, and therapeutic contexts for the professional workers themselves. Medicine that is attentive to the person who is cared for is also medicine that is attentive to the person of the professional worker. Indeed, it is undoubted that professional workers can represent the first and most important therapy. But it is equally certain that care is required in a geriatric institution for those people (nurses, therapists, occupational therapists, physiotherapists etc.) who are responsible for it. This is the case for various reasons: their daily experience with disabled elderly people, suffering and death; intimate physical contact with patients; the physical trials of providing care; salaries that are not always in line with the work performed; responsibilities; low professional training in the case of certain workers; and professional training that is provided from the perspective of physical healing and thus certainly unsuitable for patients with chronic pathologies, disabilities, or pathologies at the terminal stage.

Can one thus understand the encounter between an elderly patient and the world of care in a different way? A health man or a healthy woman – the professional workers – encounter an elderly man or an elderly woman – the patients who say that they are ill. A healthy man or a healthy woman – the professional workers – even though they are called upon by the face of the sick person, which reflects a common humanity, often re-affirm this 'apparent' full health of theirs by relating to the patient without any personal involvement, something, indeed, that is seen as an obstacle to scientific and professional conduct.

This approach is the result of a technical-scientific professional training that seems to have built its power on the exclusion of human subjectivity, neglecting the experience of patients but also the experience of the professional workers themselves. But is everything as it seems? To ignore psychological and spiritual questions does not mean that these do not exist. Daily co-existence with situations of pain and situations of suffering can provoke numerous ambivalent feelings, which can also be unconscious and which are not always easy to recognise or accept, in the professional workers. Side by side with the feelings of compassion and pity that are generated by the suffering of others, we can also encounter feelings of repulsion, fear, anger, and anxiety that are generated, for example, by piercing screams or endless complaining.

In reality, every request for care contains not only a simple request for technical help with a view to the restoration of health but also a need for a relationship. This is an interhuman relationship which arises because of a need, the need for care as such, whose two poles are two subjects – the professional worker and the elderly person –who as people have an existential need to understand themselves and also to understand each other. The professional worker must understand himself or herself at the level of his or her professional responsibilities and understand the patient at the level of his or her experiences and requests. The sick person must understand himself or herself at the level of his or her own situation of frailty and understand the professional worker at the level of his or her desire to help.[2]

This relationship between the professional worker and the patient can be seen from many angles. Side by side with the cultural, sociological, psychological, clinical and ethical approaches, here the perspective of shared human citizenship will now be analysed. From this point of view, can this relationship be exclusively considered from the perspective of a sick elderly person? Is the professional worker truly 'healthy', given that the same humanity characterises him or her? Limits derived from the same human nature mean that for the professional worker as well there is the possibility of growing old and falling ill; the professional worker, too, has the certainty that he or she will die. In addition, health is not only absence of illness. To be healthy means to be in harmony with ourselves, with other people and with our environment – both the natural environment and the socio-cultural environment – and certainly, last but not least, for many people it also means having a good relationship with the Transcendent. A state of health that is momentary, that is lost and reacquired during the course of daily life. Furthermore, which experiences of illness, disability, old age and death have marked the personal experience of professional workers? And what meaning do professional workers give to the suffering that they encounter every day?

The answers are so important that there exists the risk that the encounter with the vulnerability and frailty of others can become an excessive burden; indeed an intolera-

ble burden when one has to bear it alone. It can induce approaches involving running away or in contrary fashion that involve omnipotent responses, to the point of degenerating into feelings of indifference or even feelings of hostility, cynicism and anger towards the suffering of the person who needs care.

A suffering that imprisons and conditions the patient who often, however, has the idea that he or she will move out of it, whereas the professional worker has this suffering as the daily background of his or her professional life. A suffering that is an element of growth in the history of a man or of a woman. This statement does not want to be an exaltation of suffering – an incorrect approach from a religious perspective as well – but, rather, a rational reading of it: a moment of pain is a moment of extraordinary truth that forces everyone to pose ineluctable questions about the meaning of life. If one wants to encounter the pain of other people, one must first of all reconcile oneself with one's own pain. In order to treat, in the broadest sense of the term, one must be aware of one's own need to be treated.

Now the care process can be realistically seen as a journey taken together for a stage in life by two people – the professional worker and the patient – who are wounded in their humanity, and where the professional worker can bring technical knowledge, the patient can bring the value of a human experience, with the possibility of, and perhaps the need for, mutual help between the two.

It is necessary to go beyond the idea that there is a universe of 'healthy people' that looks after a universe of 'sick people'. This is explained by Jean Vanier, the founder of a network of communities for helping handicapped people – *L'Arche* – when he states that a therapeutic community is a place where people who are not completely healthy care for people who are not completely sick.

Hence the proverb quoted by Jesus in the Gospel according to St. Luke, who for that matter, is seen by tradition as a physician: 'doctor, heal yourself' takes on a meaning that goes beyond a purely exegetic interpretation.

The figure of Chiron is significant here: he who learnt from Apollo the art of healing and transmitted that art to Asclepius. But he was himself the bearer of an untreatable wound so that he was the 'archetype of a man who treats but at the same time has a wound that will never heal over. The figure of Chiron contains this duality: care for other people at the same time requires care for oneself. In treating the wounds of other people Chiron in part alleviated his own wound'.[3] An emblem of the structural frailty of medicine where the possibility of treating is conditioned by the capacity to see one's own wounds, that is to say by knowledge of one's limits and a readiness to learn from them.

Everything that has been said in this paper about the relationship with the patient, however, does not have an exclusively human, psychological and ethical value. It should also be seen from the point of view of better professional practice. In the Platonic idea of the health of a man considered in an overall sense it was stated that just as one cannot treat an organ or a part of the human body if the body as a whole is not kept under control, so one cannot treat a man in his entirety without also treating his soul. 'To treat the soul' means to consider the problems of the patient.

Lastly, the goal of the physical healing of a patient cannot be the sole finality of professional activity because this is often not attainable, as is the case with people who are disabled, elderly people with chronic pathologies, and people at the terminal stages of their illnesses.

It is necessary to make an appeal for a more realistic concept of healing that always provides the opportunity of having a therapeutic goal. A goal that is always possible if we understand healing as the capacity of a person not to be squashed by the reality of life so that he or she has courage, faith, and the strength to remain the 'master' of the situation, as much as this is humanly possible.

Thus care in the broadest sense of the term means trying to help an elderly person and having the strength to address and manage his or life situation, which is threatened by suffering, by disability and by death.

In conclusion, to speak about care for the elderly involves posing oneself the following question: what value do civil society and ecclesial society give to disabled elderly people? What value is given to them by professional workers? What value is given to them by geriatric institutions?

Better and more suitable care certainly depends on the answers to these questions.

Prof. MASSIMO PETRINI,
Director for the Promotion and Development of Geriatric Care, The 'A. Gemelli' Faculty of Medicine and Surgery, The Catholic university of the Sacred Heart; The Cammillianum International Institute for the Theology of Pastoral Care, Rome, Italy.

Note

[1] MAGGI S. *et al*., 'Epidemiologia dell'invecchiamento', in Gensini G.F., Rizzini P., Trabucchi M., and Vanara F. (eds.), *Rapporto Sanità 2005 Invecchiamento della popolazione e servizi sanitar*i (Il Mulino, Bologna, 2005), pp. 27-42

[2] RUSSO M.T., *La ferita di Chirone. Itinerari di antropologia ed etica in medicina* (Vita e Pensiero, Milan, 2006), p. 8.

[3] AA.VV., *La ferita del centauro* (Moretti e Vitale, Bergamo, 2005), p. 87.

3.The Pastoral Care of Sick Elderly People from the Political-Social Point of View

JOHN PATRICK FOLEY

3.1 The Mass Media

Regarding the pastoral care of the sick and the role of the media, I would like to make three principal points:

One is government policy regarding electronic media and the sick and the elderly. As you know, the electronic media in countries where you have commercial media are determined by the market they serve. So they seek to reach consumers, and individuals who are sick or elderly normally are not great consumers of the media or of things that are sold. They are not able to get out to shop. They are confined to their beds, or to their room, or to their communities, so they are not big consumers. Therefore they are not well served by the electronic media in nations which have an unregulated media system. So I would think it is most important to make sure that in the assignment of broadcast frequencies, there be a requirement that all communities be served, including the sick and the elderly; that they not be excluded merely because of the fact that they cannot buy a lot of things. There are services that can be broadcast or telecast that would be of great interest to them, but often this programming is denied them because they cannot buy things. So our basic media policy is one area where I think there is needed a continuing intervention, including by the Church, to guarantee that certain things such as religious services are available in the media to the sick.

A second point is what services exist to inform the general public about the sick and elderly. It is very important to have accurate information about those who are in need of regular visits, who are in need of letters, who are in need of special care. Because once these stories are known to a wide community, then there is much more likely to be a large reservoir of volunteers who will visit, who will help, who will care for those who are sick and for those who are elderly and provide them the loving service that can be easily denied if they are easily forgotten.

And now to the sick and the elderly themselves; what can and should the media do? Let us first look at television which is so popular with everyone, but of course especially for the sick and elderly who cannot get out for other forms of entertainment. It is important that wholesome programming be provided, also spiritually enriching programming such as the Mass, the rosary, informative and inspiring programs. And it is also important that there be access to substantive news reports, not merely sensational news reports but substantive news reports that can help the sick and the elderly. It is also important to have a supervision over the commercials, the advertising which is directed often to the sick and the elderly. Often there is advertising of insurance policies, which in some cases may be superfluous, in other cases there is the advertising of apartment medicines and, depending on the society, if there is not a good regulation of that which is made available through medicines, then individuals can be exploited and even harmed by what they consider they have to buy because the commercial says it is good for them. There are many instances, unfortunately, in which false insurance schemes have hurt many elderly people who are all too easily exploited.

But I would hope, tied in with what I earlier said about government requiring broadcast services for the sick and elderly, that they may have made available to them such things as the broadcasting of the Mass, of the rosary, of things which will bring to them spiritual consolation. And of course the same is true for the radio. And one thing that can be offered on the radio, relatively easily, and which has been offered now in several countries is a radio retreat. In the United States, for example, I had asked the communication committee to consider the possibility of a retreat on the radio for all people but especially aimed at the sick and the elderly. This was done and with apparent great success across the entire nation, in a retreat offered by a number of bishops on the electronic media.

Of course publications are always useful. I would think that especially prayer books can be most useful for the sick and the elderly; prayers with which they have become familiar, prayers which are dear to them. Some may already have such prayer books, others are in need of them. Popular magazines can also be helpful in a number of ways: one, they can have articles on how to cope with illness and how to cope with growing older, and there can also be articles on how to deepen one's own spiritual life. There can be reflections on the lives of the saints, especially

saints who have been ill, saints who have been elderly.

And of course now we have the Internet. There are a lot of elderly people who have become active on the Internet. Of course, we have to be careful that they are not exposed to material which can damage their own spiritual lives; this is a problem across the board. There should be websites, which can serve the sick and elderly and bring not only accurate information, but also consolation and inspiration. It is most important to stimulate the interest of the elderly to keep their minds alert, and the Internet can do a great deal also through means of corresponding with others by email. But also at the same time it is important that individuals not be subjected once again to harassment or to exploitation through unscrupulous persons who can defraud them or can deceive them. Our speech should be free but it has to be responsible and in many cases also regulated for reason of not doing harm to those who are most easily exploited.

I would say in general there is a failure to cover the sick in the news well. When individuals are sick, when they are elderly, they are often forgotten. And I think that our news media have a responsibility to make people aware of the number of sick and elderly in our society and how these individuals can be better served. We all grow, as we know, by the help that we offer to others, by the love which we show for others and we can only do that if we know about their needs. And so there should be more adequate coverage of those who are sick, those who are elderly without exploiting them, without violating their dignity or their privacy. But there should be adequate news coverage so that we will all join in helping to conquer some of the forms of illness which afflict many people, and so that we may also join together in solidarity with those who have done so much for so long in love for us and for others.

So how do we serve the sick and the elderly? By guaranteeing that there is a sufficient government policy regarding the media to guarantee that these often forgotten segments of our society are adequately served. Second, that there be services in the electronic media, which will strengthen their spiritual lives and bring them consolation and inspiration. Third, that there be adequate news reports about the sick and elderly to inform all segments of society and to motivate them to do something about problems that exist or about individuals who are in need, without in any way violating their privacy or their dignity. And finally I think that a motto of all the media should be: "Love one another as I have loved you." If the media can be instruments of love, if they can bring people together in love, in service, in care, then we will have a much better society not only for the sick and elderly who are served, but for those who are providing them service in the name of Jesus.

H. Em.Cardinal
JOHN PATRICK FOLEY
Grand Master of the Equestrian Order of the Holy Sepulchre of Jerusalem

PEDRO ANTONIO REYES LÓPEZ, LUIS ALBERTO LASSES

3.2 National and International Health-care Policies, Legislation, Migration, Economic and Technological Resources, Food Policies and Social Hygiene

Health, which is a divine gift, is a universal human aspiration, a fundamental need, and a social value. The development and growth of a society, whether it is rich or poor, can be assessed on the basis of the quality of health of a population, in addition to fairness in the distribution of the resources that are allocated to health and the level of involvement and care offered to sick people and the disabled. Fairness is the basic premise of *every health-care system*. Everything that strengthens this fairness (at an international level and in every individual country) is also connected with health, at the level of prevention or care and treatment, and the socially established conditions that allow people to live, grow, work and grow old.

The Dictionary of the Spanish Language (the twentieth edition) states that the adjective 'elderly' applies to a man or woman who has lived many years and it uses this qualifying adjective for everything that is specific to such people. In our society, the stereotype of an elderly person is an individual who is at an inevitable disadvantage, with an accentuation of problems and weaknesses, and with a low view of his or her contribution to society. But at the level of fact, an elderly person, a person who according to a conventional limit is over sixty-five years of age, can today be seen as being independent and useful for many years to come (table 1), and the limits that discern in the ages of seventy-five or eighty the points of weakness of human capacities are not absolute – there are in fact individual differences. Although the moment arrives when old age establishes insuperable limits, in general there are circumstances that separate elderly people who are equal at a chronological level, such as, for example, higher education, income, and the ability to adapt to situations, and which show us that the stereotype, which in the end is only a generalisation, is unreal. This points to the adoption of initiatives that can solve problems that are seen as having no solution. It is useful to recall that people over the age of sixty-five make up 12% of the working population of the United States of America and that people who are over the age of seventy make up 7% of the same working population. In Eastern Europe people over the age of sixty-five make up 16% of the working population.

Anyway, the depreciation of elderly people as a group exists to the extent to which most of them, and not the exceptions, do not have a role that is socially useful in communities that are directed to economic competence and solidity. In rural, pre-industrial, communities, or in communities with another tradition where the family structure has been maintained, on the whole there is need for manual labour, which, instead, technological progress reduces. These societies are also marked by the wider family whereby elderly people have a social value which lasts for longer over time because elderly people are economically active in work in the fields for a period that lasts longer than is the case with pensioners who live in cities. Here the family appreciates the contribution of elderly people to looking after the home, the children and the farm, where there are also domestic animals, and sees the elderly person as a guide and an adviser, helping him or her and giving him or her food, housing, and protection, and even when an elderly man marries a younger woman, he maintains his power over his descendants. Indeed, this is the case in many cities in my country where migration has altered the demographic balance.

In industrialised countries as well, where the percentage levels of elderly people is high, the family maintains a central role and in some cases children also have a responsibility of a legal character for parents who have needs that they cannot deal with on their own. However the tendency exists, which for that matter is growing, for elderly cou-

Table 1

Age groups in elderly people
From 65 to 74: functional, economically active – 55% of men and 7% of women, pensioners on the increase.
From 75 to 84: decline in functions and productivity, number of women increasing.
85 years and over: physical and intellectual decline, disability, growing and progressive dependence on others.
Note: 84% of people over the age of 65 are not covered by welfare schemes.

ples to live apart from their children in an independent way, and only on special occasions – on the whole in the case of illness – do these elderly people turn to their children or grandchildren.

The question of an elderly person who is in a state of poverty or disability is posed by institutions or various groups through organisations that operate in very different ways in individual countries: care provided by the state, by private or corporative institutions of a philanthropic character which belong to the Church, by corporations or trade unions, or by companies which seek to build residences for elderly people, organise groups for medical care or provide company for these people.

In Western Europe demographic transitions has given rise, more than in other regions of the world, to *health-care systems* that thus have a longer history behind them than similar systems in other parts of the world. It is thought that the system goes back to the England of Queen Elizabeth and the poor law of 1635 which gave parishes the responsibility to help sick elderly people. The legal measures by which the state was given a presence at a time when individual or religious charity dominated were strengthened during the nineteenth century in the Scandinavian countries, in Bismarck's Germany, and in France and Italy, where laws were approved that assured public responsibility for elderly people, the sick and the other less fortunate people of Western European society. In the United States of America it was only after the Great Depression of 1935 that a system of social support was established with the Social Insurance Act, under the Roosevelt administration, in addition to supplementary plans at a federal, state and municipal level, for example exemptions from taxes and payments, as well as health care. The Blue Cross and Blue Shield care services are of more recent date, and Medicare and Medicaid go back to the middle of the twentieth century. These last pay for the health-care costs that arise from the difficulties experienced by elderly people by increasing their incomes and purchasing power. These have their counterparts in other societies, albeit with varying levels of incidence. Unfortunately, however, large areas of the planet do not have these services of care and welfare; in other areas they are present but in a very heterogeneous way or, although legislation exists on the question, they are not always applied.

There can be no doubt that demographic and economic realities are compelling inevitable and drastic changes and, amongst other instruments available, consideration is being given to changing the age of retirement, with a variable extension that tends to increase the number of workers so as to thereby produce further contributions to the health-care systems. For example, in Germany the age of retirement has been extended to sixty-eight years of age and forty-five years of pensions payments. In many countries, attempts are being made to raise birth rates to two children for every family and to improve the supply of education so as to ensure working potential, exploit the opportunities for economic growth and development, and attenuate the demographic imbalance. However, in most of the countries in the South of the world suitable conditions do not exist for the use of the models that have been adapted in rich countries.

Elderly people have shared needs, leaving aside the age bands to which they belong, and these are, for example: health, food, recreation, and the consumption and cost of goods and services. Undoubtedly, the income of elderly people decreases or even becomes eliminated as the years gradually pass. In addition, needs change according to age band, and health can become a relatively minor concern at the age of sixty-five, if not at the age of eighty-two.

It is thus necessary to draw up general and specific policies which can be applied to this population group and, given that a social policy on ageing cannot only be a set of programmes, it is necessary to reflect on at least four political approaches. These are: a) *the social approach*, with universal access, through lifestyles, culture and recreation, to the promotion and prevention of health adapted to every income band; b) *the welfare approach*, towards elderly people with permanent or transitory disabilities, advancing illness and needs for rehabilitation; c) *other cases* that require special care in difficult circumstances: abandonment, maltreatment, malnutrition; and, lastly, d) *a policy involving social support* in cases of acute poverty, family breakdown and social exclusion. These policies must be in line with the five principles that the United Nations has laid down as being essential as regards a definition of care for the elderly (table 2): independence; participation; care (provision and acceptance); and dignity.

In all countries, in general, a certain attention is paid to gerontology and to care for the elderly. Government organisations have been created to engage in the assessment and supervision of welfare programmes, research programmes, and programmes for the drawing up of standards, algorithms and health care for elderly people, with primary services of rehabilitation, associations made up of elderly people and the organisation of geriatric services which envisage specialist medical doctors, nurses, physiotherapists, and social workers, for a population of about 30,000 people who are over the age of sixty-five.

Given that elderly people consume a third of the funds allocated to health care and occupy 60% of hospital beds in the prosperous societies of the world, strategies have

Table 2

Fundamental Principles of the UN	Risks with Ageing
Independence	Loss of physical and mental capacities
Participation	Decrease in autonomy and adaptation
Care (supply and acceptance)	Decrease in family and social role
Self-fulfilment	Retirement and decrease in income
Dignity	Loss of activity, deterioration in health

been drawn up to solve this situation which in reality is unsustainable in the face of the ageing of the world population. Health care for elderly people in the United States of America has shifted from hospitals to nursing homes, clinics and accredited structures, with almost two million beds. In Canada an institutional system has been organised which offers greater opportunities for elderly people to gain access to medical care and which tends to reduce their presence in hospitals, with economic savings and also savings as regards work burdens. Even more important, there are the same results for the health of elderly people. In other countries this mechanism is entrusted to the hands of the private sector or charitable association, where the presence of the Catholic Church is of notable relevance.

The general data that I have cited are insufficient to have a clear idea of such a complex subject as the application of *health-care systems* to elderly people, who have health problems that have been accumulated during their lives. Research into wellbeing, health and ageing that carried out in the years 1999-2000 in Latin American countries showed with representative data that 20% of elderly people believe that they have bad health and 50% see their health as normal; the illnesses that they suffer from are the following: rheumatic problems (63%); arterial hypertension (43%); diabetes (22%) and problems of a nervous kind (11%). It should be said, however, that 30% see themselves as being healthy and 6% define their health as 'excellent'. This clearly brings out that chronic-degenerative illnesses are the commonest health problem to be found amongst the elderly section of the population and that these increase with the advance of old age, and that although the demand for services of assistance in hospitals has been growing, the lack of home support services, such as nursing and care services, has become grave. Obviously enough, no health-care system exists which can solve these problems totally.

Throughout the world there has been a general awareness for many years (table 3) of this question. In 1982 the first World Assembly on Ageing was held which proposed concrete alternatives to respond to the imminent and unstoppable change in the world's population. In 2002 the second World Assembly on Ageing called for inter-generational solidarity, great care in rural areas and in relation to minorities, greater participation by elderly people in society and political representation, the promotion of health and wellbeing, and the defence of elderly people against maltreatment and violence. This Assembly ended its deliberations with a Political Declaration and an International Action Plan for Ageing, with a programme on ageing of the United Nations and the support of the World Labour Organisation, the Intra-American and Development Bank, the World Bank and other supranational organisations. All of this led in November 2003 in Santiago, Chile, to the Latin American and Caribbean Inter-governmental Regional Conference on Ageing which decided to establish a Regional Strategy for the implementation of the International Action Plan of Madrid for the Latin American and Caribbean Region.

