Presidenza del Consiglio dei Ministri

NATIONAL BIOETHICS COMMITTEE

BIOETHICS AND THE RIGHTS OF THE ELDERLY

20th of January 2006

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PREMISE

With regards to how we see old age, there is a sort of hermeneutic abyss between us and those who belong to previous generations, which is very difficult to overcome. In fact it is no longer possible today to consider the condition of the elderly by bringing together – according to another classic paradigm – the ontological and biological perspectives: it is no longer possible, in other words, to define what is old age analysing it from a reductionist point of view, starting for example from the loss of the ability to reproduce or from the "slowing down" of the intellectual activity or from the loss or the constant and irreversible weakening of any other specific physical-biological function. It is by now a consolidated point of view that "old age is the expression of a biology in an environment", according to Andreoli's expression, and that the environment is a meta-biological concept, in which psychological, political, social, historical-cultural dynamics interact.

Demography has explained how modernity has profoundly changed the structure of the population in modern societies, de-structuring the characteristic pyramidal form that characterised the relationship between generations for millennia and consequently radically changing our perception of the physicality of being elderly. It has changed with such speed that it has not allowed language to catch up: as acutely observed by Norberto Bobbio "nothing proves that a phenomenon is new better than realising that there are no words to describe it: even in official documents, tres ages follows ages", the young old, the new demographic category of those between sixty-five and seventy-five, is followed by the oldest old, who are older than seventy-five. The number of studies, which has been increasing in the last decades – as well as, more in general, the widespread experience we have all witnessed – convinced us that the paradigm of the elderly as victims of a progressive and inexorable psycho-physical decay, which annihilated his/her individual life and his/her social function, is unfounded. In other words, Terenzio's motto: Senectus ipsa morbus, has become absolutely obsolete. "Growing old – wrote John Eccles – is a relative concept. The so-called senescence is a process due to the slowing down or the reduction of intellectual possibilities, caused by a decrease in the ability to learn, memorise and create. But because it is defined in this way, there is no typical time when it appears".

Consequently, stereotypes deeply-rooted in the collective consciousness have collapsed or are in any case destined to be remodelled. The stereotype of the specific admiration due to senile wisdom, which would qualify it especially for political activity and the loss of which, still within the stereotype, is lamented by every generation, has collapsed. Envy for the once very rare event of longevity loses meaning, following the incredible increase in the average life span. The traditional irritation with the despotic, pretentious, arrogant and un-punishable old age, destined to be laughed at and chastised and that provided so much literary material, from ancient times until the 1800s, to poets, dramatists and opera writers, loses bitterness and acquires new connotations of goodness; but symmetrically also loses strength the tenderness towards a mild old age, with an almost return to infancy, portrayed in fables and myths (Filemone and Bauci). The stereotype of the atrocity of old age also collapses, an old age that can be compared to a decayed house, believed to be so detestable to make us hope for an early death (remember the classic saying Those who die young are dear to the gods, a theme we still find in the young

Leopardi, who hopes never to cross the threshold of old age); the fantastical illusions to find a way to eternal youth lose incisiveness and become vulgar in the collective consciousness, illusions that are more prosaically but also more concretely substitutes by the legitimate desire to have a healthy, efficient, socially guaranteed, sexually active old age.

Essentially, old age appears today as any other age of life, characterised (like any other age) by particular fragilities – and for this reason deserving owed and specific hygienic, biomedical and social attention -, but certainly not as an age when necessarily, because of an inscrutable will of nature, the right to health, as a fundamental human right not only to therapy, but in the broader sense of care, weakens.

Bioethical reflection has, from this point of view, infinite fields of action, especially socially. It must condemn all forms of violence, mostly underhand and indirect, inflicted on the elderly. It must condemn as a myth the idea that their psycho-physical decline is unavoidable and progressive; and it must condemn it as a dangerous myth, because it is in large part the reason for the discomfort – social, political, psychological – which often the elderly find themselves in, victims of dynamics of marginalisation that are intolerable from every point of view.

If bioethics is victorious in this battle (but really this is not a battle that can be won once and for all, because it is destined to reoccur every generation), it should not for this reason feel that its task is done. It should still fight a further battle, infinitely more complex: which has as its object not biology, but the ontology of the condition of old age as such. In fact, regardless of how much we dutifully and efficiently state the rights of the elderly and regardless of how much medicine can efficiently work to actually give them a biological support in exercising their rights, the problem of facing the biggest obstacle remains, as Romano Guardini wrote: “the secret hostility that growing life has for declining life”; we still have to face that widespread feeling of deprecation towards the elderly, which we rarely have the courage to take fully into consideration and that is rooted in the idea that it is unnatural for man to grow old and which is shown on the faces of the elderly, and it creates, in those who are not yet elderly, a profound anxiety, which is generally removed and hidden, but that even more often leads to feelings of aggression. If the task of promoting the defence of elderly life in its material dimension requires that bioethics, medicine and social politics work together, the task of taking seriously the very difficult dialectic between old age and the previous phases of life belongs probably exclusively to bioethics, as ethics of life. And we cannot say that bioethics, generally speaking, has the tools to carry it out.

With this awareness, the National Bioethics Committee in the plenary meeting of the 19th of September 2002 decided to start a working group, dedicating it to the Bioethics of the rights of the elderly. The interdisciplinary character of the research and the reflection on this topic led to nominating three different coordinators for the group, Profs. Adriano Bompiani, Luisella Battaglia and Annalisa Silvestro. Numerous colleagues were soon part of the group, amongst which Paola Binetti, Isabella Coghi, Carlo Flamigni, Romano Forleo, Laura Palazzani, Elio Sgreccia, Giancarlo Umano Ronchi. The first draft of the text was created through many and lively meetings; once the preliminary work was finished, the draft of the document was finally brought to the attention of the Committee in the plenary meeting of the 28th of January 2005 and in this occasion it was decided to entrust a further revision of the text to Prof. Cinzia

Caporale, in order to better structure and coordinate its different parts. The text that is now printed was then finally approved in the meeting of the 20th of January 2006: offering it to the public, the NBC is aware of the limits of its reflection, but at the same time rightly proud of having, with such commitment, brought this delicate and essential issue to the attention of Italian bioethics.

President of the National Bioethics Committee
Prof.Francesco D'Agostino

INTRODUCTION

The National Bioethics Committee presents to public opinion some reflections regarding the condition of the elderly in current society, inviting the public to consider more openly the dignity and the rights due to the people who are going through this particular phase of human life.

The Committee wants first of all to stress that a bioethics for the elderly is now absolutely necessary, as it is susceptible to involve different subjects (individuals, families, institutions, voluntary associations, etc.) and to be able to support a broad reflection on an urgent social issue that must be tackled from different perspectives: medical-healthcare, psycho-social, ethico-legal and finally anthropological, both with the interested people and the public.

The discussion about these topics has reached – both nationally and internationally – a very broad dimension for a variety of contributions, many of which of a very good quality. The NBC, even taking into account the main lines of thought that have emerged, did not however intend to attempt a synthesis of them, or to carry out a detailed analysis of the available literature. Neither did the NBC intend to linger on the financial issues that in many cases burden the person who has stopped working, or on the strictly political-administrative issues (although recognising that they are very important in the life of the individual), or debate the “classification” of old age with regards to the temporal limits and the denominations that have been suggested for the different classes (e.g. elderly, aging, long-lived, senior, etc.).

Including in the notion of old age that continuum of problems that happen after the end of professional work and in any case conventionally fixed at 65 years, with the present Document the NBC wants to stress with bioethical arguments the duty to adopt behaviours that – universally adopted – could contribute to reinforce the concept of the dignity of the elderly and support respect for the rights due to them.

The demographic issue

There is a widespread awareness of the importance of the phenomenon of the progressive increase of the average life-span for a balanced social set-up. A phenomenon that has grown in the second half of the 20th century, in particular in all the Countries with a high standard of living and sufficient alphabetisation and healthcare organisation, which is referred to as an element of “danger” for the foundations of the social protection system in many treaties.

Less widespread, at least in some countries, seems instead to be the awareness that the ageing of the population – intended as the global index of the social balance between the different classes of age – is influenced not only by the shift of mortality to an increasingly older age, but also by the decrease in fertility. As known, the ageing of the population and the decrease of fertility represent an inversely proportional phenomenon in many European countries, but that is particularly strong in Italy, where it is happening very rapidly.

Without entering here into a discussion about the ways in which the phenomenon can be tackled, the NBC cannot avoid suggesting that demographic phenomena should be brought to the public attention in the right manner. This approach, in any case always respectful of the choices that each individual makes when procreating, must not be intended as the mere

expression of a utilitarian ethics promoted by public authority to re-balance public welfare, but it should have the meaning of "solidarity between generations", that the NBC considers to be an essential ethical principle in the topic under examination.

In synthesis, in Italy in the last 50 years the over 65s have increased by about 150%, comprising in 2003 of almost 20% of the overall population. The growth is widespread everywhere in our country, even though there are considerable territorial differences: Liguria has the record for the highest number of elderly people (24.4% of the population); Umbria follows with 22% and Emilia Romagna with 21.9%. The lowest percentage belongs to Campania with 14.2%.

In our country as well, there are more women than men (in Italy there are 93.8 men for every 100 women). This gender difference, consolidated in the last decade for those over 75, is due to the progressive aging of the population and to women's longer life-span. In fact, although more males than females are born, men are affected by a higher mortality from a younger age, which means that in the overall population there are more women. The advantage of the female gender in terms of years lived is probably linked also to being less exposed to the risks of work and to profound differences in lifestyles: alcohol abuse is still mostly a male issue, whilst with regards to tobacco consumption young females are growing more than proportionally in number.

The aforementioned demographic variations have profoundly transformed the family, which is today often multigenerational and tends to "stretch" for the considerable reduction in brothers, sisters and cousins. The members rarely remain united in the original house where, more and more frequently, only one person lives, generally an elderly woman, due to the higher longevity of women. "Single-person" families, where there's no cohabitation with others, are almost one in four and in considerable increase compared to the past decade.

Because of its record in longevity, which unfortunately goes hand in hand with an increase in the dependency from the infrastructures[1], Italy could be a "laboratory" for other countries by proposing and trialling programmes and interventions directed to the social enhancement of the elderly who are self-sufficient elderly, but also to the prevention and care of the needs of the elderly who are not self-sufficient.

The epidemiological point of view

Together with the ageing of the population, we are seeing radical epidemiological changes, which interest first of all medicine and – more closely – healthcare and the different allocation of financial resources.

These epidemiological changes can be summarised as follows:

- The constant forward shift of mortality coincides with the progressive prevalence of chronic-degenerative diseases (cardio-vascular pathologies, tumours, diabetes, osteoporosis, dementia) compared to infective diseases which on the contrary dominated until the first half of the 20th century.
- The prevalence of chronic-degenerative pathologies goes together with other two typical aspects of the aging of the population: the increase in age –

[1] The "index of the elderly's dependency from the infrastructures" is the relationship between people of working age (15-64 years) and those of pensionable age (65 and beyond).

linked to co-morbidity and polypathologies, and disability, measured as common activities of daily life – namely, being self-sufficient in controlling the sphincters, washing and dressing themselves, moving within the house, feeding and taking care of themselves.

- The increase in age – linked to co-morbidity and disability is not however such to lead to a poor state of health for all elderly people: even amongst the over 80s, there is always a percentage of individuals – from 5% to over 20% - that does not have any illnesses and is perfectly self-sufficient.

From a medical point of view, old age is interpreted as that period of life when the probability of having to recur to medical treatments and therapies is higher.

This probability is certainly minimal in the age following – normally – pensionable age (in OCDE countries, about 65 years), whilst it becomes generally more relevant with the passing of time (from the concept of senior to elderly, etc.).

According to the most important conclusions to draw from the demographic-epidemiological data gathered so far, the NBC believes it possible to share these principles:

- Effective prevention is still “possible” also for very elderly people, as long as they are properly looked after by expert geriatric teams.
- The combination of co-morbidity and disability expresses the concept of “fragility” in old age, and it requires the intervention of workers with different professional specialisations and specific training.
- The fragile and disabled elderly needs an integrated system of services able to ensure continued assistance.

Whilst these principles apply to the ethics of the rights of the single elderly person, in parallel the demographic evolution described has invested public ethics, for which old age is examined in the perspective of legal regulations and, more precisely, of justice in the distribution especially of the medical-healthcare resources in a certain social context, in which the seen rapid increment of the elderly population and the corresponding increase in the cost of healthcare force us to establish criteria to fairly allocate limited resources. In this way started a debate on the essential characters of a healthcare system to be considered “fair”, a judgement that is given without contrasts in relation to the main ethico-political traditions (personalism, utilitarianism, liberalism, contractualism, communitarianism, etc.) found in society.

The “self-sufficient” elderly

Before examining more directly the bioethical issues arising from the fragility of dependency, the NBC believed appropriate to focus on considering also some aspects of the “physiology” of aging, intended from a point of view not only of physical changes, but of the “experience of old age” most people have.

This process of “being aware” of our existence as an elderly person and of the possible changes as such, is unavoidable for those who advance in age, and is present both in the condition of “self-sufficiency” and “dependency”. It is

however influenced by these states, it is felt differently by each individual, and it is in any case linked to a multiplicity of factors, partly “innate” and partly “environmental”.