In 1978, in my country, the National Institute for the Third Age was founded and in 2002 some changes were made to its statutes. At the same time the first Law on the Rights of Elderly People was approved and the name of the above-mentioned institute was changed to the National Institute of Elderly People (*Instituto Nacional de las Personas Mayores* – INAPAM). This was entrusted with public policies in this sector and had representatives within the local federal agencies and in local municipalities. It was also given centres for overall care which now offer services of medical consultation provided at a minimal cost and linked to local hospitals; as well as associations for the third age, cultural centres, gerontology units, and mobile units for information and education in relation to health. A credits programme exists which involves credits for people over the age of sixty and there are also programmes for the reassessment of elderly people which seek to bring them closer to their communities by involving them. For example, in elementary schools and nurseries, telling stories to children, or in shops which sell craftsmen's products for elderly people, or in national sporting events and cultural activities.

Almost everywhere *laws* protect elderly people but there are some gaps. If we look at the legal context, we can observe a relevant, sad and at the same time shameful feature: violence against the elderly. This is a problem which is on the increase and which lends itself to preventive action. Violence within the family is something that is relevant but less evident to which visibility has to be given and where it is necessary to identify elderly people who are at risk. Man is the only creature in nature who takes care of his progenitors and at times this leads him to violence which also includes the maltreatment of children and women. In the academic field, in 1975 an article was published in the *British Medical*

Table 3. International Action and Proposals for Ageing

Meetings and Assemblies	Principles for Fair Care
1982: Vienna, World Assembly on Ageing	Autonomia
1991: UN resolution 46/91 in the elderly	Active Ageing
1994: Cairo, Summit on Population. Resolutions 46/94 7 and 45/106. International Action Plan on Ageing	Prevention is better than treatment
1995: Copenhagen, World Summit on Social Development	Flexible programmes
1999: Kobe, International Year of the Elderly, UN	Decentralisation
2003: Santiago, Chile, Regional Inter-governmental Conference on Ageing	Sufficient subventions

Journal which demonstrated indifference on the part of health-care workers to family violence, with it not being identified as such, perhaps because they did not have available criteria by which to establish instruments of screening, but today it is known that violence can take on various guises: *physical abuse*, with blows, fractures, bruises and internal bleeding, burnings, segregation, and an inappropriate use of drugs and medicines with the intention to cause harm; *psychological abuse*, with shouting, insults, emotional injury, the making of noise and the privation of sleep, isolation, humiliation, and treating elderly people as children, leaving elderly people on their own amongst the traffic or in vehicles; *sexual abuse*, as in the case of sexual contact of any type without the elderly person's consent; *material* exploitation – the illegal use or theft of the property of elderly people, their savings or their property, forcing them to beg; and *negligence* – the denial or lack of care, including the fact of forgetting to provide food and medicines and to deal with other needs, at times self-negligence in the case of elderly people who are unable to obtain goods and services, abandonment on the part of adults who are responsible for them, and thus violation of the fundamental rights of the person.

The elderly people who are most vulnerable to violence are those who rely on other people, the disabled who have lost their own autonomy and are discriminated against and vulnerable. Often the aggressor has personality disturbances or a psycho-pathology, is unemployed, and has a low level of schooling, whereas the victim has at least cognitive and physical defects. There can also be relational factors that have lasted a whole lifetime. The progressive deterioration in the mental and physical condition of elderly people and the low level of information provided by medical doctors or care-providing personnel who accept facile explanations that are not very valid or do not take into account the complaints of the elderly people involved, help to increase this problem which is caused by a number of factors. And then one should not forget that the aggressor is often the very person who should care for the sick elderly person involved and who, in turn, has problems. One should address these cases with great prudence and impartiality, offer help and understanding, but firmly reject violence of any kind. The campaigns for public sensitisation and education have had a certain impact, and an international network exists for the prevention of the abuse and maltreatment of elderly people, with its national committees and associations. However, in many cases legislation in this field does not exist and in those countries where such legislation is present it is very unlikely that a public prosecution will take place. However, the expression of a legal precept that lays down that violence against elderly people and the most vulnerable and least protected is a crime is indispensable in limiting this problem before irreparable damage is done. I know of no study in Mexico that has sought to establish specific statistics on this social problem. I do not possess precise data on other countries but it is my fear that this is a problem that is avoided and thus a problem that requires attention on the part of legislators and the cooperation of people who are capable and motivated.

Migration would appear at first sight to be a phenomenon that is extraneous to the elderly part of the population but in many countries it is as relevant as never before and in rural areas it is even on the increase – migrations from rural areas to poor areas on the outskirts of large cities, and international migrations in their illegal form which largely involve small localities and agrarian economies, with their systems of social support and support at the level of health. Such migrations mean that whole areas no longer have younger generations. In this way, fertility rates are reduced and the elderly and middle-aged women and children suffer because of changes that are caused to family structures which a short time ago provided housing, care and wellbeing to elderly people. In Mexico, 31% of municipalities have registered a demographic fall that has been caused by migration and this has involved a reduction in the federal budget and the influence of the municipality in the regional economy, a reduction in market flows, a decrease in agricultural production, environmental deterioration, a reduction in natural resources, and a weakening of the opportunity structures. Moreover, all this takes place to the disadvantage of cultural change and is accompanied by a loss of traditional values. In these rural areas the cover offered by health-care systems through state programmes has never been good and it has even got worse for people who are over the age of sixty. In these areas there has been a slight increase in life expectancy but the social programmes are not able to protect the elderly part of the population and in the best of cases they

have an ephemeral impact which, conjoined with the loss of family networks, has become transformed into a large social debt which has been added to that social debt which has been accumulated over the years. However, one should not forget that in addition to the economic consequences of all this, there is also a generational conflict: elderly people are having to face up to the migration of young people or of themselves in a context of their own meaning of life and its affirmation which, indeed, they perceive as being wounded. The young migrant thus migrates feeling frustrated, repressed and in search of a compensation, in addition to being angry, and all of this generates a psychological conflict that is rarely taken into consideration and is even more rarely addressed.

It is of indispensable importance and also very urgent that the policies in the sphere of migration in Western Europe, which receives African and South American migrants, in the same way as the United States of America and Canada receive immigrants who come from Latin America, are thought about in a new way. In addition, policies regarding professional migration to Australia should also be reviewed. In this review, the joining of immigrants by their elderly relatives should also be envisaged in a way that takes into account the phenomenon of ageing. There should also be created a model for public intervention that will strengthen the social fabric, generational changeover, and the presence at a community level of elderly people. Addressing this reality is not easy, even though it is of urgent importance and requires the professional involvement and attention of many members of the academic community.

In the health-care systems of most of the world economic resources are allocated to curative action, to treatment for the seriously ill in hospitals, but there is a lack of structures devoted to the chronically ill, whether these are elderly people or not. Even though the first may survive the infirmities of a multi-factor aetiology that arise with old age, and which are at times present from an early age, being associated with genetic and environmental factors, including lifestyles, health-care systems are not ready to address the future increase in the numbers of the chronically ill and disabilities generated by the demographic transition. Unfortunately, not having available other resources, elderly people continue to bear their infirmities for many years in addition to bearing those that come with age. There is growing pressure in this sense and it is necessary to achieve greater fairness in the distribution of benefits through a balance between costs, quality of care and access to services. To all of this is should be added the enormous cost of contemporary medical technology at the level of diagnostic images, complex operations and the not very realistic hopes of medical doctors and patients who ignore or forget about the principle of the proportionality of treatment and require services in the health field that can produce situations that involve exaggerated treatment.

In recent years reference has been made to catastrophic expenditure in the health-care field, with emphasis being placed on the fact that often care is provided with the costs being placed on patients or their families and the fact that the costs of modern hospitals are usually very high. A definition of catastrophic expenditure is when it exceeds 30% of the actual income of an individual (that income not allocated to what is necessary for survival) and it is very easy for this to happen in the case of elderly people or a family that looks after one or two elderly people.

At the level of society, catastrophic expenditure is expenditure which exceeds 20% of the resources of the budget of an institution for working expenditure on medical care and treatment. These problems have led experts throughout the world to review the 'expenditure to be paid' for health care are well as the subject of fairness. Here there are two central aspects: universal access to services and the quality of care. In the first case one is dealing with the fact that an elderly person has access to services that he or she needs, quite apart from his or her capacity to pay, his or her geographical location, or the social context in which he or her lives. Quality of care refers to the ability of a health-care system to assure similar results in its health-care institutions, with an efficiency in the employment of resources.

Today, it appears that solutions to both these questions do not exist and the suggestion has been made to shift the direction of health-care systems towards the promotion and prevention of health. But this does not solve the problem that already exists, which involves the fact that almost all over the world health-care systems are no longer up to their tasks.

The suggestion has been made to create in the short term health-care national institutions parallel to national promotion and prevention programmes, with an effort directed towards social development and an identification of the critical points and the drawing up of practical and sensible clinical guides. Subsequently, there will be an integration of middle-size hospitals which supply equivalent services for the whole of the population, ending up, over the long term, with (in order to maintain what has been achieved) a policy directed towards strengthening hospitals with a high level of specialisation, but in this case the pathologies to be treated by the higher health-care body will be selected. The resources to make this system operational will be generated through universal insurance. All of this requires a profound reform of health-care systems that has not yet been set in motion, and this is a cause of concern for the World Health Organisation and has encouraged the United Kingdom to establish the National Institute for Clinical Excellence with over twenty-nine agencies in various countries. I do not know whether there has as yet been a response. In addition, obviously enough, to considerations of an economic character, it will be necessary to envisage a bioethical dimension and the safeguarding of rights. It is vital to consider the biological basis of old age and along these lines investigate certain aspect of health care with the splendid contributions that the *advance of science and technology* made during the last century and which

today allow a life expectancy that is more intense, even though not always longer, than that dictated by the telomeres of our chromosomes.

I have already observed in this paper that 30% of elderly people see themselves as healthy and behave accordingly. However, most elderly people suffer an accumulated morbidity because of chronic-degenerative illnesses and other pathologies that are connected with old age. For this reason, disability and illness are common, painful and conditioning problems for elderly people.

Let us now briefly survey geriatric morbidity. Our skin displays the signs of time, it loses elasticity and wrinkles appear, the hair on our head becomes white and thinner, and at times an irritating hairiness appears in women. There are then often dermatological changes: xerosis, cheratosis, acantoma and tumours of varying degrees of seriousness. Pupils can change their direction and the eyelids can injure the cornea, internally injuring it (trichiasis); the tear duct becomes obstructed and the quality of tears changes; there are changes in refraction and the eyes can have glaucoma, cataracts, haemorrhages of the eyeballs, detachment of the retina and macular degeneration. If diabetes is present, or arterial hypertension, the retinas can undergo very serious problems. There is hearing loss, earwax accumulates and otosclerosis emerges, with at times a change in the vestibular system. There is a cognitive deterioration, depression, and neuroses last, but psychoses are rare, and if they do take place they often have a physical basis. Before thinking about the presence of dementia in an elderly person, one should ascertain whether there is a chronic sub-dural haematoma or endocrinal hypertension. Senile tremor and Parkinson's disease are frequent and transitory cerebral ischemia can presage a parenchimatose cerebral-vascular illness with serious consequences. It is not rare to encounter sclerosis of the aortic valve and stenosis, arrhythmia because of auricular fibrillation, and other disturbances which are at time asymptomatic and serious or even fatal without their being any pre-alarm; myocardic ischemia is also common and there is a reduction in pulmonary mechanics. There is a reduction in the secretion of gastric acids. One easily encounters anaemia, stomach hernias, gastroparesis and a slow emptying of the stomach. At times there is pancreatic-duodenal insufficiency and chronic constipation is very common, something that increases the mobility of the diverticles in the colon. In other old people faecal or urinary incontinence are very serious problems.

Muscular-skeletal illnesses are very common: osteoporosis with the risk of bone fracture, progressive dorsal curvature, stenosis of the rachid canal and osteoarthrosis are almost all universal when people reach the age of eighty. Sarcopenia and weakness are very complex problems. Because of lack of symmetry and the loss of coordination, instability is encouraged and the frailty of elderly people is an emerging concept in geriatrics and of great importance for public health. This frailty is expressed in a general weakness, hyporexia, loss of weight, low or even absent tolerance to force, low physical activity or inactivity, and an unsteady step. This is a 'biological syndrome' where there is a reduction in homeostasis, and homeostenosis is often the final stage.

All this is the result of *clinical research* which is beginning to be methodical in the field of geriatrics, a field that is new and which has a future, but which is still little known about by medical students in countries which, in the space of one or two generations, will have one-fifth of their populations made up of elderly people.

When does all this develop? At times starting with life in the maternal womb. The first environment that we experience is an determining factor in the length and the quality of life that we will have later. Before being born we pass more biological stages than at any other phase of life. During these moments the embryo and the foetus are very sensitive to adverse prenatal environments; there are permanent changes in our cells, tissues and organs during our lives inside the maternal womb, during which period there is a 'development programme' where our genes and environment establish response models faced with the specific challenges imposed on an organism at a critical time. This is one further reason for protecting life from its beginning in conception.

Recent research point out that there are periods of vulnerability to sub-optimal conditions both during the pre-natal period and during the period that immediately follows birth. By way of example I will refer here to the fact that a mutation in the gene that codifies the glucochinasis enzyme associated with low weight at birth has been discovered which could have consequences for resistance to insulin. In addition, one may think of the 'saver genotype', an adaptor mechanism to deal with the recurrent famines which at least since the industrial revolution no longer exist in many countries. This adaptation mechanism, being no longer necessary, could be associated with the metabolic syndrome and cardiovascular illnesses in youth. The effects are permanent, involve structural changes, and can be passed on to the next generation. There are clinical areas where planning for development (PD) seems critical:

Obesity – there is a strong relationship between low weight at birth and an index of body mass higher than thirty in adults, with the risks of illness that this involves.

Diabetes – in the same way there is a relationship between low weight at birth and type 2 insulin resistant diabetes and alterations in the metabolism of the lipids.

Arterial hypertension – in this case, as well, low weight at birth prefigures illness. And one may think that the metabolic syndrome, the cause of so much illness in adults, develops beforehand, even in the womb. And there is more.

A PD has been developed in cases of depression, bone function and hip fracture, and the proposal has been made to improve nutrition, engage in physical exercise and provide more treatment to pregnant women and children through policies intended to meet their needs, with the administration of iron, foliates and vitamins to strengthen maternal breast feeding and create affective ties.

Going beyond this, during the

post-natal period nutrition is basic for successful ageing and this is an environmental effect that acts on the genetic inheritance and the PD, which is accessible with relative ease. Over the last twenty years our diet has changed (fig. 1) and now we manage to delay the epidemic of obesity (the prevalence of obesity in children increases up to 30%), iron and foliates are added to the diet, physical exercise is promoted, carbohydrates are avoided, including fructose, which is the principal component of fizzy drinks, which are very popular, and induces hyperucemia, with the limitation of dietetic fats to no more than 30%, with the consumption of more vegetable proteins such as soya. It is likely that through an *alimentary policy and social hygiene* a good part of the population can age well.

It is a complicated matter to address such complex questions and issues which interact and are relatively little known about and then present to those who are listening an overall vision with the intention of sensitising the community and the various levels of government so that an attempt is made, with a firm political decision and with the support of everyone, including the Church, NGOs and families, to search for the best way possible of disseminating what is known about but which remains obfuscated in the context of advertising that is directed by irresponsible commercial interests.

We must be able to implement committed social policies, to use the resources that are already available in the best way possible, to encourage research directed towards life and the common good, and man, and obtain social consensus in all countries so that our presence in the world fosters the Kingdom that was promised to us by our Lord Jesus Christ.

We should not, however, forget that the pathway that we have to follow will lead us to old age and in addition we should not forget that in order to receive it is necessary to give, and that we have many opportunities to serve elderly people. The United Nations on 1 October declared the World Day of the Elderly. Even if this is only a symbol, I think that it is worthwhile to indicate it in the calendar of the activities of the hospital where I work, in Mexico City, which every week treats twenty to thirty elderly people and which has already recorded five hundred cases in its clinic for geriatric cardiology, at a time when the request in other areas has diminished.

Prof. PEDRO ANTONIO REYES LÓPEZ,
Director of Research, The 'Ignacio Chavez' National Institute of Cardiology, Mexico

Dr. LUIS ALBERTO LASSES,
The 'Ignacio Chavez' National Institute of Cardiology, Mexico

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4.The Pastoral Care of Sick Elderly People from the family Point of View

GOFFREDO GRASSANI

4.1 The Sick Elderly Person, his or her Family, and Health-care Personnel

I. The Elderly: a Difficult Definition

This subject requires thought about old age, that category of people who are the subject of this paper. In order to specify the context of old age we can refer to different parameters: a legislative parameter, which indicates elderly people all those who have reached, because of well defined age limits, the right to have a pension, given that they no longer engage in work; a statistical parameter which specifies the average age of contemporary man and in this context specifies the years of old age; and a parameter relating to the individual involved so that his or her old age is determined with reference to state of health, personal capacities, his or her activities and his or her personality.

When this last parameter is preferred, which for that matter corresponds more to the 'unrepeatable' condition of a person, the category of the elderly is objectively defined by a common denominator which is provided by the unfolding of the project of earthly existence towards its end. Elderly people, therefore, are those who are directing their existence, even if they are still healthy and working, towards the end of earthly life.

This definition takes into account the extension of human life because of improved conditions of life and the new conditions of health that have been allowed by the imposing developments of science and in of particular medical science

2. The Elderly Person and his or her Needs for Preservation and Development

An elderly person, like every other subject who is structured and develops in relation to other subjects, places the person once again at the centre of our reflection; he or she is a subject who constitutes himself or herself in relating and develops beginning with his or her conception, generating an inter-subjective structure that characterises his or her personality and culture.

An elderly person, like every other person, is not only 'rationality'; he or she is also 'relationality'.[1] The constituted relationality of the person-being is made evident by Revelation which makes clear the suffering of non-relationality – 'it is not good that man should be alone' (Gen 2:18). Relationships are not only an appropriate means for the fulfilment of the human person but are also constituted so that 'that they may be one even as we are one' (Jn 17:21-22). This metaphysical finality placed and impressed by the Creator in the human person becomes a pathway of unity and the foundation of the full development of every human person.

The human condition, which is a reality that passes, makes all men equal but at the same time it makes them unrepeatable and distinct because of the infinite variety of their relations, modalities, sensibilities, and cultural means by which they perceive that condition, live it and transmit it.

A sick elderly person is a status of the person that reverberates perspectives, hopes and needs proper to him or her which must be conserved or strengthened in their identity on the basis of a specific culture which is born, which is constituted and which develops in the context of well defined family and affective relationships.

The gift of old age

An elderly person, like every other human person, is the bearer of gifts, which he or she transmits to the culture of the new generations.

This is the gift of witness that leads to a summary of the experience of life, which tells of the lights and the shadows of that pathway, of the overcoming of difficulties and of defeats, a human and spiritual story, an open window onto the love of God for man.

We may refer to the letter of John Paul II who, when addressing elderly people as an elderly person strongly declared: 'Our lives, dear brothers and sisters, was written by Providence in this twentieth century'.[2] It is thus Providence that locates elderly people in the plans of God and characterises their personalities.

Side by side with anthropological witness, the elderly are the bearers of a higher gift, that of explicit or implicit faith, without which the hard pathway of man does not reach the fullness of old age.

Although, indeed, a person is, as regards his or her being, a participation in the being of God, it is in old age that this ontological condi-

tion is better felt and perceived by those who are moving along the road to the setting of the sun. We reproduce here the teaching of the Pontifical Council for the Laity which identifies in the elderly authentic charisms such as: free self-giving, memory (understood as witness), experience, interdependence, and a more complete vision of life.[3] It is believed, in fact, that these elderly people experience the values of responsibility, friendship, patience, wisdom, respect for the Creation, and relationships of peace and of detachment from power, with great depth. From these virtues and their practice, which are facilitated by the very condition of fragility and dependence of elderly people, they manage to experience a contemplative dimension. Old age, therefore, is the fruit and the result of a long process that transforms every human subject in the sphere of his or her own identity as a person.

Feelings – a new juridical category: the love of grandparents is already a right for the very young

This subject has finally entered juridical reflection and deserves to be referred to in the recent return to the subject that has produced doctrine on it.[4] The positing in our juridical system of a right to love imposes a premise of a general character about the juridical relevance of feelings. Here there emerges the low level of attention that the facts of feelings, as opposed to the facts of knowledge or will, have received from civil law doctrine.[5] The almost total juridical irrelevance of feelings must be attributed in the first place to the fact that feelings are seen as elements within the human psyche and as such are ungraspable.

Other reflections are then based upon the legitimate need not to impose assessments of an ethical character on assessments of a technical character.[6] In this systematic framework that seems not to attribute any relevance to feelings in themselves attention should be paid to an authoritative doctrinal voice which, analysing feelings within the context of the general theory of law, limits the sphere of reference to facts of feelings that are objectified and translated into values of the system and which accompany exterior facts (which are usually facts of behaviour).[7]

An explicit normative reference to the right of minors to affective relationships with their grandparents is to be found in Bill n. 2435-A- 'The Right of Grandparents to Visit'. Article 1 of this Bill envisages the insertion into the corpus of the civil code, article 317 – three: 'Minors have *the right to affective relationships with the ascendants of their parents* where this is not in contrast with their interests. Whoever exercises power over minors has the duty to allow and not to obstruct this relationship'.[8]

In a European context in the recent special laws that have introduced the right to visit of grandparents there clearly emerges an orientation towards the recognition of an equal right held by the minor. The Spanish law n. 42/2003 expressly recognises *the right of a grandchild to communication and visits*.[9]

These reflections which base the relationship between grandparents and grandchildren on the existence of a subjective right of minors to affective relationships are also applicable to all other family relationships and in particular to the relationship between parents and their children. The recognition of a subjective right of minors to affection, to love, thus allows a enlargement and quantitative selection of the sphere of the obligations of parents towards their children. The violation of the right to love is, in addition, itself a source of compensation for tort, quite apart from the performance of obligations of another nature, including those relating to property.[10]

The family, therefore, is a place where affective relationships are generated which law takes into consideration in order to advance juridical guarantees that defend the development of the person within the system of law.

The role of the family

The above observations bring out the need for family society to perform its function of promoting 'communion' between all its co-participants – grandparents, parents, and children. The family as a subject has a particular and specific 'relational patrimony' with elderly people, whether grandparents or parents, which is characterised by affective and experiential ties lived out in a context that unfolds in history itself and in the experience of every family community.

This a patrimony of knowledge of the other that is generated by an experiencing in multiple human relationships of the anthropological characteristics, virtues, defects, desires, magnanimity and limits of each human person.

One is dealing here, therefore, with a relational and experiential patrimony that constitutes a further 'family patrimony' endowed with certain particular connotations that are specific to every family society.

The family, as the living cell that unites a number of generations, is known and is defined by its formation and planning as a society that experiences, drafts, produces its culture, achieves family relationships, formulates projects, and becomes 'that' family'.

Plasticity

In these processes, which are a subject for study of a large number of disciplines, such as education, psychology, sociology anthropology, law and the medical sciences, we should perceive a characteristic element, specific to family society, that is provided by the plasticity of the making of human relationships.

Aware adaptation to achieve family harmony; the taking upon oneself of responsibility for the other and his or her development, is a constitutive fact of the 'form' that each family acquires. No other human relationship, however important and relevant it may be, for the person can take the place of this good which is the 'form' of each family. It follows from this that an elderly person must maintain this patrimony, which is specific to the family to which he or her belongs, in the heart of his or existing as a gift and as a personal history.

It should also be observed that this specific 'form' of the community of values that every family community, like every person, is able to recognise, is unique and unrepeatable just as the specific character of every human person is also unique and unrepeatable. It thus becomes necessary to ask ourselves how we can help the family and its co-participants to live out the relationship between elderly people and the family.

Formation

On the basis of experience we should observe that families exist that represent an exemplary model of lovingness as regards how they accompany and support their sick elderly relatives. A large number of families, with both parents already strongly occupied, have known how to welcome, care for and live with the parents of one of the marriage partners within the difficult context of our urban societies. If we examine closely these models of life which have been implemented nowadays we observe certain characteristics that deserve to be used as a basis for our reflection.

We should begin with the premise that a sick elderly person represents a series of care and health-care problems which require planning without which the life of elderly people is destined to end up with a delegation given by the family to third parties to provide care for its loved ones. We should know how to create the relationship between a family and an elderly member. To obtain this result it is necessary to identify a series of instruments that are suited to this purpose.

The family project

An elderly person in a family is a source of joy but also a problem that is a represented by his or her psycho-physical condition. He or she cannot address this specific question, with the necessary readiness to help, if those taking part in the family are not prepared for it. The preparation required is first of all of a spiritual and anthropological nature. The young betrothed must ask themselves about what behaviour will be requested of them as regards their elderly parents in order to draw up a project for family life. This investigation which requires intelligence, will and heart, must be followed by a specific grounding as to how to relate to an elderly parent. This is made up of three stages: instruction as to how to care for sick people; the planning of a model of life with one's own elderly parents; and the implementation of this model with reference to the overall needs of the family.

The family must prepare itself for the project of receiving an elderly parent and should attend to providing areas, service of assistance, and home medical services. This formation of the family should include the planning of holiday periods for the elderly person as well as the planning of life together. It should also envisage how to face up to emergency situations, the illness of other members of the family, and a shortage of nursing staff.

The stable presence of medical personnel and others providing care

A good rule is to obtain the help of people who for an elderly person are a constant point of reference made up of friendship and good will. Always forming a part of the same group they should know how to take turns in assisting the elderly person, thereby avoiding sharp fall-offs in the presence of care.

Talking with elderly people

Where sick elderly people are dispirited even though they do not need to be admitted to hospital I believe that it is useful, indeed experience proves the fact, to talk with them about their human histories. An elderly person must be invited to talk about the past: his or her family, studies, holidays, people of the past; this will enable him or her to live again, with gratitude, a time that becomes the present, today, which reflects the experience and the emotions of each segment of his or her life. A life, even though past, that is interesting and continues to be interesting; the transmission of experience becomes a reason for living for the elderly person.

But a relationship between the elderly person and his or her own family is not sufficient. The relationships between families should also involve the elderly person who must feel that he or she is an active part of the relational life of his or her family with other families.

To achieve these objectives a solid spiritual and educational grounding is required but accompanying entrusted to expert professionals is also necessary.

The role of family counsellors

Family counsellors, and in particular Christian family counsellors, were created to provide families with an interdisciplinary consultation service that links educational, psychological, health-care, juridical and care expertise, the high quality of which is based upon a wished-for development of scientific and anthropological research on the family. The accompanying by family counsellors of the family in welcoming and looking after an elderly person should be promoted. The

network of counsellors is present in every region of Italy and it responds to families who knock at the door of an office and request professional help and support in the provision of care. This network then extends its activities to the homes of families, thereby creating a network of help provided at home.

There have been many reasons for the growth in this network. Indeed, families, and especially those that are less informed or more isolated, need special solidarity that first and foremost takes them out of their isolation. Because of their detachment at the level of feeling from the poorest families, our large cities often appear to be crowded and noisy deserts that are not very attentive to real forms of poverty and not aware of the need for participating proximity so as to address the central core of human suffering – loneliness.

It must be recognised that great efforts have been made by the social services which, for that matter, cannot take the place of the family and its relational patrimony, to which reference was made above, as regards nearness to elderly people.

In this context one must promote, in line with the principle of Christian subsidiarity, the role of family counsellors and their capacity to prepare the family for receiving and welcoming elderly people on the basis of its inner character and the training it has received.[11]

Society: the elderly, the role of ethics and the formation of a new right

Society, which we can subdivide into the society of institutions, based upon positive law, the society of associations, based upon statutory autonomy for the shared goals of the members of associations, and general society, must shoulder its specific responsibility for elderly people, as it has already done for minors, for the disabled, for the sick, and for all people who need special care. Here we have to address a cultural subject of great importance, beginning with the observation that society as a whole has to address, namely the flowing of forms of cultural mobility, albeit with an immutability of values.

We have noticed that a deepening of scientific knowledge and technological innovation bring about a change in the knowledge and in ways of facing up to needs of the human person and this of the sick elderly person.The question here arises of the ethical principles that should be borne in mind in relationships with the elderly in order to establish a new system which creates a status of the elderly person and his or her right to live in a family. With respect to the elderly, contemporary culture must ask itself about ethical principles and the working together of these principles in the drawing up of a law that defends the person at every stage or phase of human life.

Ethics and law and the ethics of law

It is necessary to begin with the premise that it is not possible to construct a serious juridical system without an experience of individuals, families and society that is based on ethical principles. The relationship between ethics and law must be examined from the point of view of certain fundamental profiles or points. Indeed, there is a genetic point when the ethics of a specific society produce law; a subsequent relationship between the positive law of a given society and the ethical developments of that society; and a relationship between law and its application in the light of ethical principles.[12]

These relationships must be located within the sphere of family, health-care and welfare rights, that is to say of that complex of regulations that preside over the defence of the family and the person. One may observe how the increase in sensitivity towards, and care for, man allows the formation and the unfolding of cultures of service that are more advanced than previous ones – cultures, therefore, which should be seen as sources of obligatory juridical regulations. From cultures of service to the formation of a new law the step is not an easy one or a brief one but it can take place only when those cultures exist. Thus ethics are fundamental for the development of law and its practical application. Indeed the legislator, in establishing a regulation, takes into account the sensibility of the social body and its capacity to implement a law. This demonstrates the enormous relevance of ethics in the formation of juridical systems.

Conversely, when the social conscience, in multiple historical processes, regresses and does not proceed along the path of greater ethical growth, laws themselves lose their authentic foundation and remain incomprehensible, not implemented, and applied in a contradictory and controversial way. It is advisable to observe that this complex process, which arises from ethics and goes towards law, proceeds in addition from law towards society, thereby creating its overall growth brought about by the juridical character and thus the obligatory character of the norm as well which is extended to all subjects, leaving the ethical maturity that they have achieved.

This juridical point, also constitutes an acquired culture, or better, fosters the growth of a new sensibility which in turn fosters new systems in a circular process that situations of crisis may interrupt or even mutate into an opposed procedure given that systems are the outcome of ideologies or programmes specific to the subjectivism of individual groups.

The right of elderly people to live in a family

The values of this system must be read in the light of natural law and the inviolable rights that make up the foundation and the criterion of the interpretation of article 2 of the Italian Constitution which relates to the principles of solidarity; of article 29 of the Italian Constitution which relates to the family founded on marriage; and of article 118 of the Italian Constitution which privileges the function of the person and the family and the related projects intended to achieve goals of general interest such as the promotion and defence of elderly people.

On the basis of natural law which reads, in line with reason, the requirements of the human person, it is necessary to defend at a juridical level the affective relationships that exist between elderly people and their families. Family relationships

which are necessary to life are ethical duties that must be defended as juridical duties.

I believe on the basis of the observations that have been made in this paper that it is necessary to perceive in the structure of the inviolable rights guaranteed by natural law and our Constitution the right of elderly people to their families. The transfer of elderly people into protected structures when this is not required because of their conditions of life and health which do not permit elderly people to be near their families appears, indeed, to be the negation of this fundamental right which is rooted in the need to maintain the original culture of every family, the foundation of the very 'relationality' of the human person.

The right of an elderly person to his or her family, which is analogous to the right of a minor to his or her family, are rights based upon the need for life, protection and development. From a juridical point of view, it is necessary to rejoin incumbent affective relationships, before feelings, as can be deduced from the doctrine that has been invoked in this paper, to acts of will which on the basis of a discernment wants and implements the good to be done, leaving to feelings their ancillary function. Feelings, therefore, must place themselves at the service of wanting good and implementing it, as is required of the human person in his relationship with the elderly.

Conclusion

To be up to these tasks we must draw heavily upon family culture, the educational, scientific and juridical systems that I have referred to, and here we are talking about the foundation of the promotion of the family, in order to transmit through these disciplines and counselling services for the family God's Love for man which sanctifies our responsibilities, thereby strengthening the flowing of the culture of the generations which begins with the Creator of all things and return to Him.

Law. GOFFREDO GRASSANI,
President of the Lombard Federation of Centres for Assistance to Families, Milan, Italy.

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Notes

[1] CARDINAL DIONIGI TETTAMANZI, *Nuova bioetica Cristiana* (Piemme), p. 43.

[2] Cf. JOHN PAUL II, *Letter to the Elderly*, n. 3.

[3] Cf. Pontifical council for the Elderly, *The Dignity of the Elderly*, chap. 1.

[4] MARZIA BIANCA, in *Rivista di Diritto Civile* (2006, Cedam), p. 155 and ss.

[5] On this point see A. FALZEA, *Ricerche di teoria generale del diritto e di dogmatica giuridica. II. Dogmatica giuridica* (Milan, 1997), p. 437 ss., who stresses that in the sphere of figures where facts of conscience are traditionally distinguished – will, knowledge and feeling – the facts of feeling are those to which juridical doctrine has paid least attention; M. PARADISO, *La comunità familiare* (Milan, 1984), p. 32 ss., who in the field of the family sector perceives the danger of these doctrinaire tendencies that attribute juridical relevance to feelings: 'that are taken on not as "*dato grezzo*", as "*ratio*" of norms or a mere competing criterion for the assessment of *behaviour*'; and F.GAZZONI, *Amore e diritto ovverosia i diritti dell'amore* (Naples, 1994), p. 3, who stresses that this 'right encounters difficulties in regulating the so-called facts of feeling, not only because of reasons relating to juridical lexicon but also because the events that involve feelings (and not patrimonies) are by their very nature ambiguous and obscure, in particular as regards the facts of love'.

[6] M. PARADISO, *op. cit.,* p. 32 ss.

[7] V. A. FALZEA, *op. cit.*, p. 437 ss., esp. p. 523, who after systematically subdividing facts of feeling into three classes – 1) feelings-values; 2) feelings-anti-values; 3) neutral feelings, which commit society neither negatively nor positively – states and concludes that the specific juridical relevance of feelings is closely connected with the identification of objective values, of values: 'Within the framework of juridical assessments, the feelings in relation to which law takes a stance are distinguished according to their positive or negative polarisation, characterising them respectively as feelings-values or as feelings-anti-values… Feeling does not emerge at the level of law unless in virtue of its exteriorisation and this, in turn, takes place, if not exclusively, on the whole through behaviour'.

[8] On the recognition of the right of minors to the love of their grandparents see C.M. BIANCA, *La famiglia*, *Estratto per i corsi universitari della quarta edizione del Diritto civile*, II (Milan, 2005), p. 325.

[9] See in particular the new formulation of the second section of article 94 of the civil code: '*Igualmente podrà determinar, previa audiencia de los padres y de los abuelos que deberàn prestar su consentimento, el derecho de comunicaciòn y visita de los nietos con los abuelos, conforme al articolo 160 de este Còdigo, teniendo sempre presente el interés del menor*'.

[10] On the violation of the right to love as a source of compensation see Cesare Massimo Bianca who expressed himself in the following way during a conference on tort: 'Compensation for Torts. Old and New Perspectives', which was held in Naples on 23 October 2004 at the Institute for Juridical Studies MCM. During this conference Cesare Massimo Bianca, when speaking about compensation for injury to the right to love quoted the decision of the Appeal Court of 31 May 2003, n. 8828. In that decision the Appeal Court stressed the 'intangibility of the sphere of affections and mutual solidarity in the family sphere', as well as 'the inviolability of the free and full carrying out of the relation-forming activity of the human person in the sphere of that singular social formation constituted by the family, whose defence can be referred to articles 2,29 and 30 of the Constitution'. (The phrases in inverted commas reproduce the text providing the reasons for the decision). During the same conference Cesare Massimo Bianca also quoted the decision of the Appeal Court of 7 June 2000, n. 7713, in *Corr. giur.*, 2000, p. 873. This decision was equally significant in that when dealing with violation of article 570 by a parent in relation to an underage son or daughter expressly states that this should not be understood in a restrictive sense and in its material sense a lack of provision of means for subsistence but 'emphasises at a civil level violation not of a mere right with contents relating to property but of underlying and more pregnant fundamental rights of the person, as a child and as a minor' (The phrases in inverted commas reproduce the text providing the reasons for the decision). The question of the right to compensation for a tort as a direct consequence of the recognition of the right of minor to receive visits was raised by German doctrine with reference to § 1684 BGB: see D.HENRICH, *La riforma del diritto di filiazione in Germania*, p. 43.

[11] G. GRASSONI, *Atti del Convegno Il principio di sussidiarietà, XV Simposio dell'Arcipelago, Bocca di Magra (SP), 4-7 settembre 2006 "Matrimonio e famiglia"*; C.M. BIANCA, A. BETTETINI AND G. GRASSANI, *Codice della famiglia e dei servizi sociali* (Giappichelli, 2007).

[12] Cf. C. ROMANO AND G. GRASSANI, *Bioetica*, p. 208 and ss.

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LÁZARO PÉREZ JIMÉNEZ

4.2 Dioceses, Parishes and Sick Elderly People

Introduction

One of the greatest challenges that the Catholic community is facing today relates to the change that contemporary culture has worked in relation to the concept of real life as applied to human temporality.

By 'real life' is meant exclusively the productive stage of life, which today, usually, is limited to the period that runs between the age of eighteen and the age of forty. This is also the period of life that at other times was called 'reproductive', an aspect that today one sees being constantly marginalised and replaced at a practical level with the period when one can obtain the greatest pleasure from life in all its aspects. Little importance is given to the period before the age of eighteen, and the period after the age of forty is seen with a pessimistic and negative attitude, a period of life which can, and for some people 'must', finish as quickly as possible.

In the Christian world, the concept of temporality is widespread and in principle ascendant because the life of a human being is born from God's design because we come from God and we return to God; in the divine plan of salvation all the stages of human existence are valuable, and, even more, they become enriched with the passing of time. Even old age is valuable in itself and is converted into an age that deserves respect, veneration, esteem and care.

This observation is closely connected with the humanistic idea of man where man is understood as a being who is situated beyond what he produces and the needs that he has to meet; Christian anthropology gives more emphasis to being than to any other dimension of man.

This does not happen nowadays. First of all we are witnessing a cultural process that looks almost exclusively at the practical dimension of being from a dual direction: the pleasure of life in the strictly material sense and the productivity of existence in economic terms, a reality which by its very nature is not given to the elderly or is limited, and which means that a human being searches for ways by which to dissimulate his usefulness, to prolong his threatened functionality, to and ensure pleasure of greater length, something which is often at the price of his dignity and the very health that he is searching for.

Independently of the resources that are employed to address these limits which society is imposing on real life, we are witnessing an early old age which maintains a certain logic since all the stages of life, from childhood to maturity, today are expressed under the sign of precociousness, with the notable difference that early old age is a cultural imposition and not the consequences of a yearning.

Whatever the case, this places us face to face with an unprecedented situation: old age, including old age that is healthy, is seen as a threat to the individual, to his family and to society.

In this cultural context there arises an observation about sick old age which is added to one which is already a depressing condition of our epoch – the stigma of illness.

The Sick Elderly Person

We must observe here that illness and old age are often seen as being synonymous but the most serious illness is of course chronic illness, together with the normal degenerative process of existence.

The dominant pragmatism of our times naturally offers drastic solutions to this experience, such as, for example, recourse to euthanasia which far from being a proposal that has emerged from juridical or philosophical areas and then seeks to impose itself, is increasingly becoming an aspiration. Indeed, many young people and adults who are faced with the prospect of sick old age express in a convinced way their decision to have recourse to this instrument to end an irremediable situation that threatens to prolong an existence which lacks what in medical jargon is called 'quality of life'.

Between euthanasia as a definitive solution and the early appearance of illness there extends a horizon that is thick with contemporary medical technology whose enemy to be defeated is pain, which it sees as being without meaning. It certainly tries to prevent and correct the physical uselessness of illness and in the meantime it clouds the lives of sick people and influences the lives of others.

In this state a sick elderly person sees himself as a burden; but institutions, too, increasingly see him as an onerous cost generated by someone who does not produce although during his 'useful' life he was indeed a producer. If an elderly person maintains his consciousness he can still, after a certain fashion, put up resistance to treatment that is inhuman or even criminal, but an elderly person who loses awareness of his identity ends up in the hands of institutions, in particular because of the fact that the centuries-old process of the unbinding of the family means that relatives become uninterested in the fate of such people and leave ultimate decisions in the hands of old people's homes and hospitals.

Secular Reactions

Despite the dehumanising secularism that has been imposing itself in Western culture there have been positive reactions to help elderly

people in general and sick elderly people in particular. Thus the official establishment of a so-called 'third age' that brings with it a long list of benefits for those who reach this moment, the objective of which is to make the burden of a life that is seen by everyone as being an excess more tolerable. Along the same lines we may observe the creation of a discipline of medicine specially directed towards treating the illnesses of elderly people, and old age as such, what in fact gerontology is today, but also the validity in many medical faculties of the study of a thanatology, understood as what in other times was 'helping people to die well' and which has developed as a process of the human accompanying of sick people in a terminal situation at the end of their natural lifespan.

The Christian Commitment

The response of the Church at this point requires an overall and complex endeavour, but also one which is indispensable and urgent, that includes *(in the short term)*: an appeal in international forums against euthanasia; draft laws which are always up to date that assure the security of sick elderly people in the face of the permanent risk of extermination; the creation of effective systems which support care for the sick especially in poor countries; a reinvigoration of cultural customs and traditions in which old age is appreciated and esteemed, with a transcendent meaning being given to illness; boldly deciding in favour of the creation of a new cultural universe that reacquires the meaning of old age and illness through the establishment of diocesan and parish ecclesial structures that form communities on this subject and welcome sick elderly people by renewing the means by which both physical and in particular spiritual care is offered; a basic review of the contemporary conditions of health centres that are supported by religious orders, dioceses or Catholic lay people in order to ensure that the elderly sick are cared for in line with the spirit of the Church; and an assessment of whether old people's homes for consecrated people are the best choice from a human and Christian point of view by which to live out the last stage of human existence, in particular in the case of sick people.

And in the long term: accompanying processes of evangelisation with a prior reflection on the meaning of extended and transcendent time, as well as the value of the different ages of life of human beings and of the value of man himself as such, in order to change the direction that is leading our civilisation to shorten real life; giving a meaning to each stage of life and to Christian humanism which cannot support the purported 'dissolution of the human' which is very much postulated today by so many actors on the stage of our culture; fighting (therefore) to overcome the reductionism that we are now witnessing by which real life is shortened in pragmatic terms and is lengthened as a throwaway; looking for current ways by which the legitimate pragmatic interests of the contemporary world are reconciled with the human-Christian values of life; and generating substantial processes that support the Christian vision of the committed family – this must continue to be the healthy context in which people go through the various stages of their existence in safety and happiness.

Given that care for sick elderly people by dioceses and parishes requires human and Christian qualities, it seems to me advisable to refer to a text from the encyclical *Deus Caritas Est* in which Benedict XVI exhorts those who work with the sick in general to carry out their work with true professionalism and humanity: 'Yet, while professional competence is a primary, fundamental requirement, it is not of itself sufficient. We are dealing with human beings, and human beings always need something more than technically proper care. They need humanity. They need heartfelt concern. Those who work for the Church's charitable organizations must be distinguished by the fact that they do not merely meet the needs of the moment, but they dedicate themselves to others with heartfelt concern, enabling them to experience the richness of their humanity. Consequently, in addition to their necessary professional training, these charity workers need a "formation of the heart": they need to be led to that encounter with God in Christ which awakens their love and opens their spirits to others. As a result, love of neighbour will no longer be for them a commandment imposed, so to speak, from without, but a consequence deriving from their faith, a faith which becomes active through love (cf. *Gal* 5:6)' (n. 31).

These principles which are directed to all sick people without doubt have greater application in the case of sick elderly people.

H.E. Msgr. LÁZARO PÉREZ JIMÉNEZ,
Bishop of Celaya, Mexico.

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AURELIA CUADRÓN

4.3 Religious Orders and the Sick Elderly

Introduction

Life, which is a gift of God, is a whole that includes being born, living, growing old and dying. Today, in most countries, life has been extended in terms of years but as yet a sufficient grounding does not exist that would allow taking responsibility for and addressing the problems caused by this development, for example the high number of sick elderly which continues to increase throughout the world and in a special way in industrialised countries. Today much reference is made to social problems but too little is said about the need to draw near to our elderly people who have need of us in bearing the weakness of their bodies and that loneliness in their hearts that is present during the final stage of life. Mankind and the Church, and within the Church religious institutions, have the task of extending the mercy of Christ who passed by 'doing good and healing everyone' (Acts 10:38), with a commitment to overall care in the sector of health which today, indeed, has especial need of this.