For some time we have tried to identify “physiological” aging, offering an anthropological judgement valid for the conditions of self-sufficiency. However, in literature it seems evident that we cannot give a uniform judgement of it.

The NBC recognises that in the anthropological context we can define as optimistic comes forward in all its strength of millennia, expressed in the different cultures, the image of old age as the bringer of wisdom. A notion that is at the basis of gerontocracy in many societies that developed in the course of the centuries. This role, certainly today very weakened in western technological societies, is however not completely suppressed. Actually, many state that the elderly’s task to be wise is even more urgent in a society in which technological development risks of compromising human values.

On the other hand, in the widespread inclination towards a pessimistic judgement of aging, there’s an insistence in highlighting that senescence brings closer the perception of death, limits the display of physical and psychological potentialities as well as the harmonious relationship with the environment, emphasises any fragility and weakness with regards to health which, although they cannot yet be called illnesses, are the source of obstacles to better exercise any vital functions. The pessimistic judgement sees in old age a socially disagreeable condition, as it is linked to being “ill”, which very often society attributes to the elderly, and is in any case a source of “discrimination” with regards to exercising the ability to decide that can still be carried out by the elderly in society.

The NBC believes that each of the points of view is “authentic” in relation to the context in which each observer has experienced it. Visual perspectives that force us to make appropriate distinctions in formulating judgements regarding the age group under consideration, the state of health and especially the lifestyle. However, it is certain that biological life and psychological life happen in close and essential vicinity with the environment and that the lack of environmental stimuli (visual, auditory, of movement, etc.) reduces the brain’s ability to adapt at any age (as it can also be documented with an ECG).

From these considerations comes the suggestion – shared by the NBC – that in old age it is important to maintain a “job” able to stimulate interest and the senses, carry out physical exercise to consolidate motor skills, and develop a relationship with the environment that is “gratifying” for the individual (this corresponds to the so-called “active aging”).

We must also react to the progressive loss of “self-esteem” that generally happens with the loss of a work life or the loss of the primary role within the family and the rise of financial problems, and which leads the elderly to voluntary isolation and passivity. Literature validates the fact that the elderly who live alone, without family stimuli or in hospital, goes through this involution more. To tackle this phenomenon it would be useful to support the development of interests and occupations parallel to work, in order to widen the elderly’s cultural horizons and their socialisation.

The studies of religious philosophy – finally – confirm in the current elderly population the frequent presence of a spirituality open to religious faith. This factor is able to give hope and creative optimism in the elderly. Often it stimulates the solidarity towards other elderly people and it contributes to the cohesion within the family and in the community. Respecting each individual

conscience and the right to religious freedom, where this need is felt, it must be welcomed and supported, as faith, together with spirituality, are essential dimensions of the human spirit.

The elderly who are not self-sufficient

The NBC has considered, with particular attention, the "moral" situation of the elderly who are not self-sufficient, also called "dependant".

This is the state of those who – for reasons linked to the lack or loss of physical, psychological or intellectual autonomy -, need considerable assistance and/or help in order to carry out coherent actions in their life. Today, for the elderly, the following expression completes the definition: "in elderly people, dependency can equally be caused or aggravated by the absence of social integration, relationships of solidarity and sufficient financial resources"[2]. There are many bioethical problems that come from this context and some are of considerable interest:

a)Dependency and the measure of the quality of life

The problem has two aspects: subjective and objective. Both pose issues of definition and measurement. The quality of life could be defined "the satisfaction life gives, the individual well-being, physical, the ability to adapt to concrete situations (subjective assessment). The objective criterion, however, consists of measuring, according to a variety of scales and indexes that explore the absolute or relative dimension of a person's satisfaction, comparing his/her actual situation to the ideal situation in different spheres. We can ask ourselves if some of these investigations, carried out sometimes without much regard for the dignity of the elderly and the respect due to them, correspond to bioethical criteria regulating the research on man. The definition of quality of life is complex when facing dementia, where – in the investigations – there's no effective consent of the person. Welfare criteria that prevail in literature – and that indicatively are today widely accepted – seem to want to add quality to the remaining years rather than add years to a life without quality.

b)The bioethical principles that must be applied also to the condition of dependency of the elderly are:

- respect for the elderly's moral autonomy;
- integrity of the person, with "beneficial" attitudes and rejecting every expression of "maleficence".

From these two principles derive first of all the applications exemplified in articles 11, 15 and 23 of the Social European Charter of the Council of Europe (2000 edition) for dependant people, namely: right to the protection of health; rights of the handicapped – and many non-self-sufficient elderly people are – to enjoy their residual self-sufficiency, an adequate social integration and participation to the life of the community; the right of the elderly to social protection.

[2] Specialists of the European Group of Social Cohesion CDCS of the Council of Europe, 2002.

c)Strategies of assistance

These rights suggest five principles useful as the basis of the strategies of assistance:

- We must respect (as much as possible) the preferences of those who are dependent in order to encourage their sense of autonomy and well-being.
- Support services must be multidisciplinary and solutions that include care in the home should be preferred.
- The offer of services given must focus on the needs of the individual person.[3]
- It's important to ensure the equality of access to services that must be shared within the territory proportionally to the density of the population and made easy to access.

d)The respect for the integrity of the elderly and the non-maleficence

The NBC also considered bioethical issues regarding the respect of the physical and moral integrity of the elderly, focusing its attention on mistreatment, abuse and abandonment, including violence. With regards to this, we must stress how containment can become maleficence towards the elderly, intended as mechanical or pharmacological limitation of an individual's capability of free movement. This containment is absolutely wrong when it is applied without a more than justifiable reason and only for the purpose of protecting the person's well-being. The same identical judgement is valid for an unjustified isolation.

We must also highlight the changed public conscience, also in our country, towards the problem that is historically and seriously emerging from the protection of the weaker subjects – amongst whom, obviously, the elderly, especially those affected by pathologies -, a change that has led to a new way of reading articles 2 and 3 of the constitution, clarifying the meaning of some fundamental values (dignity, equality, freedom, physical, psychological, relational and spiritual integrity). A renewed respect for the human being, for his/her autonomy and his/her legitimate expectations, has been emphasised also in international and European Community documents. We can mention the Ajax Convention of the 13th of January 2000, which recommends the protection of weaker subjects and indicates, amongst the tools to use, the possibility of the individual to provide a mandate to act, given both through a contract and a unilateral act, for the future and eventual hypothesis of the onset of a state of incapacitation or limited capacity. In addition, the European Union's Charter of Fundamental Rights (2000), which in article 25, "The rights of the Elderly", recognises their right to "have a dignified and independent life and participate to the social and cultural life"[4].

[3] In this sense, it is useful to assess these needs accurately: see the "multidisciplinary nucleus of assessment", anticipated in Italy in the "Progetto obiettivo anziani", positively operating in some places.