1. Ageing in the World

Ageing is not a demographic process that only involves the industrialised countries and in particular 'old' Europe. All societies are characterised by this phenomenon, although we should take into account the fact that there are differences between countries, regions and continents.

According to the data of the United Nations,[1] in the year 2000 industrialised countries were faced with statistics which indicated that 14-15% of their populations was composed of people of the age of sixty-five or over and it is estimated that this figure will rise to 25.9% by the year 2050. It is calculated that in that year developing countries will have a corresponding figure of 14.6% compared to 5.1% for the year 2000. Although the percentages for the ageing of the populations of developing countries is not greater than that of industrialised countries, one may observe a rapid growth rate which will lead within the space of fifty years to a tripling of that figure (Graph 1).

2. The State of Health of the Elderly

Life expectancy is one of the principal indicators that allows us to know about the state of health of a population. At a world level in the year 2000, according to the United Nations, this was 65.4 years of age. Africa is the region in the world with the lowest life expectancy (49.1 years), in part because of the consequences of the human immunity deficiency virus and the acquired immunity deficiency syndrome (HIV-AIDS), whereas Europe, for its part, exceeds the other regions of the world in terms of ageing primarily because of the decrease in fertility levels. The statistics published by Eurostat in 2005[2] showed that life expectancy in Spain was 83.6 years for women and 76.9 years for men (Graph 2).

The most important unknown caused by demographic changes with respect to the future development of old age is that of the limits

Graph 1. Percentage of the population of 65 and over by regions 2000 e 2050

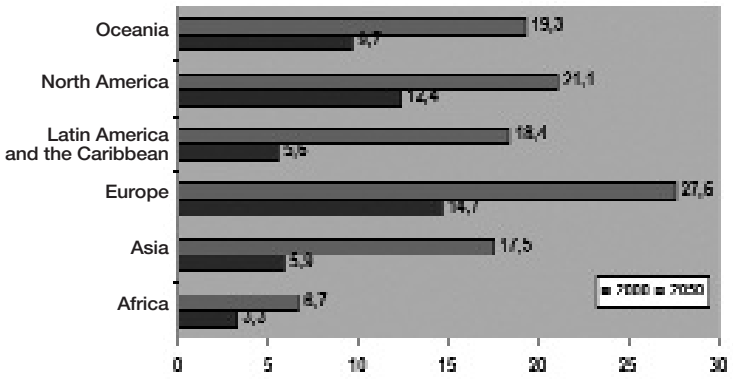
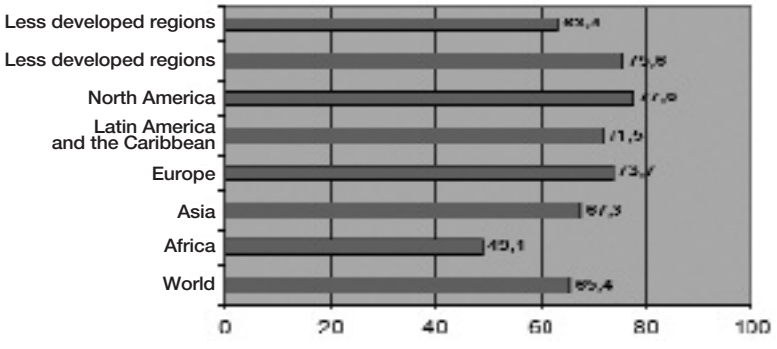


Grafico 2. Life expectancy at birth



of human longevity and the state of health that will result from its extension, and here we are primarily dealing with the phenomenon of life expectancy without infirmity.

Here we may observe an increase in the number of elderly people over the age of eighty which is the group within a population in which most situations of dependency are to be found. The presence of non-lethal but chronic illnesses such as traumas, respiratory and circulatory illnesses, and tumours, is at high levels in this age band. In industrialised countries in the year 2016 one in three people out of every ten who are over the age of sixty-five will be over the age of eighty.[3] Neuro-degenerative illnesses, to which dementia belongs, afflict 15% of people over the age of sixty-five and attain an incidence of 40% in people over the age of ninety. These illnesses constitute a cost for individuals, families and governments.

The principal illnesses of elderly people in the world (WHO 1998)

- Cardiovascular illnesses
- Hypertension
- Cerebral-vascular illnesses
- Diabetes
- Cancer
- Chronic obstructive lung illnesses
- Muscular-skeletal illnesses (osteoporosis, arthritis)
- Mental illnesses (dementia, depression)

3. Situations that Old Age Brings Today

The ageing of a population is an expression of a human goal – that of living longer and better – but at the same time it constitutes a challenge to which we must respond. One has the impression that mankind is not prepared for that brusque and massive extension in life expectancy that has been created in industrialised countries, and as a result is not prepared for facing up to the economic, occupational, social, family, medical and health-care problems that the increasingly high levels of elderly people are generating in modern societies.

Entering a nursing home seems to be the most suitable solution for these situations despite the fact that surveys reveal that there is a rather general rejection of them and to such a point that only 3% of elderly people wish to live in them. Studies exist which show a high percentage of suicides amongst people over the age of sixty-five[4] and although this extreme decision may not be reached there is nothing sadder than nostalgia and the wish that some elderly people have for the arrival of death. In these cases it is not dying that they want but, rather, an escape from harsh conditions and inhospitable contexts.

Such suffering is alleviated when a person experiences the affection and the concern of his or her family relatives. An elderly person who is loved awaits his or her hour with calm and without the pressing desire to end his or her own history as soon as possible.[5] The Church, and inside the Church religious institutions, perform this function of protection so that nobody will suffer from loneliness or being abandoned in social terms.

A further aspect is that of the social protection of old age, not in developing countries where this does not exist, but in industrialised countries where the progressive increase in the number of dependent elderly people is acquiring major importance in medical care, the economy, pensions systems, family life and decisions about the end of life. All the countries of the Western world realise that it is not possible to increase social expenditure and also that in the face of a demand that is constantly increasing resources are limited.[6]

4. The Action of the Church and Religious Life in the World of the Sick Elderly

Love is what marks out the disciples of Christ (Jn 13:35). The early Christian communities expressed this love in the form of hospitality not only for those who arrived from outside those communities but also for the poor and the sick.[7]

In order to engage in this charitable action, deacons were created in Jerusalem (Heg 6:3.7). There were also deaconesses such as Phoebe, to whom reference is made in the Letter to the Romans (Rom 16:1), or Tabitha who was raised from the dead by Peter (Acts 9:36-43).

Such hospital action has been carried on down the centuries by religious life. At the outset charitable activity was organised around monasteries. From the twelfth to the fifteenth centuries the pilgrimage routes in Rome, the Holy Land and Compostela (Spain) were dotted by monasteries which took care of pilgrims and sick people in their structures for outsiders.

In 1113 Rome approved the first religious order, the Hospitellers of St. John of Jerusalem, which were followed by other orders such as the Hospitellers of the Holy Spirit (1180), the Templars (1313), the Trinitarians (1198) and the Mercedarians (1218).

From the sixteenth to the eighteenth centuries new congregations flourished that were wholly dedicated to the needs of the poor and the sick, for example the Hospital Order of St. John of God (1495) and the Order of the Ministers of the Infirm (1550), as well as others.

Female health-care religious life has its most significant point of reference in St. Vincent de Paul and the Daughters of Charity (1633). The nineteenth and twentieth centuries saw the flourishing of numerous organisations, in particular for women, dedicated to the world of health and health care.

5. The Presence of Religious Institutions in Care for the Sick Elderly

Religious life has always been present in places of suffering and social abandonment, following in the footsteps of Christ, the divine Samaritan, physician of bodies and souls,[8] with generous dedication that has been often heroic and which corresponds to the prophetic character of consecrated life.[9] Today religious life responds to the needs of the world of the elderly, and especially the sick elderly.

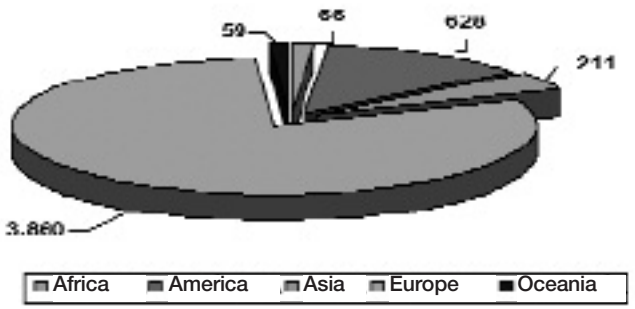
According to INDEX, health-care structures for elderly people (homes for the chronically sick, homes for the elderly, hospices, clinics for the elderly) supported by religious institutions number about

five thousand add represent 22.17% of the total of the structures of the Church in the world of health and health care (Grafico 3).

work in this sector, directing their mission to care for those most in need.

This option of the consecrated has concrete charismatic and apostolic aspects that constitute great wealth within the spiritual inheritance of the Church.

Graph 3. Health-care structures of the Church for care for the elderly



6. The Spirituality of Hospitality

The Samaritan activity that religious life engages in within the Church in service to the sick elderly has its roots in a specific spirituality. Answering the call of God, through consecration, religious are the direct expression of His love. 'Allowing themselves to be conquered by Christ (see Phil 3:12) they set out to become after a certain fashion an extension of his humanity'.[10]

The preferential option for the poor, to whom the Kingdom of God belongs, is fundamental in consecrated life. The poor evangelise us and help us to discover the face of God that is present in a special way in people who suffer. Benedict XVI tells us that 'The Christian's programme – the programme of the Good Samaritan, the programme of Jesus – is a "heart which sees." This heart sees where love is needed and acts accordingly'.[11]

Thus following Christ, the only path possible, leads consecrated people to 'take care of the deformed divine image in the faces of our brothers and sisters'.[12] Amongst these faces Jesus is present today in the sick elderly.

There are some institutes whose specific mission is care for the sick, for example the Sisters of the Poor[13] or the Sisters of the Abandoned Elderly.[14] Others have the vow of hospitality, for example the Fatebenefratelli and all the institutions that

The aspects of this charismatic identity are:[15] living in love and bearing witness to God who is love and portraying Jesus Christ as the mercy of the Father, through the practice of charity unto heroism, where this is necessary. Loving human beings so that through our charity they experience the redeeming liberation of God that is worked in them.

Care is given to: the sick elderly, especially if poor; the physically and mentally infirm; those who suffer because of age, poverty, loneliness or difficulties of other kinds.

This takes place: through corporeal and spiritual service and help according to the various socio-cultural realities that are present, with a special vow to provide help to the poor.

7. Challenges

Religious life has always been attentive to the signs of the times[16] so as to be able to respond to the call of God in the needs of the poor and the sick. In this service of care to dependent elderly people, religious institutions have to face up to certain challenges to which it is necessary to provide an answer so as to be able to continue proclaiming the Gospel in the world of health and health care.

a. Helping people to die with dignity in a technological society

The art of accompanying the dying is not an easy task. On the one hand, death has become a 'taboo' subject. It has been observed that in Western society the fact of dying is concealed and people avoid thinking about death.[17] In addition, the secularisation of society and the loss of human and Christian values prevent people from having an ultimate explanation of death. People live as though they do not have to die.

On the other hand, the debate about a dignified death in our cultural context is sterile in practical terms because the notion of dignity is employed to defend aspects that are opposed;[18] it is employed, for example, to defend euthanasia and at the same time to defend exaggerated treatment.

Other ethical questions that arise are discrimination in the allocation of resources on the grounds of age, questions that bear upon the end of life and a host of dilemmas associated with the long-term care and the human rights of poor and disabled elderly people.

This situation leads me to list certain points:

– In the ethical debate about dying it is of fundamental importance to introduce the notion of *vulnerability*, acknowledging the fragility of human beings,[19] accepting that the power of science is limited, and trying to accompany people to live out their last moments with serenity.

– Recognising the dignity of the sick, who are the image of God, of God weak upon the cross; and knowing how to discover what they offer us. Loving care for a elderly terminal patient gives us realism and for believers this is a constant exercise of hope in definitive life, that life that lasts for ever.

– I am not an expert as regards exploring the situations that derive from this new way of addressing death and which are the subject of a social debate, but I perceive the need for our institutions to open themselves to reflection, to attend to formation in the field of bioethics, and to create committees that will help them to solve the problems that arise in this area. There are religious institutions that are already addressing this chal-

lenge, for example the Hospital Order of St. John of God, the Camillians, and the Congregation of the Hospital Sisters of the Sacred Heart of Jesus.

– It is not always possible to treat people and an attempt to treat people in certain circumstances can even be counterproductive. However, to care is always possible. When a sick person feels that he or she is accompanied, he or she lives out this last part of his or her life in a dignified way and we may rightly says that he or she dies well.

b. Giving an impulse to palliative care

As has already been observed in this paper, there exists in our culture a rejection of death which is paralleled by the cult of youth. This creates approaches that involve escapism and the use and abuse of intensive care units, with the actual needs of the patient being forgotten about.

As a response to these problems as a basic human right, when treatment is not possible, recourse can be made to palliative care (PC). The aim of palliative care, according to the World Health Organisation, is the active and total care of a patient whose illness does not respond to treatment. Palliative care allows people to die with dignity or, to put it better, to live with dignity until death arrives. This is a matter of supplementing scientific advances with humanitarian elements. This is because science and humanisation are not antagonistic realities. The control of pain and other symptoms is of fundamental importance and the same may be said of psychological, social and spiritual problems.

There are many authors who believe that before running the grave risks that are inherent in the decriminalisation of euthanasia in a narrow sense, it is necessary to engage in a further exploration of palliative care as a preferential alternative in order to give a positive response to the situations of human beings who are experiencing the drawing near of their deaths.

c. Caring for those who care or sharing charisms

In service to, and care for, the sick, of fundamental importance is not only the moral recognition of the person who is being care of, who in our case is a sick elderly person, but also of those who take care of him or her. To this category belongs an increasing number of secular people who work in health-care centres that are directed and managed by religious institutes.

This situation, which has probably been brought about by the decrease in the number of religious, which in turn has been generated by the shortage of vocations, must be an opportunity to share our charisms. These are gifts of the Spirit that have a universal destination for the good of mankind and the fostering of the communion and of the mission of lay faithful within the Church.[20]

In addition, the growing secularisation of our societies, especially in industrialised countries, challenges us to work not only with those who see themselves as Catholics but also with the followers of other religions and with men and women of good will, even though they do not have a vision of faith. The Biblical text on the meeting of Peter and Cornelius (Acts 10:34-8) shows us the inclusive nature of the Kingdom, whose boundaries and members are determined by God alone. God 'shows no partiality, but in every nation any one who fears him and does what is right is acceptable to him' (v. 34). We must ask how these activities will continue to function, and in particular how they will continue to be charismatically evangelising, when there are no longer consecrate men and women.

This reality leads us to extend the range of our tent (cf. Is 54), to give an impulse to shared mission. This is not only a proposal for a concrete area of work but also for a sphere of communion, for being part of the same charism.

Sharing values and institutional culture, attending to the choice and formation of personnel that work with us, and watching over conditions of work, amongst which is to be listed levels of pay, are aspects that are needed if we want to conserve the identity of an institution and to train hospital communities that will be workers for evangelisation in the exercise of the ministry of health.

d. Caring for institutions

Care for sick elderly people is developed in institutions such as hospitals and rest homes or at home. In many cases these institutions belong to the Church or are managed by the Church, as was observed in this paper in the statistical section. But we recognise that what defines a hospital, or a care centre, is not specifically its infrastructures, even though this is not an aspect that should be despised, but the morality that one can breathe in it and the way in which people, and especially infirm people, are treated. For this reason, the centre of gravity of these institutions must be vulnerable people and all the health-care workers must be governed by this law.

In addition, although the centres and the services that are managed by religious institutions cannot be profit-making it is necessary to envisage an income that is sufficient not only to finance human resources but also technical resources and infrastructures, with an attempt being made to obtain a balance between economic needs and ethical requirements and to reconcile 'good intentions' with the needs of the market and the law of supply and demand, so that the result of everything is an increase in the quality of care.

e. Being committed to the least

We religious follow Jesus who, at the beginning of his ministry, proclaimed in the synagogue of Nazareth that the Spirit had consecrated him to bring good news to the poor, to proclaim the freeing of prisoners, to restore sight to the blind, to set free the oppressed and to preach a year of grace of the Lord (cf. Lk 4:16-19). Religious life has always been near to the least and this has been a constant criterion of discernment when apostolic decisions are taken.

In this field as well we are called to work in developing countries where, indeed, sick elderly people suffer greater abandonment. This call takes practical form in:

– Providing care to people who grow old in rural areas (60% of the world). Urbanisation, emigration,

and young people leaving in search of work are all phenomena that can lead elderly people to become isolated in rural areas and to have few resources and scarce or even no access to health-care and social services.

– In many developing countries the percentage of people who live on the outskirts of cities or shacks is increasing rapidly because of migration and this brings the risk of social isolation and bad health.

– In all the countries of the world it is families who provide most support to elderly people in need of help. The welfare system is increasingly turned to but in developing countries welfare programmes are insufficient and do not reach elderly people.

f. Giving an impulse to pastoral care in health

Illness is an experience of finitude and powerlessness which deprives people of their sense of security. Helping sick people does not mean only improving their pathology but also meeting other requests that require a large dose of humanisation and sensitivity. Often technical care, rather than human and spiritual care, is attended to.[21]

Statistics show that religiosity increases in elderly people[22] and that the ending of very many illusions and an encounter with pain are propitious opportunities for the birth of the only Hope, that of faith. Pastoral work should engage in a respectful and prudent effort to restore removed faith so that sick people distance all their fears and experience God not as a judge but as a Father who leaves his house every day hoping for the return of the Prodigal Son (cf. Lk 15:11-31).

The presence of religious and of agents of pastoral care is fundamental because the truths that touch the deepest part of men can be communicated only with a heart full of humanity and delicacy,[23] full of the love itself of God.

Conclusion

A great deal remains to be done and religious institutions must go on responding to this challenge by taking acre of sick elderly people, following the example of their men and women Founders who began this pathway. Even though the way of accepting and helping may change, the freely-given love of giving cannot change because 'in addition to justice man needs, and will always need, love'.[24]

Sr. AURELIA CUADRÓN
Hospital Sisters of the Sacred Heart of Jesus

Note

[1] *Las personas Mayores en España*., Ministerio de Trabajo y Asuntos Sociales, Informe 2006

[2] Statistics Office of the European Community

[3] National Institute of Statistics (INE). Spanish population projections calculated starting with the census of 2001.

[4] 'El suicidio en la ancianidad en España', *Revista Española de Investigaciones Sociológicas*, 73 (1996) 127-148

[5] E. López Azpitarte *Envejecer: destino y misión*, (1999), p. 97.

[6] *Las personas Mayores en España*., Ministerio de Trabajo y Asuntos Sociales, Informe 2006 (p. 139).

[7] Cf. *Hospitalidad*, Diccionario Teológico de la Vida Consagrada (Publicaciones Claretianas, 1989).

[8] Cf. John Paul II, *Salvifici doloris*, nn. 28-30.

[9] Cf. John Paul II, *Vita consecrata*, n. 83.

[10] John Paul II, *Vita Consecrata*, n. 76.

[11] Benedict XVI, *Deus Caritas est*, n. 31.

[12] John Paul II, *Vita Consecrata*, 75.

[13] *Valparaiso, Viña del Mar, Chile (América del Sud)*, 1885.

[14] *Desamparados Huesca – España-*, 1873.

[15] These notes are taken from the following Institutes: Sisters of Charity of the Holy Face, Theresian Carmelites of St. Joseph, Franciscan Missionaries of the Nativity of Our Lord; Hospitallers of the Sacred Heart of Jesus; Handmaidens of Mary; Mercedarians of Charity.

[16] Second Vatican Council, Pastoral Constitution *Gaudium et Spes* (*GS*), n. 4.

[17] Cf. Ariès, Ph., *El hombre ante la muerte* (Turus, 1992).

[18] F. Torralba, *Morir dignamente* (Bioética &Debat, 1998).

[19] Cf. J Masiá, *El animal vulnerable*. Madrid Universidad de Comillas, 1997.

[20] Cf. John Paul II, Apostolic Exhortation *Christifideles laici,* 1988.

[21] E. López Azpitarte, *Envejecer: destino y misión* (San Pablo, 1999), pp. 176-177.

[22] *Ibid.*, p. 157.

[23] *Ibid.*, p. 195.

[24] Benedict XVI, *Deus Caritas est,* n. 29.

ANTHONY FRANK MONKS

4.4 The Pastoral Care of Sick Elderly Patients and Religious

1. Introduction

1. Prof. Golini's excellent presentation on Thursday morning showed quite clearly that people are living longer today. That is certainly true of diocesan clergy and male and female religious. I was recently in a province of our Order with 199 religious: forty-five were under fifty and of the other 154, eighty nine were over seventy-five. I live in a community of eight religious, five of whom are the recipients of state pensions and have earned the title 'senior citizen'.

Since we religious accept that we are the main carers of our own elderly, quite a burden falls on the young and not-so-young religious who are already the main providers of service/ministry to the people of God. The challenge here is self-evident and is heightened when you bear in mind that there are fewer vocations here in the West where there is greatest concentration of elderly priests and religious.

2. One of the basic criteria for judging the extent to which a people is civilised is the care, respect and concern it shows to its most vulnerable members: the unborn and infant at one end of the spectrum and the senior citizen, the elderly at the other.

3. Our credibility as a Church, before a watching and critical world, will be gauged by the care we show for colleagues and confreres who have borne the heat of the day, and no matter what disease or illness may be afflicting them. This is a fundamental witness which we must give. And we should openly acknowledge that we do not do so badly. After all, if we do not show respect and genuine practical care to our own colleagues and confreres then the care and concern we show to others will be rather shallow, and those we attempt to reach out to will be the first to recognise this.

4. Healing is not an added extra which the Church may or may not perform. It is evident from the gospels that Christ saw preaching and healing as the main components of his ministry (Lk 18; Mt.11:1-5), and that he wanted his disciples to follow his example (Lk 9:2). Rather than occupy a peripheral role in relation to other pastoral ministries, healing is an integral part of the mission of the Church. As religious working in health care, we consider ourselves privileged to be involved in the world of the sick and suffering as our ministry is situated at the heart of Christ's message – we are engaged in charity/love at its most practical. More people pass through a hospital in a week than a Church in a year, and the hospital is a door which is still very much open to the Church. Nobody escapes exposure to suffering, whether it be as a patient or a visitor/carer of a close relative or friend.