[4] We can also remember that with regards to provisions about the fostering of minors when a family is in crisis, it has been recently dictated by the legislator that the minor has the right to "maintain significant relationships" with their relatives. A regulation anticipated in the law that, for some time already, recognised and regulated the chance to meet and see grandparents, believing in family tradition ties, of which the oldest representatives are a fundamental point of reference for a correct psycho-physical development of the minors (Cassation number 9606/1998; number 1115/1981).

Expressions that have been a primary point of reference for our legislator in deciding to issue law number 6 of the 9th of January 2004, which instituted the "support administration" and that represents a break from the previous and consolidated rigid and ancient cultural schemes with regards to the protection of fragile individuals. In fact, it is a law that intends to "support" all those who cannot, even temporarily, look after their interests and express the principle that the "support" of the care of the person and his/her interests is not limited to the financial sphere, but also takes into account the needs and aspirations of the man, including every activity significant to social life. An institution that has allowed, in cases like that of progressive dementia, to leave to residual legal solutions the deprivation of civil rights and disablement that, perceived by the community as "social death", are "excluding" events in the social context, far from supporting and promoting the individual.

Voluntary work and "looking after" the elderly

The NBC highlights the importance of the development of a network of voluntary associations and/or non-profit-making cooperatives, which show society's focus towards the problem of caring for both elderly who are self-sufficient but lonely and without the support of a family, or non-self-sufficient. Obviously, we must stress that these initiatives must not and cannot substitute the duties of public institutions, but maybe should integrate their action. The expression of a "friendly" section of society is also the voluntary work that looks after the elderly by simply managing the "presence" and the "company", when the elderly is confined (especially because of age or slow chronic illnesses) at home. Voluntary work offers empathy, for example by reading, talking, substituting for a few hours a family member who is necessarily occupied elsewhere, carrying out small household chores. The positive "moral significance" for those receiving, but also those offering, this sharing of experiences seems evident.

The rehabilitation

Rehabilitation must be intended not only as a set of techniques and methodologies, but also as a philosophy of interventions intended to give back to the person his/her previous functional and environmental state, or, alternatively, to maintain or maximise his/her remaining functions[5]. Therefore, the ethical contents of it are high: it is a philosophy of intervention that is antagonistic to disability and the passive acceptance of it. A moral tension will have to support the individual to rehabilitate and the personnel, to overcome physical and psychological barriers, to compensate that margin of disability and handicap that remains insurmountable, to develop new potentialities in the person as a whole.

[5] Williams, 1985.

PART ONE: **BIOETHICS AND SENESCENCE**

1. OLD AGE BETWEEN PHILOSOPHICAL REFLECTION AND BIOETHICAL INVESTIGATION

In the current bioethical debate, the issue of aging is mostly considered from two points of view: a medical point of view (old age is interpreted as that period in life when the probability of having to recur to medical therapies and treatments is higher) and a public ethics point of view (old age is examined in the perspective of the regulation theories of justice and, more precisely, of the equity in the distribution of the medical-healthcare resources available in a certain social context).

The two points of view, however important and full of problems, seem however of limited import as they offer a partial – if not reductive - understanding of the experience of aging. In fact, as well as overlooking the psychological and socio-cultural aspects relative to the significance of old age in contemporary society and the issue of the relationship – especially the communication – between generations, in the profoundly changed contexts of family and society, do not properly tackle the crucial problem of the meaning of old age in the life of the individual and the collective existence.

Aging today is a phenomenon that has peculiar characteristics at least from three points of view[6]:

a. The quantitative dimension (we talk about a structure of the population that, in perspective, could even be dominated by the elderly);

b. The prolonging of life and the parallel increase in the lack of autonomy (or no self-sufficiency), which causes situations of dependency that require increasing healthcare interventions.

c. The different way of organising and living free time in comparison to work, forming a family, as well as a new system of rights and duties that considerably influence the cultural change.

It is, therefore, a structural phenomenon that corresponds to a problem this industrial society is going through, and that signals a big social change, relative to our model of development and to the rules of living together.

As I approve of a youth that has something of the old man in him, so I am no less pleased with an old man that has something of the youth; he that follows this rule may be old in body but can never be so in mind.

Cicero, De Senectute

Unfortunately aging even today is not active, the way it could (and should) be: marginalisation, exclusion, isolation but also frauds, aggression, abuses, threaten to make it a dangerous age. Our culture does not give old age a good image: if anything, it suggests the idea that it is possible to stay young forever. Even the messages we get from some spheres of scientific research tend to convince us that aging can be fought, making us hope that it will not exist or that it will affect only others, those we see as old. From this, the need of a reflection that, as well as showing how aging involves all of us directly, invites

[6] R. Scortegagna, *Invecchiare*, Il Mulino, Bologna 1999.

us to discover its contents, know its ways – both to understand other people's old age and accept ours.

1.1.THE CONSPIRACY OF SILENCE[7]

Recognising the process of aging, in its authentic reality, understanding it in its characteristics and fluctuation is the condition necessary to fully own it. On the contrary, in modern society aging tends to become a sort of taboo, a forbidden topic, as if it didn't exist. But against the incurable disease of aging neither the exorcisms of analytical reason nor the processes of collective removal are effective.

The category of "other" could be adopted to characterise the condition of the elderly as perceived – and often treated – in society. Namely, adults tend to see in the elderly not another person like them but an "other". An "other" whose image can be sublimated or degraded but that is in any case outside of the human.

The situation of the elderly can be seen from this particular point of view: although they are, like any individual, an autonomous freedom, they discover and choose in a society that forces them into the role of "other". The drama of the elderly consists in the conflict between the fundamental claim of every individual to be essential and the needs of a situation that makes him/her inessential. Given this condition, how can he/she claim his/her full humanity and gain that minimum that is necessary to lead a life deserving of this name?

According to de Beauvoir, we push this ostracism so far that we even force it on ourselves, refusing to recognise we will be old.

Of all realities, old age is perhaps the one of which we retain a purely abstract notion for the longest time", Proust rightly said. All men are mortal, that we admit. But that many will become old, almost no-one thinks about as a metamorphosis.

Simone de Beauvoir, La Vieillesse

But how does discovering old age happen? According to Goethe "age catches us by surprise". Each of us is, for him/herself, the only individual, and often we are surprised when the common fate becomes ours as we face illnesses, misfortunes, deaths. Old age is a destiny and when it comes into our life it leaves us shocked: that the universal passage of time leads to a personal metamorphosis is disconcerting. But old age is particularly difficult to accept because we have always considered it as alien: would I therefore become someone else whilst still remaining myself? In effect, we consider with more clarity death than old age. Death is part, in fact, of our immediate possibilities, threatens us at any age, we happen to brush with it, often we are afraid of it, whilst we don't get old in an instant. Young or fully mature, we don't think we are already inhabited by our future old age, which is separated from us from such a long time that in our eyes it becomes confused with eternity: a faraway event that seems unreal. At twenty, at forty, thinking about being old is the

[7] Cf. Simone de Beauvoir (1908-1986) in *La Vieillesse*, the book that maybe more than all others broke the "conspiracy of silence" on old age (Editions Gallimard, Paris 1971).

same as thinking about being someone else and there's something frightening about any metamorphosis.