5. It is important when dealing with the elderly to remember that the uniqueness of the healing power of Jesus lay in his ability to care, and this is something which is far too often overlooked when presenting Jesus and his ministry. In concentrating so much on the extraordinary (miracles) in the life of Jesus we fail to notice the ordinary (human warmth) which preceded the extraordinary. He did not raise Lazarus from the dead without first weeping for him and accepting the reproaches of Martha and Mary. He did not feed the five thousand without first having the humility to accept fish and bread from a small boy in the crowd. What we see and in fact like to see are the extraordinary things he did and we tend to overlook the ordinary which preceded the extraordinary.

2. Elderly Religious and Priests

1. We should remember first and foremost that priests, sisters or brothers are members of the human family with the same needs as everyone else. I have been privileged to see priests and religious face suffering and the aches and pains of old age with great courage and fortitude. I have also seen others struggle to come to terms with their condition. Priests and religious experience the same traumas as others in sickness, but there are some shades and colouring which are proper to our state.

2. *Old Age and loss*

When we attempt to look at the challenges of advancing years we must never lose sight of the fact that besides physical and emotional pain there is also spiritual pain.

Illness and the advancing years always involve some form of loss:

a) There is the loss of self at a physical level.

Imagine the effect on your self image brought about by mutila-

tion, say in the form of an amputation.

b) The loss of the self at the level of identity.

Our ability decreases and our debility increases bringing constant fatigue. You saw yourself very much in the light of the good health you took for granted, whereas now your leisure, pleasure and work are totally transformed.

c) The loss of self at a relational level too.

Many experience abandonment by friends, parishioners and even relatives.

d) The loss of self at an existential level.

This is when we can no longer see any meaning to what we are experiencing, when our values don't seem to be helping, when we are asking a lot of 'why me', 'why this', 'why that' questions.

Basically old age involves:

a *loss of space***,** as it takes us from a situation where the whole world was our village to now being confined to a very restricted area of movement;

a *loss of mobility* where we are dependent on a wheel chair or confined to bed, and where we are unable to perform even the most basic of tasks, such as going to the toilet unaided;

a *loss of control* over who invades our confined space;

a *loss of control over time* as medicines are administered at times that convenience others rather than me;

a *loss of control over what is done to my body***,** as for the healthy their skin is a kind of barrier (you won't get under my skin) whereas now needles, tubes, liquids are regular unwelcome intruders;

a *loss of contact* with friends, as you can no longer go to people and the ones you want do not necessarily come to you.

Basically you lose your *independence*: as one elderly priest once put it to me – 'when they take away your trousers you know you are going nowhere'. This loss of independence involves an experience of *separation* from life's patterns, from work and play rendering 'the sick person the loneliest exile in the world'; an experience of *fragmentation* as you cannot fulfil your ordinary role of priest, nurse, teacher, administrator; an experience of being *devalued* as you are now a receiver and cannot contribute. This often results in my faith becoming confused and I find I can no longer pray.

It is a very useful exercise in dealing with the elderly to attempt to put yourself into the shoes of the person in front of you and attempt to imagine what the likely consequences might be for you had you to cope with their losses. When we can do this, then we are moving beyond definitions and are beginning to understand what spiritual pain is.

3. 'As you were in life so you will be in old age', is an old adage. This certainly applies to priests and religious. Those who during their life were renowned for their kindness, consideration, respect and tolerance seem to become totally consumed by these qualities with the advent of old age and illness, and give incredible witness without saying a word. On the other hand, those who were awkward, difficult, authoritarian or cynical during their lives tend to become almost impossible in old age, as one or other of these qualities seems to almost totally dominate their later years. The old adage: 'as you have lived so shall you die', in my experience, is almost always borne out in reality.

This is a reminder to examine carefully our attitudes at present as that is how we will likely die! Certainly a holy death is the last great witness that we are called to give as priests and religious, indeed as Christians. Rahner puts it rather beautifully when he states, that the comfort of time is 'the belief that to close life well is also to attain oneself completely, with all one has been and done, in strength as well as in weakness' (Theological Investigations II).

4. Illness requires a lot of humility. Health-care professionals tend to dread having doctors, nurses and priests as patients. I have often wondered why. Is it because we are too analytical and consider ourselves to be very knowledgeable about things medical ('a little knowledge being a dangerous thing'), and more than a little cynical in our dealings with others? A wise doctor never medicates himself as it is almost impossible to be objective regarding oneself. Perhaps it is not very easy for us to adapt to the role of the 'patient' as all our formation was geared to producing 'leaders' for the assembly – to command!

5. The vast majority of lay people retire in their sixties. Religious never really retire as the fact of vows being for life is drummed into us thus making the concept of retirement rather alien. The priest being a priest forever according to the order of Melchisedech does not easily adjust to 'being', as distinct from 'doing'. Clergymen very often experience great *loneliness* in old age as there has been little attention given during life to developing genuine community, and as a result they tend to over identify with work. There is a lot of emphasis during formation on intellectual and pastoral training, and on a 'work' at all costs mentality, with not enough attention being given to the development of a genuine spiritual life. A lot of attention is given to external devotions and discursive prayer with little wise guidance on issues of the interior life. This often results in a great difficulty in letting go of the ministry as the years advance and coming to accept illness and old age.

Much more attention needs to be given during the sixty to seventy period of life to preparation for active ageing and preparation for senior citizenship. I have found many clergymen living in dread of being 'parked' in a home with fellow priests or religious and having nothing whatsoever to do. There is a very real fear of no longer being productive, or of being seen by others as not being productive.

I think, too, that the care of elderly priests should not just be the concern of their bishop and fellow priests. Certainly the community he has served for years has a role to play in his care. Often the priest has been stationed in a parish for years and is closer to his parishioners than to his fellow priests. In this regard, more attention should be given to the location of the priest's retirement. He may well welcome a transfer to a distant home but it is not always the best option, as it cuts him off from the support of his people.

6. With regard to the fear of being 'parked', perhaps we need to define what we mean by the term 'elderly'. For me a person being 'old' has less to do with age and much to do with attitude. You are old when you are tired, disinterested, closed into your own small narrow world. I know eighty-year olds who are a joy to be with and who continue to share the wisdom of the years to the great benefit of those around about them, while I have known other confreres and priests who died at fifty but did not get buried until their eighties. Bishops and religious superiors should seek to utilise better their gallant and eternally young confreres.

7. Professional religious people worry in old age as to whether they have urged a spirituality on others that they have not fully practiced themselves. The caregiver should treat these self doubts very seriously and not pooh-pooh them or push them aside as being the workings of an over scrupulous conscience. I remember a renowned theologian weeping on receiving the sacrament of the sick because, in his own words, 'I have administered the sacrament of the sick many times, always paying meticulous attention to the ritual, but without ever really praying on the situation in front of me or personalising it for the person before me'. There is a lesson here for all of us as we do run the risk of being seen as the little men of the ritual incapable of applying the sacrament in a personalised way to a given situation in front of us. I remember a friend telling me that he and his family were left in the pouring rain in a cemetery for a half an hour as the priest had forgotten his ritual and had to return to the church to get it. How sad that he could not say a meaningful prayer over a corpse going down into the earth without the little book!

8. I Can't Pray.

Very often you will hear religious and priests say when ill, 'I simply can't pray'. I have heard this lightly pushed aside, particularly when voiced by a religious sister, as attention seeking or false humility. This kind of attitude shows a total lack of understanding of illness and of the spiritual pilgrimage.

a) All of us pray within the context of our lives. At the moment I pray within the context of the fact that I can get out of bed in the morning, decide when I go to the chapel, go for breakfast, celebrate mass, and go about my daily routine. However, when I am sick, all of this is turned on its head. Praying simply becomes more difficult. Listen to the words of the saintly Cardinal Bernadin: 'I spent only one night in the intensive care unit. Then they brought me back to my own room, where I

experienced the discomforts one normally encounters after going through intensive surgery. I wanted to pray, but the physical discomfort was overwhelming. I remember saying to friends who visited me, "pray while you are well, because if you wait until you're sick you might not be able to do it." They looked at me, astonished. I said, "I'm in such discomfort that I can't focus on prayer. My faith is still present. There is nothing wrong with my faith, but in terms of prayer, I'm just too preoccupied with the pain. I'm going to remember that I must pray when I am well. I find myself telling priests and parishioners more and more to develop a strong prayer life in their best moments so that they can be sustained in their weaker moments". What an accurate and beautiful insight.

b) Furthermore, we need to bear in mind that loss of God is not uncommon among those who have progressed along the road to sanctity. Look at St. Therese of Lisieux and what she experienced during the illness which was to lead eventually to her death. Initially she experienced 'a faith so living and so lucid that the thought of heaven was the sum of my happiness. I couldn't believe that there really were godless people who had no faith at all'. But she soon entered a state of emptiness where 'everything disappeared' and she would experience only darkness filled with the mocking voice of atheism: 'it's all a dream this talk of a heavenly country…and of a God who made it all… All right, all right, go on longing for death. But death will only give you – not what you hope – but a still darker night, the night of nothingness'. She would write at one stage: 'I no longer believe in eternal life; it seems to me there is nothing beyond this mortal life. Everything is brought to an end. Love alone remains'. As Gallagher notes, 'this was the strange secret of Therese that she retained the core of faith which is love, even while suffering the loss of all emotional and intellectual sense of faith'. At the experiential level everything was gone but her faith conviction remained. She would write, 'although I have no feeling of faith, I still carry out the works of faith'.

Recently we have learned through the publication of her writings that her namesake Blessed Teresa of Calcutta struggled for half a century with a desolate prayer life. Yet like St. Therese she went about her acts of faith from conviction even if experience was very painful and dry. She would write in prayer: 'Lord, my God, who am I that You should forsake me? The child of your love – and now become as the most hated one – the one – you have thrown away as unwanted – unloved. I call, I cling, I want – and there is no one to answer – no one on whom I cling – no, no one – Alone. Where is my faith – even deep down right in there is nothing bur emptiness and darkness'.

I am sure you would agree that the sick person stating that 'I can't pray' is to be taken seriously.

c) On the other hand Joseph Card. Bernadin would pen these words thirteen days before his death: 'as I write these final words, my heart is filled with joy. I am at peace. It is the first of November, fall is giving way to winter. Soon the trees will lose the vibrant colours of their leaves and snow will cover the ground. The earth will shut down, and people will race to and from their destination bundled up for warmth. Chicago winters are harsh. It is a time of dying. But we know that spring will soon come with new life and wonder. It is quite clear that I will not be alive in the spring. But I will soon experience new life in a different way. Although I do not know what to expect in the after life, I do know that just as God called me to serve him to the best of my ability throughout my life on earth, he is now calling me home'.

9. All of which shows quite clearly that spiritual pain, or 'soul pain', is very real and it is important that the pastoral assistant to religious and priests are aware of it. Rene Leriche defines pain as 'the result of the conflict between the stimulus and the whole person'. Pain affects all aspects of our personality: physical, emotional, intellectual, spiritual. A pain which is diagnosed as being of a physical nature does not just affect the body, but will invade all other dimensions of our being, as we cannot compartmentalise one part of who we are and isolate it from the other dimensions. Each dimension is a part without which the whole is incomplete, with no one part functioning independently of the others.

I believe that it is important for the pastoral assistant to distinguish between 'disease' and 'illness'. 'Disease' is the structural disorder in an organ or tissue that gives rise to ill heath. **'**Illness'**,** on the other hand, is the individual's experience of ill health, his experience of dealing with that structural disorder. 'Illness both affects and is affected by all aspects of the sufferer's being' (A. Reading). Any one or all dimensions of our being are affected by the disease, and each dimension of our being may have a profound effect on the diseased limb. To paraphrase Cassell one could say that the identical disease in a different patient results in a different illness, pain and suffering. So when you find a different patient in the same bed, in the same ward, of the same age and sex, who is diagnosed with the identical disease as last week's occupant, you cannot presume to treat them in the very same way because you can be sure that the effect of the disease on each of them will not be the same.

No two people respond to the challenges of old age in the same way and this is an important consideration in caring for the elderly.

Cicely Saunders, one of the great pioneers of hospice care in the later part of the twentieth century speaks of 'Total pain/Total Care', and goes on to describe pain as an experience with different overlapping and interweaving aspects, namely physical, psychological, social and spiritual.

10. Pain is brought about not just by disease but also by a break with the expected normal func-

tioning of the body, the intellect, the emotions, and the spirit. How important this is in old age.

In Christian terms when we think of spiritual pain we immediately think of Jesus in the garden of Gethsemane, or on the cross, or perhaps we think of St. John of the Cross and the 'Dark Night of the Soul', but there are other forms. When you are young and well you have a sense of connectedness, of belonging, of alignment, of harmony and meaning. On the other hand what you experience when there is disconnectedness, a sense of not being wanted, disharmony, and disintegration might be described as spiritual pain. Nothing makes much sense any more. The values on which you have based your life seem to be somehow worthless, to be disintegrating before the frightening lived experience of the present moment. Spiritual pain arises when the main tenets on which you have based your life and your actual experience of life as you are experiencing it right now, no longer gel and are, in fact, in a state of conflict.

11. A factor in spiritual pain for the elderly is the meaninglessness created as a result of a break with the expected normal network of relationships that function to connect one to life. A key ingredient in that pain is the sense that the normal network of relationships and experience with life are failing to meet the individual's needs, and the expected satisfaction and 'meaning making from life' (P. McGrath) are not forthcoming. As such it overlaps into all aspects from the physical to the psychological to the social to the spiritual. Now, while definitions of physical and psychological pain are readily available, when it comes to spiritual pain our definitions become a bit hazy. However, this is no excuse for shying off and not attempting to verbalise our intuitions and experience.

12. I will always remember while working in the hospice, where patients incidentally were not exactly jumping out of their skin at the idea of being considered among its hallowed guests, a patient turning to me on the death of his neighbour in the next bed and saying: "I can't think of a better place *to live*" (note, not to die). He was a healed man in so far as he had accepted that while death was just round the corner, he was still very much alive within the limitations imposed by his illness and was living this moment.

13. It is not easy to go from being an active productive priest or religious to finding that you have reached your sell by date. The effort we make to understand, to help people rediscover meaning, to be truly present, which is none other than true care, can restore the will to live. Love in the form of care can and does restore meaning.

Pain is unpleasant and the health-care professionals admirably seek to remove it, but this does not necessarily work for spiritual pain. I cannot give an aspirin for spiritual pain. In the medical model we throw the individual a life line to get him out of the deep waters, in coping with spiritual pain sometimes we have to help them wait in the deep and troubled waters. Spiritual pain is not a problem to be solved but 'a question to be lived'. You walk the walk with the person even though you do not have answers, but rather you help *them* to find them.

Try to help them discover what it is that connects for them. What it is that gives meaning to this moment of their life. Give them space to discover their inner resources. Meaning can be restored by helping them face the situation: 'the best way out is always through' (Frost). 'I have to see that the uncertainty about what the client and I are really there for – is what we are really there for' (Hillman). There will be confusion, a sense of powerless, but this is largely counteracted by the sacrament of presence. Today people are prepared to give things but not always their time, to give themselves, to truly listen. They can no longer see much meaning to what is happening to them, and so we try to remember that 'someone with a why can bear any how' (Nietche). *Listen* and try to get to know the person in pain. Stay with the situation avoiding *fight* overcoming a strong urge to do something about the situation, and *flight* by which we say oh, this is not my territory, call the Camillians. An African priest friend of mine initially would write lovely spiritual letters to his very sick mother, but after a while he began to acknowledge his own confusion and powerlessness and express his desire to understand and be present to her. His mother's response was 'at last you are beginning to understand what it is like to be in my situation'.

14. The Role of Prayer.

I believe we should see prayer as the point of arrival and not as the point of departure. We do not begin our pastoral encounters with prayer as we know nothing about the patient, but rather we seek to eventually arrive at a situation where we can pray freely with the patient. Our prayer should show an awareness of the situation as we have encountered it (and in this way it is to a certain extent patient led). This applies also to the administration of the sacraments: we should personalise the administration of them as much as possible. Praying on the situation we have encountered makes the prayer more meaningful, and also gives us an opportunity to show that we have been truly listening, truly present to them. Naturally, this will involve trusting your pastoral instinct.

We should pray with them and not at them. With priests and religious they often appreciate the Office prayed together, especially when they have difficulties reading.

We should be totally at home with the ritual and the possibilities which it offers. We do not recite it, but rather pray it. I have my own well thumbed ritual which is made up of the essential parts of the ritual and of prayers which experience has taught me touch the lives of sick people.

The administration of the sacraments is an essential part of my ministry and a very privileged and

humbling experience. I have been privileged to see the power of God at work through His sacraments, which is inspiring and also an opportunity for my own personal spiritual growth. The greatest sermons I have heard on faith have been preached by the dying without a word been spoken. We are so privileged to be allowed into another person's life at such a profound level.

If in doubt as to whether to pray or not, then you simply ask the patient and have your uncertainty clarified.

There is nothing to prevent one praying privately for the situation encountered. As a matter of fact I believe that as a professed practicing Christian this is an obligation.

Conclusion

Every sick person we meet is an unopened book. The sick will be our teachers if we are prepared to enter the unknown, and be led by them.

We should not underestimate the preparation we have had right from the beginning of our Christian pilgrimage and our religious consecration. For example, I am convinced as Camillians the spirit given to St. Camillus has also been given to each one of us, but we must have the courage to exercise it and to collaborate with the grace it bestows.

For this reason I firmly believe that that the most important preparation in not the fact that I am a doctor, a nurse, a theologian or any other health-care professional, but rather the fact that I am committed to my own inner journey. If I am, then I will be aware of my own vulnerability, of my own not knowing, and will be less judgemental in my relations with others. As Michael Kearney says so beautifully, 'it is the belief that in this area it is not so much about the skills I have but the self who I am'.

Medicine and each one of us need the mental conviction that care is positive therapy, that it is a medicine required by the sick person just as much as the medications and operations. All dimensions of the human personality are touched in real healing. The hallmark of Catholic health-care has always been personalised care: 'You are called to humanise sickness, to treat the sick as a creature of God, a brother of Christ. You, by your presence and your patient loving charity, make faith in Christ and the fatherhood of God credible' (John Paul.II).

Our challenge is to be healers – to use the gifts the Lord has given us, and to use them with love.

Rev. ANTHONY FRANK MONKS, M.I.
Member of the Pontifical Council for Health Care Workers, the Holy See.

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PIOTR KRAKOVIAK

4.5 Volunteers Dedicated to the Care of Sick Elderly People. New Ways to Involve People in the Experiences of the Hospice Movement in Poland

Elderly and Terminally-Ill People are a Socially Important Issue – Let's Talk about it

Discussion about old age, death and dying are as old as human history. However, in the 1950s and 1960s the Western world was so confident about the progress of technology and medicine, at the same time trying to forget about the war atrocities of the twentieth century, that the subject of death disappeared from both academic publications and everyday speech. It was discovered that the word 'death' was no longer used in colloquial and scientific language, being replaced by numerous euphemisms.[1] Death in Western society had become a taboo and people were afraid to talk about dying.[2] It was then that the medieval idea of the hospice was revived and rediscovered by Cicely Saunders in the UK, Elisabeth Kubler-Ross in the USA, and Mother Theresa in Calcutta.[3] Practically at the same time, they started to talk, confidently and openly, about dying and death, suggesting a return to ancient and Christian care for the terminally ill and dying. In this spirit, the contemporary hospice movement originated, which today comprises thousands of hospice centres for palliative medicine all over the world. It is based on the idea of disinterested and humanistic care for the human being, inspired by Christian love for one's neighbour[4] and open to all religions and cultures, which was demonstrated most beautifully by Saint Mother Theresa of Calcutta[5] through her service to the poor and dying. In addition, the history of the origin and development of hospice care in Poland can teach us that co-operation between the Church, the health-care system and the third sector (the term used today to describe voluntary service) can effectively improve the situation of the elderly and terminally ill through joint action.[6] The Catholic Church continuously teaches about care for elderly and the terminally ill.[7] The mass media, which plays a key role in cultural and social life, can be helpful in educating the public about ways of helping and changing the situation of the elderly[8] and terminally ill, as is proved by the recent experience of the hospice movement in Poland.[9]

Solidarity and a Time of Transition – the History of Voluntary Work in Hospices in Poland

The development of the Polish hospice movement officially started in 1981 in Krakow, after several years of work of the Diocesan Synod introduced by Karol Cardinal Wojtyła. It was a group of lay people – health-care workers and volunteers – who discussed better care for people nearing the end of their lives. As a conclusion to their work, they decided to build a hospice home similar to St. Christopher's Hospice in London. It was difficult during the Communist period and the project took many years to finish. The hospice group from Krakow contributed, however, with many publications and a wide public discussion about the end of life, especially in the Catholic press.

In Gdansk, the birthplace of Solidarity, health-care workers and students used to gather in a church. In 1983, during martial law in Poland, the first home care hospice team was formed which gave help to the terminally ill and the dying with great support from the Church. It became a model for creating more than a hundred home care programmes in Poland, based on the voluntary work of physicians, nurses, chaplains, and others. The Church was, and still is, a very strong supporter of hospice programmes in Poland. In 1987, Pope John Paul II acknowledged the great amount of work done by hospice volunteers when he used the following words during the meeting with sick and disabled people, health-care workers and volunteers: 'I admire the hospice, which has undertaken its service in Gdansk and is spreading into other cities. It was born out of the common concern of the chaplaincy and doctors standing by their patients' beds about the proper place and conditions for patients at the end of their lives. This concern is expressed in their shared attention to and nursing of ill people in their homes, in heartfelt and disinterested "self-sacrifice"'.[10]

This blessing was decisive for the further development of the hospice movement in Poland. Bishops and parish priests became

more open to doctors, nurses and other people and asked their local church to start a hospice programme. There was informal training for doctors and nurses in Poland. Many hospice volunteers had had the opportunity to go to London, and to be trained in St. Christopher's Hospice. A personal friendship between Dame Cicely Saunders and many of the Polish doctors and nurses, as well as the support of charitable organisations, helped to develop most of the hospice programmes based on voluntary service.