But old age is also different from illness, with whom is at times confused (senectus ipsa morbus): this in fact tells us of its presence and the organism defends us against it. Illness in addition exists more evidently for the individual who suffers it than for those who surround him/her and often don't realise its importance.

Old age, instead, appears to others more clearly than to the individual: it is a new state of biological balance and, if adapting happens without shocks, the individual does not realise he/she is getting old. Artificial things, habits, allow the attenuation, for a long time, of psychomotor deficiencies; indispositions due to senescence can be just about perceived and kept quiet: we must have an awareness of our age to decipher them in our body. Many want to believe they are young at all costs, preferring to think they are in bad health rather than old. Others find it easy to define themselves as prematurely old, seeing in old age a sort of alibi; others, without accepting old age, prefer it however to illnesses that scare them and would force them to take countermeasures.

Therefore, how does the discovery and the acceptance of old age happen? The revelation of the other who is in us, of our new image, comes in fact from the outside, from those who look at us.

1.2. THE IDENTIFICATION CRISIS AND THE PURSUE OF MEANINGS

In our old age we have an identification crisis: our image is at stake. We try and represent who we are through the way others see us. There are times when this is enough to reassure us of our identity – this is the case with children who feel loved and are satisfied of that reflection of themselves which they discover through the words and behaviours of their family and to which they conform, accepting it as their own. At the beginning of adolescence, that image shatters and a similar wavering also happens at the beginning of old age. In both cases, we talk about an identification crisis even though there are great differences: the adolescent is aware of going through a transition, his/her body changes and this embarrasses him/her; the elderly individual feels old through others, without having felt serious changes: inside, he/she does not agree with the label given to him/her, and ends up being unsure of who he/she is.

In this new condition, whether we like it or not, we end up giving in to the point of view of others, but this is never easy.

There is in fact a discrepancy between the situation we live and experience inside and the objective form that it has for others but that escapes us. In our society, the elderly person is designed as such by habit, by the behaviour of others, by vocabulary: he/she has to accept this reality. There is an infinity of ways to do this, but no-one will allow me to agree with the reality that I accept. To avoid old age becoming a comedic parody of our previous existence, there is only one solution, namely, to continue to pursue aims that give meaning to our life: dedication to other people, the collective, a cause, social or political, intellectual or creative work.

Contrary to what is sometimes suggested by moralists – who preach the serene acceptance of the evils science and technology cannot eliminate – we should maintain into old age passions that are strong enough to stop us from

falling back on ourselves. Life, in fact, has value as long as we give value to the life of others, through love, friendship, indignation, compassion. We retain, then, some reasons to act and talk. The condition of old age seems to suggest a reconsideration of the relationships between men. If culture was not an inert knowledge, acquired once and then forgotten, if it was living, every individual would have a hold on his/her environment able to realise and renovate itself during the years and he/she would be an active and useful citizen at any age. If the individual was not atomised since infancy, closed and isolated amongst other atoms, if he/she participated to the collective life, as daily and essential as their own, he/she would not know the exile of old age.

And how should a society be, for a man to remain as such even in his old age? The answer is simple: it would be necessary for him to have always been treated as a man. It is in front of old age, in fact, that society takes away its mask: the way in which it treats its inactive members tells a lot about it and how much emphasis it places on the mere productive function of individuals.

On the other hand, the elderly can also become accomplices in an oppressive culture of having to be, which is assigned to them by authority. In exchange for the protection it offers, they can be pleased with the role of “other” and trade their freedom, their individuality for that protection, which is actually more apparent than real. We know, in fact, that every individual, as well as the need to be known as an individual – which is an ethical need – has in him/herself the temptation to escape his/her freedom, to transform into an object. It is a fatal journey but it is also an easy journey: in fact, in this way we avoid the anguish and the tension of an existence lived authentically.

It is not, in fact, only society but our subconscious that defines the elderly as “other”. Whilst in the first case the process of deconstruction of what is “other” regards the social (the images, myths, stereotypes that surround old age), in the second, our subconscious is involved and this process appears, therefore, more complex because the taboo involves us. On the other hand, we can see a collusion between society’s myth of youth and our subconscious.

In front of the image of our future that the elderly propose, we remain incredulous, a voice inside of us murmurs absurdly that this won’t happen to us, that we won’t be ourselves anymore when this will happen. Old age is something that only regards others.

And this way we can understand how society is able to stop us from recognising ourselves as elderly. To see in old people not “others” but people like us, in order to no longer be indifferent to the destiny of someone we feel as far, alien, separate but is instead close, familiar, near, it is necessary what we could call a perspective identification, the recognition, that is, of our identity before that time in our life.

Individual aging is part of the human adventure that raises the fundamental questions of existence: confronted by its limitations, the elderly person reinterprets his/her presence in the world. In this story he/she is not isolated but remains strictly in line with the cultural, social and family group to which he/she is connected. In fact, each society attributes, implicitly or explicitly, a role to their elderly and it organises responses to the needs of the weakest, in particular of the non-self-sufficient “great old”.

Also in light of these comments, we can be surprised about the little interest towards the problems of the elderly in ethical debates, which certainly do not ignore the data relative to the so-called “weakest subjects”, however, the issues linked to old age (socio-family isolation, lack of financial resources,

dependency) are rarely the object of an in depth reflection. Old age still remains a marginal issue in our western society despite medical progress putting in a new context the experience of aging and the approach to death.

In the West the most important things, functionality and usefulness, make us age really badly. In fact, we don't age only because of biological decline but, as we have seen, also and especially for cultural reasons and precisely for the idea that our culture has of old age. On the other hand, the discussion about the meaning of old age cannot be purely theoretic. Each of us is confronted with the reality of a possible event, for him/herself, his/her parents and friends: the questions to ask presuppose a personal investigation in relation to the issue of being "other". It is, at the same time, about recognising the "other" as him/herself and respect, beyond what is expressed, the secret of his/her complex individuality. In situations of dependency, all those involved (and there are many, from the children to their families to the institutions and political authorities) must appeal to their ideas of person and respect for his/her dignity. Each person is in this way called to justify his/her interpretation of the notion of solidarity, progress, the idea of its power on life.