After the democratic changes in 1989, palliative medicine became a part of the national health-care programme. The first Palliative Medicine Department was created in the Medical University of Poznan and this provided scientific knowledge to voluntary structures.[11] In 1994, the first home care children's hospice was established in Warsaw, setting an example for children's hospices in Poland.[12] Today in Poland there are around 200 hospice programs and another 200 palliative care units and local palliative home care teams. There are more than 400 hospice and palliative care units altogether – from big hospices and palliative care university units through smaller structures to small home care units, run mostly by volunteers. Still, there are areas in Poland with no adequate hospice and palliative care.[13]

The Meaning of Spirituality in Hospice Care. The Participation of the Church in Poland in Palliative Care

With the development of palliative care, interest in religion and spirituality has seemed to grow. However, commentators on the history and development of hospice care may appear inclined toward a viewpoint that sees that something has been *lost* in recent years from the original concept, with the espousal of the thesis of the *secularisation of hospices*.[14] Apart from the historical dimension, current research and clinical practice confirm that terminally-ill patients and their families often draw strength and hope from their religious belief system and their spirituality. During times of illness and crisis, people may find that their spiritual needs increase. Attention to religious and spiritual needs can contribute to an increased quality of life.[15]

Religion is the relationship between an individual and God and is characterised by belief in, reverence for, and desire to please, that God. Patients with religious faith are less likely to have unmet spiritual concerns if their religious needs are met. In the palliative-care setting, a person's faith, no

matter how strong or weak, will influence, and be influenced by, everything they experience as death approaches.[16] Spirituality can be defined as whoever or whatever gives one a *transcendent* meaning to life. This is often expressed as religion or a relationship with God, but it can also refer to other things: nature, energy, force, and belief in the good of all. Spirituality is important during all phases of one's health and illness, but spiritual and religious factors play an especially prominent role in a patient's experience with terminal illness, the dying process and death.[17] Palliative medicine is the only branch of medicine to have its specific part in the *Catechism of the Catholic Church,*[18] so it is important to remember that cooperation of the Church with hospices and palliative medicine is a part of hospice philosophy. Depending on the other denominations, ecumenical aspects play an important role in religious and spiritual care for patients and their families.[19]

The Church in Poland, being in most cases seen as the initiator of hospices, established the position of National Chaplain of Hospices in order to sensitise the clergy to the hospice movement. Rev. Dutkiewicz was a lecturer and retreat leader in most of the seminaries in Poland and gave talks in most of the Polish dioceses about the hospice movement and importance of the religious and spiritual aspects of care. More than three hundred priests and religious figures are involved full-time in palliative medicine and hospice care in Poland. There are others who help as volunteers. Many students in the seminaries choose hospices as a pastoral field experience. To achieve this, constant educational work has been, and still is, needed.

In 1992, the First European Congress devoted to the spiritual and religious needs of hospices and palliative care was held in Poznan. It was jointly organised by representatives of the London Hospice and hospices in Poland. The European meeting was attended by clergymen and women of various denominations and doctors, nurses and volunteers interested in the spiritual aspects of medicine and hospices.[20] This important aspect of care calls for further development and hopefully more of such meetings will be held in the future. Poland is the venue of regular conventions for hospice staff and volunteers. Specific local, regional and national teams organise reflection days and retreats for hospice teams. There are also gatherings for hospice chaplains and prospective chaplains. Many hospices also conduct regular religious and spiritual meetings, opening up to other health-care workers and local hospitals. Hospice care is a field where, apart from professional medicine and palliative care, the importance of religious and spiritual care is commonly acknowledged. The Church and health care

successfully co-operate in this sphere.[21]

In 1999, on the initiative of the National Chaplain of Hospices in Poland, a training programme was organised for hospice chaplains. Among its guests was the President of the Pontifical Council for Health Care Workers, Cardinal Javier L. Barragán and the Polish Minister of Health. Chaplains from all over the country attended it and achievements and challenges were presented by speakers from Poland and lecturers from the Vatican, the USA and Germany.[22] The experience was a significant inspiration in the process of the education of chaplains for hospices and palliative medicine units in Poland. In recent years, the Catholic University of Lublin has offered a post-graduate course with elements of pastoral theology, psychology and palliative medicine, providing an excellent training for hospice chaplains. In 2004, on the initiative of Caritas, the 60th Week of Charity in the Polish Church was devoted to palliative and hospice care. All week long, hospices were the subject of liturgy in all churches and of religious instruction in schools and during parish meetings. Thus, the mission and tasks facing palliative and hospice care could reach the entire Church. This certainly helped to break the barriers still present in people's thinking and ease anxieties associated with the word *hospice*.[23]

The process of informing the clergy about helping the seriously ill, the elderly and their families continues. In 2007, the National Chaplain of Hospices had a guidebook published on helping families suffering loss, bereavement and mourning. Distributed free of charge to all the hospices and palliative medicine centres and dioceses across Poland, this practical guide will reach every parish and help the bereaved in a more effective way. In addition, the book describes the typical problems encountered by priests meeting people suffering from bereavement. It also lists the most difficult cases encountered during pastoral meetings with the families of accident victims, people who have committed suicide and missing persons. A separate chapter is dedicated to care for the elderly living at home or in an assisted living facility.[24]

Public Education and Encouragement for the Voluntary Hospice Service

Following democratic changes, after 1989 Poland and the whole of Central and Eastern Europe were faced with a completely new socio-economic environment. A drop in the number of volunteers offering their help to charitable organisations, including hospices, was noticed. This was due to the fact that people started to seek jobs *en masse* in order to cope with the growing problems posed by the new reality. The 1990s were years of crisis for the voluntary service in Poland. Thanks to the inclusion of the hospice movement and palliative medicine centres in the national health programme, it was possible to preserve ten years' worth of work experience by drawing on the voluntary hospice service. Many volunteers were engaged as hospice physicians and nurses, as well as chaplains, psychologists and social workers. However, by putting hospices and palliative medicine centres into an institutional framework, the hospice movement was slowly losing its exceptional character, with palliative medicine specialists working together with medical and non-medical volunteers, accompanied by a considerable involvement of the Church community through its local parish structures, religious life communities or Caritas centres.

In response to a noticeable crisis in the provision of selfless help, charitable institutions made efforts to promote voluntary service ideas in the Church and society at large. Caritas Poland developed the volunteer network in schools by establishing Caritas school clubs.[25] In addition, voluntary services were established attached to parishes – Caritas parish groups[26]. Caritas can pride itself on the most dynamic growth in the number of volunteers, of whom there are now over seventy thousand in Poland. Many diocese Caritas branches, as a part of their activity, also provide palliative and hospice care, training and involving volunteers in such care. The preparation and distribution in all churches of catechetic and homiletic materials for the 60th Charity Week in 2004 devoted to palliative and hospice care helped immensely to promote care of the elderly and the terminally ill.[27]

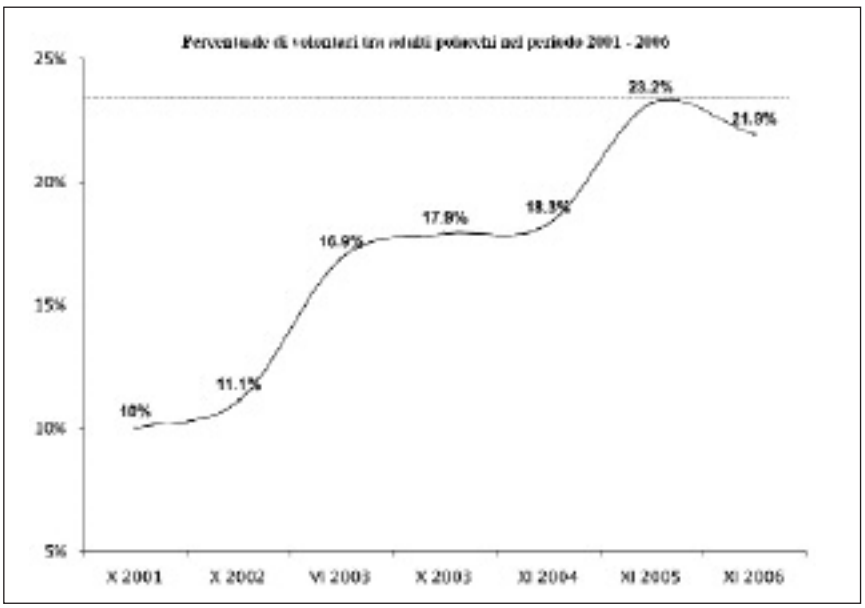
Studies on the Development of Voluntary Service in Poland

Since 2001, studies on voluntary service and philanthropy have been carried out, commissioned by the Klon/Jawor Association and Voluntary Service Centre. Presented below is a handful of data obtained from those studies in 2001 and 2006. In 2001, 10% of those surveyed declared their involvement as volunteers during the previous year in the work of institutions and organisations. What does volunteers' work involve? One third of volunteers working through organisations and institutions worked directly for those in need. 18% of volunteers collected funds. 17% participated in the preparation of events, campaigns and celebrations. 14% of volunteers devoted their spare time to participation without remuneration in the deliberations of a board, council, committee, etc. 70% of those who were not involved in voluntary activities or did not financially support any organisations or institutions said that they did not do this because, first of all, they had to take care of themselves and their families. 59% claimed they have not been asked by anyone. 53% said that they had no time for social work.[28]

In 2006, over 21.9% (20% of men and 24% of women), i.e. approximately 6.6m adult Poles, devoted their time to free work in the interest of others. This is twice as many as in 2001, although that year saw the slow-down of growth due to the opening of borders and considerable economic migration outside Poland. Who are volunteers? Women are slightly more often involved in social work (last year, 24% of women were involved in voluntary work, compared to 20% of men). Those with

a background of higher education account for the biggest group of volunteers. As in previous years, in 2006 young people (students and pupils) predominated among volunteers. Those over 55 were found to take up voluntary service much more seldom. Voluntary work is done more often by those in employment than by retirees and pensioners. The popularity of voluntary service considerably differs between regions – in western and southern Poland, more people admit to taking up such activities than in eastern, northern and central Poland. Why do they do this? The most frequently cited reasons for doing social work are the volunteers' moral, religious and political beliefs (these are mentioned by 50% of those surveyed). 27% get involved in voluntary work expecting to receive help in return in the future. 21% take up social work because of their interests or the satisfaction they derive from it. The growth of interest in voluntary service is aptly illustrated by the following chart:

Figure 1. Volunteers in NGOs, Social and Religious Movements (percentage of adult Poles)



Taken from: Herbst J. and Gumkowska M., *Wolontariat, Filantropia i 1%. Raport z badań w 2006 (*'Voluntary activity, Philanthropy and 1%. Research for 2006') (Stowarzyszenie Klon/Jawor, Warsaw, 2007).

Also of importance from the point of view of cooperation between the Church and NGOs is the clear correlation between the willingness to offer selfless help and involvement in religious practices or concern about one's own spirituality. According to the research, among those participating in religious practices at least once a week, nearly 26.5% supported public service organisations through their work, while nearly 40% offered some financial assistance or in-kind donations to social organisations or movements. This means that those who are more religious become more often involved in voluntary service. Among those participating in religious practices less than once a week, the share of volunteers and philanthropists is lower – amounting to 17.3% and 24.3%, respectively.[29]

The New Faces of Voluntary Hospice Service

Voluntary service in Poland has started to gain in popularity again.[30] Hospices and palliative medicine centres have searched for new ways of reaching the general public and encouraging self-less help. The National Chaplain of Hospices proposed a new way of talking about hospice service through co-operation with the media and public education about the end of human life. The Hospice Foundation created by the National Chaplain of Hospices is a charitable organisation that supports the hospice movement in Poland. The 2004 national educational campaign – 'Hospice is Life, too' – was launched on the main TV channel in Poland, as well as in other national and regional mass media. For four weeks in October-November there were around 1,000 media events regarding end of life issues. Collaborating with over 100 hospices from all over Poland, and assisted by the TVP1 National Broadcasting Channel, as well as by major newspapers and radio stations, we were able to create discussion on the hot issues in palliative medicine and hospice care. In November 2004 a special blessing for all hospice patients and their families, as well as hospice workers and volunteers, was imparted by Pope John Paul II. With his trembling voice, he said: 'Today in Poland, "Hospice Day" is being celebrated; its motto is: "Hospice is Life, too". The care given by workers and volunteers to those who are terminally ill and dying is a great work of mercy. I ask God to reward their love and dedication with his grace. I also entrust those who assist the suffering in their own homes to Mary Most Holy. God bless everyone'.[31]

As a result of the national hospice campaign all the hospices noticed: a breaking the taboo on end of life issues, terminal illness and problems of the elderly in the mass media; a consolidation of hospices and palliative care units in Poland and a promotion of voluntary service for those in need; and fundraising on a national and local level. As a result of this campaign, a website was created which was the first source of hospice and palliative care in Poland.[32] The description of the campaign and the method of reaching the general public through co-operation between hospices and the mass media is accurately conveyed by the book which provided an account of the campaign and the process of dying of a 19-year-old boy in a hospice.[33]

The second national campaign gave the same results, reawakening the spirit of volunteerism in

Polish palliative care. 118 hospices took part in the campaign, discussing truthfulness toward the end of life with the public. This campaign was very successful in public debates and concerts, which were launched during the first International Day of Hospice- and Palliative Care around the world. The result of the campaign was a book – a handbook for hospice workers and volunteers but also for hospice patients and their families.[34] Subsequent 'Hospice is Life, too' public campaigns helped to promote the hospice idea, encouraging new candidates to engage in voluntary hospice service. When people willing to do voluntary work presented themselves, hospice centres were often not ready to accept them and could not prepare them for voluntary hospice service through training. Thus the idea emerged of a public campaign devoted to voluntary service, as a result of which hospices throughout Poland are now preparing and training voluntary service coordinators. This idea is being implemented by the National Chaplain of Hospices and the Hospice Foundation with the motto 'I Like to Help'.

"LUBIĘ POMAGAĆ"
"I LIKE TO HELP" programme

In 2007, the topic of the educational campaign supported by the mass media was 'hospice volunteers'. The Hospice Foundation received a special grant to train and supervise volunteer coordinators from hospices in Poland. There have been more than 100 hospices involved in this programme. Most of them are from rural areas which want to develop the level of their service through the involvement of more trained volunteers. "I Like to Help" – the training of hospice coordinators – is a national initiative taken by the National Chaplain of Hospices in the hope that the vital element in the hospice movement and palliative medicine will be given back to the system of palliative care in Poland. Hospices taking part in this programme delegate the best team member to voluntary work as the volunteer coordinator and leader. Information, promotion and regular recruitment to the voluntary service is needed now. The programme 'I Like to Help' is a chance for those who want to enrich hospice care with the precious help of hospice volunteers. One of the results of this programme will be the publication of a handbook for hospice volunteers with the hope that this will be a useful textbook for all volunteers who care for the elderly and the homebound. It could be of great help for family members and other people who help elderly and handicapped people in their homes. The handbook will be available in 2008.

The next steps of the 'I Like to Help' programme will be connected with voluntary activities in schools and universities, with an attempt to reach out to young people willing to help and take up the

challenge connected with hospice service. Hospice workers and volunteers will create promotional and educational programmes with teachers and tutors, hoping to educate about end of life issues and to recruit candidates for hospice volunteers. At the end of this three-year national programme of revitalising hospice volunteers, there will be a special message sent to the group of adults and 'young retirees' called the 50+ group. Hospices will be reaching out to local parishes, clubs and organisations for pensioners with information about the possibilities of voluntary service for adults. The 'I Like to Help' programme is a way of teaching about the end of life, but also about care for the elderly, handicapped and ill people in our families and neighbourhoods.

'Sentenced to Care' - Prisoners in Hospices. New Ways of Re-educating through Voluntary Service for the Terminally Ill in Hospices

Among many forms of rehabilitation for prisoners there is the search for voluntary activities and re-education through various activities.[35] In the Gdansk Hospice, prisoners, towards the end of their re-education process, are allowed to work in the hospice, and some of them are trained as hospice volunteers. They become part of the interdisciplinary team, and collaborate successfully in the caring team. The *Hospice Information Bulletin* from London has commented as follows on this conduct test:

Prisoners in a hospice? Why not? An innovative programme to reintegrate prisoners into society through voluntary work has proved useful at Gdansk Hospice in Poland. Over the past few years, the project has helped to break down stereotyping and our perceptions of prisoners. We are less scared of them now. They became simply "our boys" in the hospice team. This unusual cooperation has attracted wide, national media coverage including weekly magazines, radio and television in Poland, as well as German television…Talking about this new opportunity for the hospice and palliative care on the TV, Gdansk Hospice Manager had said: "We have the meeting of two dramas: the drama of crime and the drama of incurable illness and death. Death is a circumstance, which doesn't leave anybody indifferent. I believe that such places as hospices, where we touch extreme experiences, contain more radical answers on questions regarding our own attitudes".[36]

The initial data shows that those who work in hospices receive better results in re-education and have the chance to receive a re-

duction in their sentences. The national pilot programme, with ten hospices and ten semi-open prison structures, will give a chance to the prisoners who will help the terminally ill and their families. The hospice teams and prison educators and psychologists will carefully study the project. Further research in this area is needed to confirm these initial data.

Conclusion

With the growing number of elderly, handicapped and terminally-ill people in our societies, we are facing new challenges. The example of the hospice movement in Poland is a realistic example of the possibility of collaboration between the Church, the health-care system and volunteers who are a great help for those in need. The mission of the Good Samaritan continues today, giving help to a growing number of sick and elderly people amongst us. The Church should be present in discussion and action for the needs of the terminally ill and handicapped. Collaborating with health-care structures, supporting volunteers in different services, and giving religious and spiritual support is part of our Christian and human mission. Pope Benedict XVI encouraged all health-care professionals and volunteers, in his message for the XVI Day of the Sick, which was dedicated in particular to hospice and palliative care:

I would like to encourage the efforts of those who work daily to ensure that the incurably and terminally ill, together with their families, receive adequate and loving care. The Church, following the example of the Good Samaritan, has always shown particular concern for the infirm. Through her individual members and institutions, she continues to stand alongside the suffering and to attend the dying, striving to preserve their dignity at these significant moments of human existence. Many such individuals – health care professionals, pastoral agents and volunteers – and institutions throughout the world are tirelessly serving the sick, in hospitals and in palliative care units, on city streets, in housing projects and parishes.[37]

With traditional and new methods of recruiting volunteers, their good energies should unite with the professional skills of health-care workers in hospices, nursing homes and home care structures to ensure better care for the elderly and the terminally ill. Spiritual help to achieve those goals can always be found in reciprocal prayer for our patients and for the carers – both professionals and volunteers:[38] 'Oh, God, Lord of Life, send your Spirit onto all the sick, especially to those who suffer from incurable diseases, to console them and bolster their faith. Grant the strength of Your Holy Spirit to all health and pastoral care workers who help the sick. And make them, always and everywhere, have a profound respect for the dignity of human life'.

Rev. PIOTR KRAKOWIAK SAC,
National Chaplain of Hospices in Poland

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[1] VEATCH R.M., *Death, Dying and the Biological Revolution. Our Last Quest for Responsibility* (New Haven, 1989), pp. 9-13.

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[4] Cf. SAUNDERS C., SUMMERS D.H., AND TELLER N., *Hospice. The living Idea* (London, 1989).

[5] MOTHER THERESA, *In my Own Words* (New York, 1997), pp. 65-72.

[6] Cf. DRĄŻKIEWICZ J., *W stronę człowieka umierającego. O ruchu hospicjów w Polsce* ('Toward the Dying. A History of Hospices in Poland') (Warsaw, 1989).

[7] Cf. JOHN PAUL II, *Letter Of His Holiness Pope John Paul II to the Elderly* (Vatican, 1999); *Letter of John Paul II to the President of the Second World Assembly on Ageing* (Vatican, 3 April 2002).

[8] SYNAK B., 'Formal Care for Elderly in Poland', *J. Cross Cult. Gerontol*., vol 4, 2/04, 1989, 107-127.

[9] Cf. KRAKOWIAK P., *Zdążyć z prawdą. O sztuce komunikacji w Hospicjum (*'In Time with Truth. On the Art of Communication in a Hospice') (Gdansk, 2006).

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[11] LUCZAK J., 'Palliative/Hospice Care in Poland', *Palliative Medicine*, 1993, vol. 7, n. 1, 68-70.

[12] *Palliative Care in Poland – the Warsaw Hospice for Children* (Warsaw, 2006), pp. 37-40.

[13] Cf. KRAKOWIAK P., *Zdążyć z prawdą. O sztuce komunikacji w Hospicjum* ('In Time with Truth. On the Art of Communication in a Hospice') (Gdansk, 2006).

[14] CLARK D., 'Religion, medicine, and community in the early origins of St Christopher's Hospice', *Journal of Palliative Medicine*, 2001, 4(3): 353-360.

[15] DAALEMAN T.P., AND VANDECREEK L., 'Placing Religion and Spirituality in End-of-Life Care', *JAMA* 2000; 284(19): 2514-7.

[16] Cf. DOYLE D AND WOODROFF R., *The IAHPC Manual of Palliative Care,* 2nd. edition (Houston, 2004).

[17] PUCHALSKI, C.M., 'Spirituality and Health: the Art of Compassionate Medicine', *Hospital Physician*, 2001.03, 30-36.

[18] *CCC* (Vatican, 1993), (n. 2279) 'Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable Palliative care is a special form of disinterested charity. As such it should be encouraged'.

[19] MURRAY D, 'Reflections on Chaplaincy in a Hospice:1977-2001', *Scottish Journal of Healthcare Chaplaincy*, vol. 5 n. 1, 2002, 41-43.

[20] GÓRECKI M., *Hospicjum w służbie umierających* ('The Hospice at the Service of Dying') (Warsaw, 2000).

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[23] ZAJĄC J. (ed.), *Życiem otulana śmierć (*'Death Wrapped in Life') (Caritas, Płock, 2004).

[24] P. KRAKOWIAK, *Strata, Osierocenie i żałoba (*'Loss, Bereavement and Grief) (Gdansk, 2007), pp. 84-86.

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[26] Cf. BOCHEŃSKA-SEWERYN M. AND KLUZOWA K., *Motywy i formy pracy członków parafialnych zespołów charytatywnych (*'Motives and Forms of Work of Members of Parish Charitable Groups') (Caritas Scientific Yearbooks, V, Warsaw, 2001).

[27] Cf. ZAJĄC J. (ed.), *Życiem otulana śmierć* ('Death Wrapped in Life') (Caritas, Płock, 2004).

[28] DĄBROWSKA J. AND WYGNAŃSKI K., *Wolontariat i Filantropia Polaków w liczbach,* [Voluntary Activity and Philanthropy among Poles in Numbers'), (Stowarzyszenie Klon/Jawor, Warsaw,2002).

[29] HERBST J., GUMKOWSKA M., *Wolontariat, Filantropia i 1%. Raport z badań w 2006* ('Voluntary activity, Philanthropy and 1%. Research for 2006') (Stowarzyszenie Klon/Jawor, Warsaw, 2007), pp. 14-27.

[30] GÓRECKI M., *Hospicjum w służbie umierających* ('Hospice in the Service of Dying') (Warsaw, 2000).

[31] JOHN PAUL II, *Angelus,* Sunday, 7 November 2004.

[32] www.hospicja.pl/en – The main information from hospices in Poland in English.

[33] SWITALA M., *Podróż za horyzont* ('Journey Beyond the Horizon') (Gdansk, 2005).

[34] KRAKOWIAK P., *Zdążyć z prawdą. O sztuce komunikacji w Hospicjum (*'In Time with Truth. On the Art of Communication in a Hospice') (Gdansk, 2006).

[35] Cf. POL J.D., *Możliwości wolontariatu w aresztach i zakładach karnych* ('Possibilities of Voluntary Work in Prisons') (Roczniki Naukowe Caritas V, 2001).

[36] SWITALA M. AND KRAKOWIAK P., 'Sentenced to Care', *Hospice Information Bulletin*, London, November 2007, p. 7.

[37] BENEDICT XVI, *Message of his Holiness Benedict XVI for the Fifteenth World Day of The Sick*, Vatican, 8 December 2006.

[38] World Day of the Sick 2007, *World Day of the Sick Prayer*, Seoul, 2007.

JAMES WINGLE

4.6 Spiritual Support for Sick Elderly People: Sacraments and Prayers

Introduction

My theme this morning is 'Spiritual Support for Sick Elderly People: Sacraments and Prayers'. Throughout this conference we have been examining in a systematic fashion the many facets of the noble and necessary work of caring appropriately for our older brothers and sisters who carry the burden of illness. In this comprehensive portrait, we have examined the actual situation of the sick elderly from a broad perspective that is expressive of the complex nature of the subject.

The Complex Nature of the Human Person

The multi-faceted nature of the human person as the embodied spirits we are, originating in God and destined for eternity, and the density of the social and cultural matrix that forms our milieu, makes it necessary to do this work if we are to meaningfully engage our subject. Too frequently, in the current intellectual and cultural context marked by a certain empirical pragmatism, we content ourselves with fragmentary approaches that do not serve well the profound depth of the human subject. As our knowledge base continues to expand rapidly, we tend to shift our focus from one specialty to another and risk losing sight of the unified subject, the human person, to whom this knowledge pertains and around whom it is oriented. While we have benefited immensely by the increase in specialized fields of knowledge, the risk of pursuing ever more intense specialization, particularly in relation to the human person, is that we end with an atomized vision. This Pontifical Council, in response to the invitation and direction of the Holy Father in organizing this conference, is performing a most valuable service to the Church and to the world. By bringing together these rich and varied fields of knowledge about sick elderly people, and stimulating a dialogue between those working most closely in the field of their care with the profound treasure of the Church's wisdom drawn from Sacred Scripture, the Fathers, the lives of the saints, theological discourse, and the lived experience of pastoral life, a new depth of understanding emerges. With such renewed understanding, our pastoral practices take on a new vigor and zeal.

Focus on the Sacraments

As we approach the culmination of this conference, I believe it is altogether fitting that we now focus our attention on that supreme expression of the Church's pastoral care for sick elderly people – that is, her sacraments and her life of prayer. Just as there are three sacraments that belong to the beginning of the great journey of Christian life, the sacraments of Christian Initiation as they are commonly called – Baptism, Confirmation and the Eucharist, so there are three sacraments that accompany the pilgrimage of life in this earth to its completion. These are the sacraments of Reconciliation, the Anointing of the Sick or Extreme Unction, and the Eucharist or Viaticum as it is called when administered to one who is dying. These, as all the sacraments, are part of the Church's pilgrimage as it journeys through time towards its fulfilment in the complete sharing in the glory of Christ, crucified and risen.[1] Before considering these sacraments, however, it will be helpful to see where they are situated in the context of the human reality of elderly people who are ill.

A corollary of the human condition is that we are all needy persons. This quality of neediness emerges in greater evidence at both ends of the spectrum of human life. The infant cannot survive without sustained attention and care for all of his or her needs. In the second phase of life, as we come into fuller possession of our talents and capacities, we become able to fend for ourselves for the most part, with an obvious need for social mutuality. As we enter the third phase of life in advanced age, we return to a more dependant mode of existence in which we have to rely on others for many of our basic needs. Movement between these phases of our human existence has profound resonance on our sense of identity, value, and self-worth.

Threats to the Dignity and Value of the Sick Elderly; the Asylum Approach

Dominant trends in our postmodern culture tend to ascribe value only to those elements or forces that are perceived to be productive. In this optic, elderly people who are ill are not usually ascribed much value or worth. On the contrary, they are frequently viewed in a cruel perspective as burdens on society, taking up valuable resources. We tend to segregate the elderly in homes that are often places of isolation and loneliness,

cutting them off from the natural inter-generational flow of family life. Much as the asylum rose in prominence in the eighteenth and nineteenth centuries as an attempted solution to crime and poverty, in our day a new form of asylum has emerged in which elderly ill people are shut away from the main stream of life in institutional settings of one sort or another. As the population of elderly people increases dramatically, and this trend is likely to continue, it raises serious questions about the just structuring of society as well as the aptitude of our pastoral planning. The late Pope John Paul II alerted our attention to this when he said in a discourse addressed to the Second World Assembly on Ageing (Madrid, 8-12 April 2002): 'Everywhere in fact there is taking place a profound change in the structure of population, a change which requires new social planning. This involves discussion not only of economic structures but also of the understanding of the life-cycle and relations between the generations. It may be said that a society shows itself just to the extent that it meets the needs of all its members, and the quality of its civilization is determined by the way in which it protects its weakest members. How can we guarantee the endurance of a society which is ageing, and safeguard the social security of older persons and their quality of life? In responding to this question, we must not be guided chiefly by economic criteria; rather, we must be inspired by sound moral principles. In the first place, the elderly must be considered in their dignity as persons, which does not diminish with the passing years nor with physical and mental deterioration. It is clear that such a positive view can flourish only in a culture capable of transcending social stereotypes which judge a person's worth on the basis of youth, efficiency, physical vigour or perfect health. Experience shows that when this positive view breaks down older people are quickly marginalized and condemned to a loneliness which is a kind of social death. And does not the self-esteem of older people depend in large part on how they are viewed in the family and in society?'

Homes and hospices for the sick elderly, when they intentionally pursue other means of facilitating the vital familial and social network of their residents, can and do serve a most positive purpose. This is poignantly the case when these homes offer programmes and services of a palliative nature to elderly people approaching death. Frequently, in the socio-economic conditions in which many families live today, it would be virtually impossible for a good number of families to provide a dignified place for their senior members to remain in the family home, even if their physical health is relatively good. This becomes more problematic when the elder member requires specialized care and a more intense degree of support. If both spouses are employed outside of the home, a senior living in the home would be left alone for long periods of time.

It is against this background of human need in the lives of sick elderly people that the Church reaches out, offering the embrace of Christ's love made concrete and effective in her sacramental rites. All of the other excellent pastoral services rendered by the men and women who surround the elderly person who is ill – visitation, prayer, counselling – are brought to an intense culmination in the encounter with the living presence of the Lord mediated by the sacraments. What is spoken by the sacramental sign is a demonstration that brings about and strengthens the communion that this person enjoys with the living body of Christ, and with Christ himself as its head. This gives eloquent expression to the particular concern of Christ's Church for her sick and suffering members in whom she constantly recognizes an inalienable value and dignity which they enjoy in God's sight. While their faculties may be failing, and illness and pain compromise their ability to relate and to function, they retain in the core of their being the splendour of their ontological identity as creatures that God created out of love and upon which He imprinted His own Divine image. Remembrance of the suffering and death of Jesus gives us the certainty of faith that the same love with which the Father beheld His Son in his agony is offered to the suffering members of Christ's body in their frailty and illness. In the language of the Introduction to the sacramental rite of Anointing we read: 'The man who is seriously ill needs the special help of God's grace in this time of anxiety, lest he be broken in spirit and subject to temptations and the weakening of faith. Christ, therefore, strengthens the faithful who are afflicted by illness with the sacrament of anointing, providing them with the strongest means of support'.[2]

The Quest for Happiness

All people, especially sick elderly people, desire happiness and fulfilment. As Pope Benedict remarks 'Man is created for that true and eternal happiness which only God's love can give. But our wounded freedom would go astray were it not already able to experience something of that future fulfilment.'[3] This is the deepest longing at the core of every human person, and one way or another, this is what shapes and drives the lives of each one of us. We need then, to pay respectful attention to the human heart and its profound longings. How are we to find the fullness of life that our hearts seek? This is the perennial question that lies behind each and every noble striving of human enterprise, whether in art, literature, music, architecture, or in economic affairs, social or political life or any other worthy human endeavour. It will not do if all we have to offer in response to the ultimate questions that arise out of the suffering of the elderly person who is gravely ill is some sort of vague word of consolation, or an opinion or some subjective interpretation. In a marvellous passage penned by the late Don Luigi Giussani we read: 'Christianity, conceived anew in its structural originality, affirms in the first place that the path to truth is something objective . . . Man's path toward the truth, and toward his destiny, is not at the mercy of his thoughts, or of the thoughts of others, or of the society in which he lives. The path is objective – it is not a matter of imagining it or inventing it, but of following it. . . A living reality that invites us to follow it: this is the characteristic proper to the Christian fact. This is now the life of the Church. What constitutes this life is, to be sure, the reading of the Gospel, the Word of God; but it is the Gospel interpreted by the living awareness of a living body, guided in turn by another living reality, the Magisterium, and this body has its own rhythm in the flowing of time, namely, the Liturgy'.[4] Each of the Church's seven sacraments is an integral part of her sacred Liturgy. They are by their very nature public acts of worship given to God that in turn bring the fruits of his saving grace into the concrete need of the lives of those who celebrate them.

Catechesis

First among the considerations concerning the place of the sacraments in the care of the sick elderly in our present situation is a pressing need for more effective catechesis. While many admirable practices and programmes for sacramental ministry to the sick elderly are prominent in the life of large numbers of particular churches, there are still many who have only a vague notion of the sacramental treasure of the Church, or they may be ignorant of it entirely. Every member of the Church, and especially the sick, ought to have a lively awareness of the power and grace available to them in the sacraments. To achieve this, effective catechesis in preparing for and participating in the sacraments of reconciliation, anointing and Viaticum is needed. Older people who are ill need encouragement to ask for the sacrament of anointing as their illness begins and not to put off the reception of the sacrament. It is of critical importance that those who care for elderly people be given a careful education about the essential nature of the sacrament of anointing, an understanding of its purpose, and an appreciation of its meaning in the lives of those they serve.

Threats and Challenges

As state agencies become ever more prominent in the delivery of health care in institutional settings, new standards for what we have traditionally referenced as 'pastoral care' are being introduced under the vague and frequently amorphous designation 'spiritual care'. Genuine pastoral care has to do with shepherding; there is so much more than the provision of emotional and vaguely spiritual support, good as these may be. The mission of pastoral service to the elderly who are ill is thoroughly incarnational. This, of course, incorporates immersion into the full humanity of those who are served, but it is radically deficient if it does not make primary reference to the God who has become incarnate in the human flesh of his Son. The sacraments are the effective signs and instruments of rendering the incarnate Christ present to the one who receives them in faith. As such, they must ever be regarded as having pride of place in any authentic plan of Catholic pastoral care. Also, many government regulated facilities are turning more and more to lay men and lay women professionally trained in programmes of clinical-pastoral education to fulfil the position of official chaplain. Sometimes these training programmes make little or no reference to the place of the sacraments in the delivery of ordinary pastoral care. It happens that a priest going to such institutions to attend to elderly people who are sick is regarded as a more or less unnecessary 'extra' who is seen as intruding. It is highly desirable and necessary that there be a true spirit of respectful collaboration among all those who are serving the sick elderly, and especially among those directly involved in pastoral dimensions of that care. With the ratio of the number of priests available to serve the faithful declining in many places, it is all the more necessary that there be a harmonious relationship between lay people and priests who work with the sick elderly. A powerful personal experience springs to mind: during the first years after my ordination I served in a parish where there was a Catholic hospital immediately adjacent to the parish church. While there was a pastoral care department in the hospital, no priests were available other than the parish staff. One of the religious sisters on the nursing staff of the hospital, a spiritual daughter of Saint Marguerite d'Youville – the foundress of the Grey Nuns – was in the habit of visiting seriously ill patients during her spare time. With gentle kindness but also discreet persistence, she would prepare them to receive the sacraments of penance, anointing, and holy communion. As I made my sometimes rapid daily visits to the wards of the hospital, on my way to other duties in the parish, Sister

would quietly direct me to this or that room where she would simply indicate 'they are ready'. Sister Cecile was deeply loved by the patients and their families who went through that hospital, and I shall not quickly forget her discreet and kindly support to me in my priestly ministry.

Professionalizing the function of chaplains in facilities that care for the sick elderly, sometimes can introduce an unnecessary and harmful note of tension between the institutional 'chaplain' and the 'pastor' of the patient or resident. While the chaplain has the immediate responsibility to see to the appropriate pastoral care of the resident, it is necessary to remember that this same resident or patient came from a parish community and at least ideally remains bonded to that community. Chaplains need to be in contact with pastors, and pastors cannot simply delegate their pastoral responsibility to the institutional chaplain. It is of great solace to sick elderly people to be visited by their own parish priests, to receive the sacraments at their hands when feasible, and to know that their illness has not cut them off from their community.

Access to proper pastoral care and the sacraments, in particular, is menaced in many circumscriptions arising from 'privacy laws'. Frequently, patients who are being admitted to hospitals or nursing facilities are not asked to disclose their religious affiliation, and hospital staffs are forbidden to disclose any personal information about these patients or residents. At the same time, priests and pastoral volunteers are forbidden to visit patients who have not specifically requested that they do so. Thus it happens that many patients who are admitted in a condition in which they are not able to make a request are deprived of pastoral visitation and the sacraments. To overcome this, vigorous efforts to educate the Catholic community to the need to clearly and prominently identify themselves as Catholic are needed. In certain places identification cards or bracelets are available that Catholic people can wear or carry that state: 'I am Catholic. In the event of an accident or serious illness, please call a priest'.

If our recourse to the sacraments in caring for the sick elderly is to be appropriate and meaningful, we must have a clear understanding of the nature and dynamism of these sacraments. In the sacrament of Anointing of the Sick, it is Christ the Lord who acting through the person of the sacred minister, comes to touch the life of the sick person. In the Gospel of Mark this anointing is alluded to as we see in Jesus sending out of the twelve: 'And they cast out many demons, and anointed with oil many that were sick and healed them' (Mark 6: 13). St. James, the brother of the Lord, explicitly charges the 'elders of the Church' to anoint those who are sick and he specifies the effect of this powerful prayer: 'Is any among you sick? Let him call for the elders of the Church, and let them pray over him, anointing him with oil in the name of the Lord; and the prayer of faith will save the sick man, and the Lord will raise him up; and if he has committed sins, he will be forgiven' (Jm 5: 14-15). Here we find the scriptural foundation of the Church's belief and teaching about the Anointing of the Sick.

The power of the Holy Spirit is signified and becomes operative in the anointing with oil that is blessed for use in this sacrament. Pope Paul VI when promulgating the rite of Anointing of the Sick currently in use in the Latin Church clearly affirms this practice of the Church rooted in Scripture and Tradition: 'From ancient times testimonies of the Anointing of the Sick are found in the Church's Tradition, particularly her liturgical Tradition, both in the East and in the West. Especially worthy of note in this regard are the Letter which Innocent I, our predecessor, addressed to Decentius, Bishop of Gubbio and the venerable prayer used for blessing the Oil of the Sick: "Send forth, O Lord, your Holy Spirit, the Paraclete," which was inserted in the Eucharistic Prayer and is still preserved in the Roman Pontifical.'[5] It is necessary to avoid anything that suggests a quasi-magical sense of the power of the Sacrament of Anointing. The grace given by the Holy Spirit in the sacrament is indeed powerful and efficacious, but it presumes faith. The one who is sick is saved by his faith and the faith of the Church. This faith holds in mind the death and resurrection of the Lord from which it draws its power, while longing for the fullness of the coming 'reign of God' of which it is the pledge. While it must be noted that a person need not be conscious in order to receive and benefit from the Sacrament of Anointing, nevertheless there must be at least an implicit desire to receive this grace. Whenever possible, the mind and heart of the one who is to receive the Sacrament of Anointing should be helped to prepare for its reception by reflection and prayer, and by a prior reception of the Sacrament of Reconciliation whenever it is necessary. This sacramental confession can be celebrated during the introductory rite, bearing in mind the need for privacy during this portion of the celebration.

Names and Meanings

There is no better summary of the reality and effects of the sacrament of anointing than that found in the decrees of the Council of Trent: 'This reality is in fact the grace of the Holy Spirit, whose anointing takes away sins, if any still remain to be taken away, and the remnants of sin; it also relieves and strengthens the soul of the sick person, arousing in him a great confidence in the divine mercy, whereby being thus sustained he more easily bears the trials and labors of his sickness, more easily resists the temptations of the devil 'lying in wait' (Gen 3:15), and sometimes regains bodily health, if this is expedient for the health of the soul'[6] From this we learn the central role of the Holy Spirit operative in this sacrament to take away sins, to give courage and strength to the sick person and help in resisting temptation, and sometimes to effect bodily healing. We can also attribute to the Council of Trent the practice of referring to this sacrament as the sacrament of the dying, since it has special significance when a person is nearing the end of their life. The

doctrinal clarity of the decree of the Council of Trent specifies that the priest is the proper minister of the sacrament.[7] The subsequent teaching and practice of the Church has confirmed this and it is recently reaffirmed in the contemporary Code of Canon Law.[8]

In the present practice of the Church, and for sound reasons, we usually now refer to the sacrament as the 'Anointing of the Sick.' As was clarified at the Second Vatican Council, this sacrament, previously called 'Extreme Unction,' is not a sacrament for those only who are at the point of death. A more generous access to the sacrament is indicated for any person who begins to be in danger of death from sickness or old age.[9] It is of the greatest importance that this clarification be clearly known by sick elderly people themselves, and by the members of their families and those who provide care to them. An increasing awareness is needed to appreciate the full ecclesial dimension of this sacrament. It is never a merely private act, but it concerns the entire Church. The Decree of the Second Vatican Council, referring to the letter of the Apostle James makes this abundantly clear as we read: 'By the sacred anointing of the sick and the prayer of her priests, the whole Church commends those who are ill to the suffering and glorified Lord, asking that he may lighten their suffering and save them (cf. James 5:14-16). She exhorts them, moreover, to contribute to the welfare of the whole People of God by associating themselves freely with the passion and death of Christ (cf. Rom. 8:17; Col. 1:24; 2 Tim. 2:11-12; 1 Pt. 4:13)'.[10]

The Sacrament of the Anointing of the Sick is becoming an increasingly visible reality in the normal life of the Church. Thanks to a deeper appreciation of its healing grace, and to the powerful witness of well publicized communal celebrations of the sacrament on the occasion of World Day of the Sick, there is a growing sense of desire to have access to this sacrament. Of course, there is also a constant need for pastoral vigilance to see that the sacrament is not abused by a trivial or frivolous attitude. Usually, in dealing with the sick elderly this is not a prominent concern.

Continuing the Healing Mission of Jesus

Many of our Catholic healthcare institutions incorporate this description as a part of their mission statements or other proclamations of the intent and identity of their work. Indeed, a fuller understanding of the Church sees her as a universal sacrament of salvation for all times and all peoples. But the task of the Church is not something she has imposed on herself. The Church receives her mission from the Lord, whose body she forms. With Christ as the living head of the body, and we its members, we are to carry on his saving mission in the world today. All through the Gospel we encounter signs of Jesus loving concern for the sick, the poor and the suffering. He sent out his apostles to heal the sick as we read in Mark's Gospel: 'And he called to him the twelve, and began to send them out two by two, and gave them authority over the unclean spirits... And they cast out many demons, and anointed with oil many that were sick and healed them'. (Mk 6:7, 13) We see from the text of the letter of the Apostle James, that the early Church understood her mission to include this continuance of Jesus healing presence and mission: 'Is any among you sick? Let him call for the elders of the Church, and let them pray over him, anointing him with oil in the name of the Lord; and the prayer of faith will save the sick man, and the Lord will raise him up; and if he has committed sins, he will be forgiven' (Jm 5: 14-15). The double action of healing and forgiving sins is not a casual juxtaposition but a poignant indication that in the ministry of the Church the life and power of the Risen Christ is effectively present.

Contemporary efforts to catechize the sick elderly and those who surround them need to continue to lay the ground work so that this grace filled encounter with the Lord in the sacrament of Anointing is not put off until the moment of death. Once again, the nomenclature is instructive and revealing. As stated in the *Catechism of the Catholic Church*, 'Over the centuries the Anointing of the Sick was conferred more and more exclusively on those at the point of death. Because of this it received the name 'Extreme Unction"[11]. Obviously, if the Sacrament of the Sick is viewed primarily as the Last Anointing, this will deter many from having access to it. .

Anointing of the Sick as a Celebration of the Whole Church

This sacrament, as indeed all of the Church's sacraments is a public act of the whole Church, a part of her sacred Liturgy. 'Ideally the anointing takes place in the midst of the family, perhaps with the participation of nurses (and doctors?)... If this happens in the presence of the whole parish community, it would be even more effective for both the sick and the faithful. It would be advisable to have such a communal celebration of anointing once or twice a year, but it has to be well prepared ahead of time... Common celebrations allow them (the sick) to experience how closely the whole community accompanies them with their prayers and support'.[12] This renewed emphasis on the ecclesial dimension of the sacrament that involves the whole Church is com-

pletely consistent with the principles guiding the entire liturgical life of the Church as set forth by the Second Vatican Council. The Church's liturgy is never private, but it manifests the nature of the Church as a community of salvation and has effects on its life.