2. FROM CARE TO TAKING CARE, TO SELF-CARE

If it is undoubtedly true that the issue of aging is closely linked to other very important bioethical issues (the end of life, the right to health, therapeutic persistence, etc.), it however needs to be examined in itself as a phenomenon that presents a specificity and characteristics that must be put through a rigorous philosophical analysis.

In particular, the issue of the value of old age cannot be examined assuming as the model of reference only health. Health, even intended as full psycho-physical vigour, does not seem an adequate measure to search for the possible meaning of the condition of old age and, in general, of the various phases of life. This is fitting for old age, where we consider the increasing frequency, with the passing of years, of the condition in between full health and full-blown illness, which does not take away value from the dignity of the elderly.

If we had to compare old age to illness, we should maybe choose a condition of "normality" in the life of a man as the only parameter to define health. This cannot happen because each human age has its "normality": there are, in other words, many normalities in relation to the different ages (infancy, adolescence, maturity, etc.). In this sense, old age is not the "loss of normality", but is in itself a normal condition, connoted in a specific way at all levels – physical, psychological, social. Too often however, according to a perspective that can be seen in Western cultural models, illness itself can be used as an instrument to mask old age: as illness can be cured, it is legitimate to hope to get better; if this then doesn't happen, it is the fault of the inabilities of medical sciences, never old age. It is a kind of idea that stops us from fully recognising old age, however, with the scientific paradigm according to which, sooner or later, we'll find a solution to the illness. It can then happen that we give up taking care of aging, in its globalism and its dimensions, to chase hypothetical treatments, with the consequence, sometimes, that the choice of the programme of care loses the reference to the elderly's quality of life.

As Daniel Callahan, one of the scholars of bioethics more involved in this topic, wrote:

"The search for the meaning of health and the search for health do not walk hand in hand"[8]. Modern medicine's temptation to put forward its ways to judge in terms of health in order to determine the global value of people's lives, does not take into account the complexity of this value that appears – in its essential traits – rather linked to time and the relationships that exist between the past, the present and the future.

The improvement of the conditions of life (more availability of resources, better diet and personal care, more secure home hygiene) and therefore of the hygienic-healthcare conditions of our life (disappearance of the great epidemics, better care of the environment, etc.) must be attributed to the technico-scientific progress. On the one hand, the results of scientific and technological research, especially in the medical and biological field, allow us to tackle in increasingly more effective ways many illnesses, with interventions and treatments that were once unimaginable, on the other, the changes in the field of the organisation of work and the economy (deriving from the applications of scientific research and technological development) allow us to reduce our effort and the reduction of the time we spend working.

We ask, in light of these issues (increase in the average life expectancy, corresponding growth of the medical needs, relative increase of healthcare expenses) regarding medical practices and their aims, in the framework of a challenge for the self-understanding of medicine. One of the main problems is how to reformulate its relationship with health and sickness. According to Callahan, we must give more importance to achieving a good quality of life than to fighting illness, putting into question again some traditional attitudes towards death and life (those, for example, for which medicine opposes death by strenuously defending life).

In this way, we support a change in our healthcare system, aimed at the cure rather than the care – a sort of revolution in our way of thinking and our habits. Instead of a system aimed at increasing life expectancy, we should elaborate a philosophy of medicine and a type of healthcare assistance able to identify a better balance between curative and aggressive (technological) medicine and the most patient one of taking care.

With regards specifically to the elderly, this philosophy should recognise that they need interventions aimed not at prolonging life at all costs, but to avoid premature death and to guarantee a qualitatively good existence within the said limits.

In the view of aging as a "race against death" there's the attempt to hide death, in which we see, in any case, the sign of defeat. For this, there are specific places to welcome the dying, quickly taking them away from the community of the living, or they are relegated in hospital wards or hospices. It is here that aging questions culture, ethics, social organisation, politics: the answer must not be looked for within the debate on euthanasia but in the system of individual rights, in the framework of a bioethics of caring, that takes on the defence of the rights of the weakest subjects.

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[8] By Callahan, see in particular: *Setting Limits*, Simon & Schuster, New York 1987; *What Kind of Life?*, ibid. 1993; *The Troubled Dream of Life*, ibid. 1993.;*La medicina impossibile. Le utopie e gli errori della medicina moderna*, it. tr., Baldini & Castoldi, Milan 2000.

Today we have a medicine that is reluctant to accept our common destiny, which is old age, decline, death. In this sense, the anti-aging movement and highly technological medicine are allies as each confirms the prejudices of the other: one in minimising the general characteristics of old age, the other in tending to fix the individual bodies deteriorated by their mortality. There is no limit, says Callahan in this regard, to the possibility of spending money to fight against the inevitable biological decline and the inevitable death, which are inherent to old age.

Callahan comments that it is the predisposition we have towards technological medicine that requires the investment of disproportionate amounts of healthcare resources.

On the contrary, a philosophy of medicine aimed at the bioethical principle of taking care and focused on defending the quality of life can better put the individuality of the person in a context of more social interdependence and of careful acceptance of our mortality. The priority of this kind of medicine will not be to infinitely lengthen life but to use our resources to make sure that old age is a time of conclusion and enrichment, putting in first place nursing assistance, wide social services in order to help the elderly who are chronically ill and their families.

It is maybe superfluous to stress that we propose not to eliminate technological curative medicine but only to put it in the right perspective, making it less important in the future, highlighting new priorities.

People, we have said, have the right to “getting old living”, enjoying, that is, a quality of life that corresponds to the highest possible level of wellbeing. But it is necessary, with regards to this, to point out the absence of an adequate reflection about the issue of the minimum parameters of quality of life to protect for the elderly, as opposed to, once again, of scientific research, clinical trials and, sometimes, therapeutic persistence. This same predisposition towards curative medicine risks of depriving old age of meaning.

2.1. THE BALANCE OF COMPETENCES FOR THE ELDERLY

Old age is characterised on the one hand by an increase in illness, inability, dysfunctions, but on the other hand we should also consider the rise in unpredictable intellectual and emotive resources, which give it new boundaries and perspectives. The lack of agreement on the concept of aging makes it difficult to collect reliable data on this issue, even if everyone agrees that it cannot coincide with merely chronological criteria.

The elderly’s level of social dependency is currently becoming the parameter of reference to predict and calculate the type of resources they will need at a certain time, in order to organise in the proper manner the necessary resources. Old age is not identified so much with age, as with the level of social autonomy, which contextually measures how the individual is able to take care of him/herself and possibly of others around him/her – often it’s an elderly couple - how he/she is able to tackle and resolve his/her own problems, using the resources usually available in the socio-healthcare system, and thirdly what is his/her the social network: the number of active relationships, their efficiency

and their mutuality[9]. For some years already, at the socio-healthcare level, there is a tendency to see the elderly in a perspective of self-care, going through a permanent project of training, so that the individual re-learns to manage his/her resources taking into account, rather than the inevitable limitations, the available personal resources or social network resources[10].

If the reference to social autonomy and the ability to face daily experiences is made more explicit, the process of aging is less likely to be tackled by medicine and to be identified with psycho-physical discomfort, even though obviously these data are important in changing the way the elderly see themselves, their personal safety and their perception of the social network. If we accept that old age can be expressed especially through the consumption of healthcare resources in a certain amount of time, because it is not identified with shared criteria, like the healthcare needs seen through hospital admissions, day hospitals, surgeries and instrumental diagnostic. These are necessary but insufficient data to describe the new boundaries of old age, not always fitting to start an effective action of prevention, or guarantee a better quality of life and limit the emerging costs.

It has authoritatively been said that the level of civilisation of a society is measured by the degree of care and protection towards the weakest individuals in the community. Given, however, that old age seems to always be a polychrome galaxy to the point of being able to refer to old ages in the plural, we must certainly overcome the stereotype of the elderly "alone" as a problem, in order to increasingly see the old person as a "resource"[11], whatever his/her psycho-physical state. This, therefore, overturns the social perspective towards the elderly also from a religious-spiritual point of view and the point of view of values.

We can therefore talk about a society that grows in civic maturity not only when it safeguards and protects, but when it promotes the person and frees his/her resources, at any time in his/her life. Operatively, this goes through the necessary organisation of services, civic administration, "adequate" housing for the man in his totality.

For the elderly person, therefore, the solution is not so much and only to increment the socio-healthcare services, but to promote what has been defined as Active Aging[12]. Old age is an age that – if "educated" – can still be active and creative according to each person's ability in each single phase of their life.

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[9] D. Demetrio, *L'età adulta*. *Teorie dell'identità e pedagogie dello sviluppo*. La Nuova Italia scientifica, Rome 1990.

[10] W.A. Mc Intosh *et al.*, *Social support, stressful events, strain, dietary intake and the elderly*, Medical Care, 1989, 27 (2), pp.140-153.

[11] Cfr. Antico, E. Sgreccia, *Anzianità creativa*; G. Baldassarre, *Da fardello a ricchezza. L'anzianità del nuovo millennio*, Edizioni dal Sud, Modugno (BA) 1999; L. Baracco, *Una vita lunga e serena*, Casale Monferrato (AL), Piemme, 1999; M. Cesa-Bianchi, *Giovani per sempre? L'arte di invecchiare*,Editori Laterza, Bari 1998; Vissani, Salvi, *La donna marchigiana*; De Rose, Sacchini (a cura di), *L'età in gioco. Anziani in Calabria tra vecchie e nuove identità.* Soveria Mannelli, Rubbettino 2002.

[12] With the term Active Aging we intend an active, creative old age, shaped – as much as possible by the individual subjective and objective situation – by the will and involvement of the elderly in different activities. With regards to this issue, see Antico, E. Sgreccia (ed.), *Anzianità creativa;* L. Antico, *Gerotrascendenza e vecchiaia attiva*, in Petrini, Caretta, Antico, Bernabei, *L'assistenza alla persona anziana*. *Aspetti teologici, etici, clinici, assistenziali, pastorali*, CEPSAG-UCSC, Roma 1993, vol. I, pp.11-22; K. Avlund *et al*., *Active life in old age. Combining measures of functional ability and social participation*, Dan. Med. Bull., 1999, 46 (4), pp. 345-349.

Moreover, a highly civilised society puts into place pedagogic strategies to prepare for the condition of old age (the so-called geragogy). What we want to state, instead, is that the human being, with his/her rights and duties, has a dignity and a richness that must be promoted in each phase of his/her existence. The elderly must be always considered as subjects participating to the construction of society, according to each individual's capabilities. In this sense, then a mature society is called to not overlook individuals when they become old but to promote their resources of culture, ability to pass on values and experiences, individual current capabilities of spirituality and religious thought: we can in this sense fully realise the notion of Active Aging.

2.1.1. HEALTHCARE CENTRES FOR THE ELDERLY

The creation of Healthcare centres for the elderly has allowed a better integration of rehabilitative-welfare interventions, unifying them in a single context in which they are more easily accessible for the elderly and their families, and it has allowed us to experiment some positive actions to improve their health, through a series of socio-psycho-pedagogic interventions, starting for each elderly person from assessing his/her competences. This assessment has the objective to let someone know his/her competences better, clarifying them in relation to a new personal or professional project, highlighting the means and phases necessary to realise it. The main characteristics of this assessment come from a synthesis of known procedures that associate a psychological analysis of the competences to an active pedagogic dimension. The most important means to carry out this type of assessment are a personalised empathic listening and careful observation, during a suitably long time, to verify the concrete ways in which different situations are tackled and managed. This is a journey that includes theoretical, methodological and operative aspects to go through together with the elderly. The perceived quality of life is linked to his/her history, and it also changes the way in which he/she responds to new situations, without someone making decisions, deciding the time scale of events, characterising the solutions he/she slowly arrives to[13]. The problems of the elderly, like anyone's, at whatever age, must be tackled with an integrated approach to guarantee the necessary level of socio-welfare quality. We cannot reduce the perception a person has of him/herself to his/her perception of his/her illness, or poverty, forgetting the cultural and professional experience he/she has had for a number of decades. Many WHO documents often highlight how the fundamental objective is to make the total life expectancy coincide with the expectation of an active life: adding life to the years is more important than adding years to life.

Currently, in the most advanced structures dedicated to the elderly, a multi-dimensional evaluation of their care-needs is carried out by using a range of tests that explore the functional and environmental issues not included in ordinary objective examinations. It is a more thorough approach, but still focused on the needs of care. To change the approach to the elderly by avoiding introducing medications and implementing instead the focus on their abilities and the energy actually available requires a project that anticipates:

[13] N.P. Roos, E. Shapiro, L.L. Roos, *Aging and the demand of health Services, which aged and whose demand?* Gerontologist, 1984, 24, pp. 31-36.

• a different anthropological basis for the definition of old age,

• a new psycho-pedagogic competence to identify the active resources on which to intervene,

• a socio-healthcare network adequately motivated and competent.

To tackle this new challenge that, although it can also involve a reduction in costs for the National Healthcare Service, must be taken on mostly for the improvement in the elderly's quality of life, the hypothesis that monitoring their health cannot be done only with the traditional clinical approach has been formulated. There will always be cases where the level of disability requires an uninterrupted intervention for their physical rehabilitation, as a consequence of cardio-vascular, neurological or post-traumatic pathologies. But even then the best recuperation happens by integrating the psycho-motor field (never only motor), with that focused on a personalised project to strengthen the learning abilities, after carrying out an evaluation of their competences. The professionals involved in this process are very varied and include the geriatrician, physiatrist, but also the nurse, the physiotherapist, the speech therapist, the psychologist, the educator, etc. With all of their contribution a port-folio is created[14], which is something simpler than a medical record, in which are collected, in an organised but often fragmented manner, the clinical data regarding the elderly: it is the description that suggests the assessment of their active competences[15].