Looking at the communal dimension of the celebration of the sacraments with the sick elderly, we also discover that the sick are not merely passive recipients of grace. They make a powerful contribution to the good of the entire Church. This consciousness, if well communicated, could do wonders to offset the erroneous notion that the elderly have nothing to contribute. The very rite of the sacrament of Anointing exhorts those who receive it, 'to contribute to the welfare of the whole people of God by associating themselves freely with the passion and death of Christ (see Rom 8:17; Col 1:24; 2 Tim 2:11-12; 1 Pt 4:13)'.[13] In the *Catechism of the Catholic Church* we are again reminded that in the celebration of the Anointing of the Sick they (the sick) should be 'assisted by their pastor and the whole ecclesial community, which is invited to surround the sick in a special way through their prayers and fraternal attention'.[14] The following article in the *Catechism* recommends that the setting for this communal celebration is ideally during the Eucharist.[15]

Strength in Suffering as a Grace of the Sacrament of Anointing

Despite our most valiant efforts to care for the sick elderly, suffering remains a part of life. Does this mean that there is some sort of insufficiency in the grace of the sacrament of Anointing or the Eucharist? Such thinking threatens to creep into the practice of certain less mature charismatic-style prayer groups. It can be profoundly damaging and constitutes a real hindrance to sound pastoral practice. The strength and healing that one receives in this sacrament deepen the presence and dynamism of the Holy Spirit in the interior dimension of the life of the recipient. As the then Cardinal Ratzinger wrote: 'A worldview that is incapable of giving even pain meaning and value is good for nothing. It falls short precisely at the hour of the most serious crisis of existence. Those who have nothing to say about suffering except that we must fight against it are deceiving us. It is, of course, necessary to do everything one can to lessen the suffering of the innocent and to limit pain. But there is no human life without suffering, and he who is incapable of accepting suffering is refusing himself the purifications that alone allow us to reach maturity. In communion with Christ, pain becomes meaningful, not only for myself, as a process of *ablatio* in which God purges me of the dross that conceals his image, but beyond me, for the whole, so that we can all say with Saint Paul: 'But now I rejoice in my sufferings for you and so complete in my flesh what is still lacking in the afflictions of Christ for the sake of his body, the Church' (Col 1: 24).[16]

What Does Suffering Mean?

What afflicts the sick elderly today far more than their physical discomfort and pain is the malign suggestion that their suffering is without meaning or value. This cruel and inhuman proposition reaches far beyond merely elderly sick people. There is, to be sure, a certain ambiguity in the experience of undergoing suffering, especially when the suffering is intense. We do not grow in suffering if we endure it only for its own sake. There is a transcendent mysterious quality in suffering that comes to the fore when we understand our sufferings in relation to those of the Son of God. 'The healing effect of the sacrament is designed to calm the sick people and enable them to integrate their sickness and its consequences into their lives in a Christian way'.[17]

Again, we must be careful to avoid any magical notions of the authentic healing power of the Sacrament of Anointing, or of any sacrament for that matter. In its *Constitution on the Sacred Liturgy*, the Second Vatican Council reminded us that: 'The purpose of the sacraments is to sanctify men, to build up the Body of Christ, and finally, to give worship to God. Because they are signs, they also instruct'.[18] Through the celebration of the Sacrament of the Anointing of the Sick we deepen our understanding of suffering by a discovery of its profound place in our relationship with God.

The sacraments of Penance, Anointing of the Sick and Viaticum bring a powerful grace to the dark mystery of suffering. In the Introduction to the rite of the sacrament we read: 'Sickness and pain have always been a heavy burden for man and an enigma to his understanding. Christians suffer sickness and pain as do all other men; yet their faith helps them to understand better the mystery of suffering and to bear their pain more bravely. From Christ's words they know that sickness has meaning and value for their own salvation and for the world's; they also know that Christ loved the sick and that during his life he often looked upon the sick and healed them'.[19]

Suffering and Understanding

In a true sense, the mystery of suffering reveals man to himself. The liturgy of the Anointing of the Sick, as all liturgy, points us beyond what we can see and experience with the limitations of our corporeal being. Again, the words of the former Cardinal Ratzinger are instructive: 'Liturgy is not only concerned with the conscious mind and with what can be immediately understood at the superficial level, like newspaper headlines. Liturgy addresses the human being in all his depth, which goes far beyond our everyday awareness; there are things we only understand with the heart; the mind can gradually grow in understanding the more we allow our heart to illuminate it'.[20] It is this personal transformation that the grace of the sacrament brings about in the depths of the person who receives it. This personal interior change gives us an entirely new perspective. We read in the *Catechism*, 'Christ invites his disciples to follow him by taking up their cross in

their turn. By following him they acquire a new outlook on illness and the sick. Jesus associates them with his own life of poverty and service'.[21]

Conclusion

The spiritual support offered to sick elderly members of the Church in her sacraments and prayers transforms the experience of suffering and sickness by revealing something of its mystery. As we pray for healing, we know that God is the source of all healing, whether of the body, the mind or the soul, and God knows what we need before ever we ask. The hand of Christ that reaches out to forgive, to heal and to nourish in the sacraments of Penance, Anointing of the Sick and Holy Communion, is the hand of the risen and glorified Christ, yet it still bears the distinct mark of the nail that pierced it through. We are not made immune to the mysterious burden of suffering by the sacraments or prayer. Bravely shouldering that burden in the company of the Lord, we are drawn ever more deeply into the heart of Christ where we discover the unspeakable joy of the eternal communion of love that is exchanged mutually between Father, Son and Spirit. This is the certitude of faith that transforms and gives life as expressed in the words of Saint Paul: 'Of this I am sure: neither life nor death, neither angels nor powers, neither things present nor things to come, no authorities, neither height nor depth nor any creature at all can separate us from the love of God that is in Christ Jesus our Lord' (Rom 8, 38).

H.E. Msgr. JAMES WINGLE,
Bishop of Saint Catharines, Canada,
Member of the Pontifical Council for
Health Care Workers,
the Holy See.

Note

[1] Cf. Second Vatican Ecumenical Council, Dogmatic Constitution on the Church *Lumen Gentium*, n. 48.

[2] See PAUL VI, Apostolic Constitution *The Sacrament of the Anointing of the Sick*, November 30, 1972, in *The Rites of the Catholic Church* (New York, NY, Pueblo Publishing Company, 1976), p. 583

[3] BENEDICT XVI, *Sacramentum caritatis*, Post Synodal Apostolic Exhortation, 2007, n. 30 (Libreria Editrice Vaticana, Vatican City, 2007), p.53.

[4] LUIGI GIUSSANI, 'Religious Awareness in Modern Man', *Communio*, vol. XXV, no. 1, Spring 1998, p.135.

[5] See PAUL VI, Apostolic Constitution *The Sacrament of the Anointing of the Sick*, November 30, 1972, in *The Rites of the Catholic Church* (New York, NY, Pueblo Publishing Company, 1976), p. 578.

[6] Council of Trent, Session XIV, Extreme unction, chapter 2: CT, VII, 1, 356; Denz.-Schon. 1696

[7] *Ibid*., cap. 3, canon 4: CT, *ibid*.; Denz.-Schon. 1697-1719.

[8] See Canon 1003,§ 1.

[9] Second Vatican Council, Constitution *Sacrosanctum Concilium* 73: AAS 56 (1964) 118-119.

[10] *Ibid*., Constitution *Lumen Gentium* 11: AAS 67 (1965) 15.

[11] *Catechism of the Catholic Church*, n. 1512.

[12] ATTILA MIKLOSHAZY, S.J., *Benedicamus Domino: The Theological Foundations of the Liturgical Renewal* (Ottawa, Novalis, 2001), p. 138.

[13] Second Vatican Council, *Lumen Gentium* 11: AAS 67 (1965) 15.

[14] *Catechism of the Catholic Church*, n. 1516.

[15] *Ibid*., n. 1517

[16] JOSEPH CARDINAL RATZINGER, *Called to Communion: Understanding the Church Today*, translated by Adrian Walker (San Francisco, Ignatius Press, 1996), p. 155.

[17] ATTILA MIKLOSHAZY, S.J., *Benedicamus Domino: The Theological Foundations of the Liturgical Renewal* (Ottawa, Novalis, 2001), p. 135.

[18] Second Vatican Council, Constitution *Sacrosanctum Concilium* 59: AAS 56 (1964) 158.

[19] See PAUL VI, Apostolic Constitution *The Sacrament of the Anointing of the Sick*, November 30, 1972, in *The Rites of the Catholic Church* (New York, NY, Pueblo Publishing Company, 1976), p. 582.

[20] JOSEPH CARDINAL RATZINGER, *The Feast of Faith: Approaches to a Theology of the Liturgy*, translated by Graham Harrison (San Francisco, Ignatius Press, 1986), p. 151.

[21] *Catechism of the Catholic Church*, n. 1506.

VITOR FEYTOR PINTO

4.7 Visiting Sick Elderly People

Introduction

1. I would like to begin my paper, which is the last of this international conference held in the Vatican in 2007, by congratulating His Eminence Cardinal Lozano Barragán on this initiative of the Pontifical Council for Health Care Workers relating to the study of pastoral care for sick elderly people. This is a study of great contemporary relevance because with the increase in average life spans the number of people over the age of seventy-five has also increased and to them, when they are ill, must be provided special care and treatment so that they can be assured a sufficient quality of life.

2. The subject that has been entrusted to me, namely 'visiting sick elderly people', is essentially pastoral in character and refers to continuous presence with the most elderly who suffer the normal illnesses of growing old. As an interesting fact, we can state that in my parish of Lisborn, which is in the centre of the city and has a population of about 25,000 inhabitants, the ultimate census revealed that there were 602 people over the age of ninety and a few thousand people over the age of seventy-five. Visiting such people during periods of infirmity is one of the most important activities of those priests and groups of volunteers who form a part of the parish unit for pastoral care in health.

3. In this paper the subject will be divided into three parts: visiting sick people, a work of mercy; who the sick people that we visit are and where they are; and the human and Christian support that we offer them.

1. Visiting Sick People – a Work of Mercy

1. In the Christian life it is not enough to receive the mercy of God. Although Jesus expresses in many ways the mercy of the Father, he also asks us to show mercy towards our brothers and sisters.

– The *Catechism of the Catholic Church* (CCC, n. 2447) tells us this expressly: 'The works of mercy are chaitable actions by which we come to the aid of our neighbour in his spiritual and physical necessities....in feeding the hungry, sheltering the homeless, clothing the naked, visiting the sick and imprisoned, and burying the dead. Among all these, giving alms to the poor is one of the chief witnesses to fraternal charity; it is also a work of justice pleasing to God (Mt 6:2-4)'.

– Physical and mental illnesses are an evident sign of human frailty and point to man's need for salvation (CCC, n. 2448). The social relationship animated by charity which is obtained through visiting allows an alleviation of suffering and the beginning of care for sick people who, indeed, are characterised by loneliness.

– Visiting sick people also allows a correlation through them of various works of mercy. Helping people who because of their age and their illnesses cannot go out of their homes; bringing them something to eat (feeding those who are hungry); tidying up their homes; attending to their needs at the level of hygiene (clothing those who need clothes and bringing people home); advising, consoling and comforting (works of spiritual mercy). This is a 'complete service', a gesture of love, of real solidarity, of sharing offered by the Christian community.

2. These gestures of mercy are support for the body, with its necessities, and for the spirit, which is so often without understanding and help. In a special way the sick elderly are enveloped in an immense loneliness. They are by now without colleagues because for some time they have left their places of work. They are also without friends given that these latter have died and very often they do not have families because their near or distant relatives are increasingly few in number. This is the syndrome of loneliness.

– 'If pastoral care is the activity of the Church by means of which, here and now, the salvific action of Christ is implemented', we may ask ourselves: how will these elderly and sick people be saved? Salvation must be overall, with responses at a human level, at a social level and at a spiritual level. Pastoral care in health must acquire this triple process of intervention.

– *There is an urgent need for co-operation* between pastoral care in health and social pastoral care. 'Nobody preaches to people with empty stomachs'. If you want to bring each one of these sick people nearer to God, it is necessary to guarantee them the health care, the social conditions, the family relationships, and the friendships that ensure that they have dignity. All agents of a shared pastoral care must be called to provide care to sick elderly people and in practice create conditions for holistic care that involves bio-spycho-social and spiritual support.

Integrated pastoral care in health meets all the problems to which sick elderly people need an answer. This is what visits to sick elderly people seek to achieve.

– *Visiting is synonymous with*

humanising. The humanisation of care, which is a true expression of a human relationship, becomes indispensable. Paying attention to the kind of relationship that exists which cannot amount to mere technical activity presupposes a relationship that contains expressions of tenderness, understanding, and listening, all of which are indispensable if one wants to achieve a truly human relationship.

– The pastoral relationship of help constitutes the central core. It is converted into a form of evangelisation given that it cultivates proximity, a confermed presence, knowledge of the person, symbolic language, and a suitable proclaiming of Jesus Christ the Saviour.

– *The time spent visiting can be transformed into a privileged time for prayer.* Sanctification, in obtaining full and perfect communion with Christ, provokes a dialogue of intimacy in which it is God who speaks and where both the visitor and the sick person become involved in the context of peace that only prayer manages to create. The Word of God is an element that is indispensable in increasing spirituality, that encounter with God that is gradually created. Humanisation, evangelisation and sanctificaton are the steps that should be integrated into the pastoral relationship of help when a sick person is frequently visited, above all if the elderly person concerned is aware that he or she is living the most important moments of his or her life, the time of great synthesis.

2. The Sick Elderly People that we Visit

1. One may speak of an overall syndrome in the case of sick elderly people. The sick person suffers from everything, complains about almost everything, and has so many things to say that reflect his or her situation. Despite all of this, there are three aspects that most characterise a sick elderly person: growing old, loneliness, and opportunistic illnesses.

– *Growing old*, with consequences at the level of being able to walk, with complications as regards sleep and rest, with requirements at the level of alimentation, with greater care needed as regards the heart, the respiratory system, the cerebral vascular system, and the central nervous system.

– *Loneliness*, given that these people are gradually abandoned since even their children feel that they no longer have the time to spend time with their parents given that they have their own famlies, their jobs and other interests. It often happens that sick elderly people are put in institutions, nursing homes or old people's homes, or are admitted to hospital or to ongoing care units, and all of these solutions to their situation increase their loneliness, their isolation, and make normal social relationships impossible.

– *Opportunistic illnesses* are illnesses that suddenly strike an elderly person when he or she is in a condition of great weakness and is no longer able to activate processes of resistance to the assault of pneumonia, cancer, or a heart attack. An elderly person as a result easily falls into terminal illnesses. These elderly people should be watched over and the visit that is made to them by the members of their Christian community should become an unforgettable blessing, the true presence of Jesus the Saviour. The visit brings them the peace that they need.

2. *Old age is a time of progressive loss*, even when Alzheimer's disease or 'senile dementia' are not present. What are these losses?

– *Job loss*, with the process of retirement which has repercussions at the level of how to fill in time, the economic quality of life, and interests at the level of professional activity.

– *A loss of relationships* takes place because the old person becomes increasingly isolated and no longer enjoys that social image that he or she projected amongst others, he or she no longer has the influence that he or she once had. As a result of all of this, even his or her most intimate friends and relatives end up by disappearing.

– *The loss of faith* can also take an elderly person by surprise, because of the simple fact that he or she no longer receives answers from the appeals that he or she makes to God to deal with his or her illnesses or to resolve other problems. *The very image of God is called into question*.

– *With the advance of age* a sick person treads a road that is rather like the road that Elisabeth Kübbler Ross sees as belonging to the 'terminally ill'. A specific kind of help is required at every stage.

– *In the face of surprise and revolt*, a sick person needs understanding and no kind of blame. Some strange gesture, some expressions of sadness, or some harsher words are only the sign of

an illness which has psychological manifestations which have to be understood and respected. An approach of love and tenderness towards the sick person attentuates this difficult period.

– *Faced with negotiation and recourse to all possible means*, the sick person deserves to be accompanied, even when the treatment that he or she asks for are, or seem to be, useless. This 'negotiation' can also be religious, with 'promises', with multiple prayers. It is incumbent to believe with the sick person that all of his or her prayers are sources of grace and that 'God works wonders'.

– *Faced with depression* at critical moments it is necessary to give the sick person the certainty that he or she is not alone, that he or she can abandon himself or herself to another person who, in addition to the professionals or even the family relatives, enables the sick person to make the leap towards *serene welcome*, in proximity to the end.

The visitors or volunteers who supplement the unit responsible for pastoral care in health in hospitals or at the home of sick elderly people (in the parish) must be ready to accompany such a development, assuring the sick person that he or she will not be left alone and at the same time that God will accompany him or her during this terminal stage of his or her life.

3. What is the Human and Christian Support that we Offer in Visiting Sick Elderly People?

Places that provide support to sick people are hospitals, clinics, ongoing and palliative care units, old people's homes or above all the homes of elderly people, where they live during this final stage of their human journey. In visiting sick people in these places what forms of care should be given to them?

– *Through a visit* relationships of proximity are established which overcome loneliness, which, indeed, is the great cross that a sick elderly person has to bear. This proximity is obtained through presence, with a pastoral relationship and with the Christian community.

– *An ongoing presence:* proximity generates friendship and 'a hour before the arrival of a friend (the sick person) already begins to feel happy' (cf. Saint Exupery). Visits to a sick elderly person must be frequent and must have indispensable quality, that is to say with sufficient time, with a friendly and very simple conversation, with a readiness to help in every way.

– *The pastoral relationship of help*: this relationship of help is a true art of communication between the sick person and the visitor, with attention being paid to emotional and ethical competence as well as the capacity to communicate. The visit must be characterised by an 'empathetic relationship', with the unconditional acceptance of the other (the sick person), and with truth and authenticity. The visitor must learn to establish this relationship of help.

– *The relationship with the Christian community*: the Christian community draws near to the sick person through the visitor or the volunteer who pays a visit to him or her in actions of the unit for pastoral care in health (whether of the hospital or the parish) which represents the community. The fact is that a sick elderly person is also an active member of the Christian community both in the hospital chapel and in the parish. If this person was active in the community where he or she was in good health, now that he or she is sick it is the community that must help him or her.

2. *Through the provision of overall care the visit acquires more quality*. When one refers to the holistic dimension of care one is aware that overall care is not defined solely by the therapy that is implemented by health professionals in their specialisation. The complete dimension of care presupposes assistance at the level of health but also social assistance and spiritual assistance.

– *Assistance at the level of health* is the task of medical doctors, nurses and other health-care professionals who have to assure the implementation of an effective therapy. They, too, go to visit sick people and it is important that these visits are planned and offered with quality when the sick person is elderly.

– *Social assistance* is also indispensable given that the elderly person when he or she is sick loses much of the help that he or she could rely on in his or her previous way of living. The volunteers of the parish unit for pastoral care in health can be accompanied by volunteers of the social group of action who tidy up the home to create a pleasing context that transforms the place where the elderly person lives into a place of peace where fraternal relationships of love and not 'charity' prevail.

– *Spiritual assistance* is equally indispensable. This spiritual support, in addition to the religious support, represents a fundamental element in the visit to sick people, even when they are elderly. In a friendly dialogue it is possible to remember the books that the sick person has read, poems full of beauty, a small moment of pleasing music, or even a little game that will help the elderly person smile. Spirituality goes beyond religion.

3. *Through religious support, to the point of full communion, the visit reaches its full pastoral fulfilment*. When the sick elderly person is a man or a woman of faith, the religious dimension of help acquires a special importance. The meaning of life, illuminated by the

Gospel, gives meaning to the terminal stage of life, even during the period when the elderly person is closest to death. Precisely for this reason there is a need to prepare the sick elderly person to live this religious support in the best way possible. There are three elements that should be appreciated – prayer, the sacraments and the relationship with the Christian community.

– *Prayer* is an encounter with God in faith, it is dialogue with God about the different situations of one's life. In the visit to the sick elderly person the visitor should emphasise prayer, invite prayer, accompany prayer, recreate a prayer of action of grace, a prayer that is much more than a supplication, a prayer that fills the heart with peace.

– *The sacraments*, 'signs that express faith and strengthen it' (CDC, Can. 840), are indispensable in the pastoral action that accompanies a visit to sick people. This assumes that priests, too, are a part of the team of visitors. Through the anointing of the sick these last implore healing and call on God for serenity. Through reconciliation they receive the forgiveness of God and find themselves at one with all their brethrenn. Through Eucharistic communion they reaffirm unity in charity and accept taking part in the paschal banquet of happiness through the resurrection of Jesus. Lastly, through Holy Viaticum, when this is possible, they prepare themselves for the road that will lead them to the Home of the Father. Here, too, the sacraments are signs that strengthen and transmit the happiness of being Christian forever.

– *Participation in the Christian community* represents a challenge for the sick elderly person and for the visitor. If the sick person still has sufficient mobility then the visit is an invitation to visit the community to celebrate Sunday or experience the anointing of the sick on a feast day with a communal celebration. If the sick person has already lost his or her own mobility then the visit is the presence of the Christian family near to the sick person. 'Is any one among you sick? Let him call for the elders of the Church, and let them pray over him, anointing him with oil in the name of the Lord, and the prayer of faith will save the sick man' (Jm 5:13-15). The sick are members of the community, they take part in it and they are integrated into it through the relationship that the visit to the sick consecrates in a privileged way.

Conclusion

In a society that abandons its oldest members and which so very often marginalises them, the Church is happy to see them as the dearest members of its communities, great witnesses to a faith that has been lived, the spring of constant prayer for those who experience most difficulties, even on the pathway of faith. Sick elderly people are a true light of grace for the life of the Church. To be with them is to be with Jesus, in the hope of the Resurrection. A visit is a time of encounter with God and an opportunity for a fraternal commitment of love. For this reason, Jesus will be able to say to us: 'I was sick and you visited me' (Mt 25-36)

Rev. Msgr. VÍTOR FEYTOR PINTO,
National Coordinator for Pastoral Care in Health, Lisbon, Portugal, Consultor of the Pontifical Council for Health Care Workers, the Holy See.

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Il dolore di Cristo, però, non è un dolore disperato e triste, di sconfitta; al contrario, è un dolore vittorioso. Questa sofferenza è la massima realizzazione di Cristo, è la sua "ora", la sua maggiore glorificazione. [View more]

HIGHLIGHTED

Message of the Holy Father for the Sixteenth World Day of the Sick

«On 11 February, the memorial of the Blessed Mary Virgin of Lourdes, the World Day of the Sick will be celebrated, a propitious occasion to reflect on the meaning of pain and the Christian duty to take responsibility for it in whatever situation it arises.» [View more]

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