To define what the assessment of competences is however, it's not easy. The assessment of competences must allow the elderly to take into consideration all their professional activities to explain their personal and professional experiences: finding and evaluating their acquisitions linked to work, training and social life; better identifying their knowledge, competences and habits; discovering their unexplored potential; collecting and structuring the elements that allow them to elaborate a personal and professional project, better managing their personal resources; organising their personal and family priorities, better use their resources in negotiating their needs with external interlocutors. The assessment of competences is found in the boundary between a retrospective dimension: the important moments of their professional activity and socio-family life, to rediscover the acquired competences, centres

[14] The port-folio is an instrument that in the last few years is becoming increasingly interesting, because it allows us to overcome the quantitative reductionism of an assessment and it opens towards a qualitative description of what the subject has done and learnt to do. And at the same time it is a memory of the things done and a project of things to do, so that it contextually explains the results achieved and the processes started. It is also important for the elderly, because whilst from a certain point of view it represents their overall history, on the other it explains their current interests, as well as their difficulties, and it changes both in a rehabilitative project. As a product it includes the things done, with the relative objective evaluations. As a process it expresses the things to do, with the subjective evaluation of the motivations and the difficulties. It therefore belongs to the sphere of the meanings that the elderly wants to achieve, intentionally calling into play strategies of change. In the portfolio there are different types of documentation: personal history, with the knowledge and the awareness of our resources; the results of all the tests carried out, to investigate particular aspects; the type of commitment with the Centre; the plan of activities anticipated for the future, with the relative people responsible; the references to the medical records held by the Centre. The portfolio is the frequent object of discussion with the elderly, which contributes to their renewal, with regards to their personal history, and it continuously revises progress and difficulties with the operators, to redress the aim.

[15] A. Di Fabio, *Bilancio di competenze e orientamento formativo, Il contributo psicologico*. Giunti, Firenze 2002.

of interests and the reasons of a perspective dimension, which allows them to realistically formulate new choices, making the right decisions.

In the assessment of competences, the diagnostic-evaluative moment is seen as educational, as it expresses openness towards a new phase of life, with characteristics partly equal and partly different from the previous ones, but in any case it is still our life. The assessment of competences, whilst giving back to the elderly an awareness of their capabilities, reminds them of the urgency to adapt them to new situations and probably also the need to gain new ones. In other words, it looks at old age in terms of a new learning phase, with its own peculiar physic-pedagogic approach, that goes beyond the confines of involving medicine (even though often necessary).

The slogan, which characterises this approach, is to remember that we need to learn to age to realise interesting things and maybe never done or done so far in a different way. The technico-methodological directive of reference therefore moves away from a strictly diagnostic notion and it turns in a new opportunity to learn, which involves the individual actively. In this way it becomes possible to think of re-evaluating the social involvement of the elderly in society, both with regards to family as a wider social network[16].

The basic objectives of an assessment of competences therefore are:

Support the critical reconstruction of their professional past, to highlight abilities and competences that can be used within other contexts;

Facilitate the identification of the individual's values, preferences, interests and motivations;

Help them to elaborate a personal and social project, eventually also with professional aspects, to negotiate the possibilities of expression and realisation of the individual.

The assessment represents for the elderly the opportunity to verify their ability to transfer the wealth of experiences and competences accumulated previously to the new situation, making the necessary changes and therefore strengthening their ability to modify in their favour the situations of change.

2.1.2. The different phases of the assessment of competences

The intervention on the Assessment of competences is structurally a team effort, in which the role of psychologist, who can be the trainer to strengthen in the individual the perception of his/her own self-efficacy[17], has the contribution of new Educators. They have to be able to elaborate with the elderly a project-development aimed at strengthening their capabilities, which go from the guarantee of the minimum levels of autonomy to higher profiles of commitment. The objective is to reach a project that reduces the gap between the plane of aspirations and the fear of our own inability to get there, to identify a way to realistically see the strategies necessary to realise what we need[18]. The educator in this phase uses both teaching-training techniques, and counselling strategies[19], to achieve a positive perception of self. The terms ability, aptitude,

[16] F. Boschi, A. Di Fabio, *Apprendimento e nuove dimensioni della mente*. Continuità e scuola, November-December 1997, pp.72-85.

[17] A. Bandura, Self-efficacy mechanism in human agency, American Psychologist,1982, 37, pp.122-147.

[18] L. Arcuri, *Il Sé come soggetto e oggetto della cognizione sociale*, Laterza, Bari 2000.

[19] A. Di Fabio, *Counseling. Dalla teoria alla applicazione*, Giunti, Firenze1999.

qualification and competence are not synonyms, even though they are partially included one into the other. Usually a competent person is able to face complex situations and resolve his/her problems using his know-how flexibly. It requires a certain dose of creativity to be able to transfer their own abilities in situations that are not always foreseeable beforehand, even when lacking the usual resources used in similar situations. Studies on the elderly's learning abilities show in these two aspects the most problems: the transfer of the abilities they have in fields that are slightly different from those who belong to the boundaries of daily life and the application to known contexts of consolidated, but reduced, abilities. The relationships between the elderly with themselves and their context are still at play: social-family, technico-organisational, etc. To teach and to learn again to manage him/herself and the circumstances is the objective of this new approach. It is a dynamic assessment aimed positively, which includes also the possibility to teach the elderly how to use new technical and behavioural strategies, overcoming the levels or anxiety linked to change[20].

The training of workers in this field is not easy or obvious. It is not about observing or assessing objectively, but being with the subjects and accompanying him/her in the effort to clarify what are the things he/she would like but can't do, discreetly suggesting alternative ways, without substituting ourselves to him/her. It is important to stimulate the elderly to exercise a strong self-attention to grasp the right associative connections between perceived competences and tasks to carry out. Rather than an expertise, it is a structuring help, strongly interactive and linked to a pedagogy of appropriation. What is decisive is to interpret old age not so much in terms of loss of ability as in terms of permanent training, with particular categories, both from the point of view of methodology and assessment[21].

The emergency elderly is still a novelty in our socio-healthcare context and it is not easy to overturn the medical approach, almost the only one until now, in favour of a psycho-educational approach, in which the focus is not the lack of competences, which makes the elderly more or less explicitly

[20] An experience of this type was carried out recently with one hundred elderly people, who frequented in Rome some social rather than healthcare centres dedicated to them. The work was tackled in three phases: (a) a welcome, explorative phase, to verify the availability to accept the new approach; (b) a phase of analysis, based on a careful exploration of the personal resources if the individual to reinforce the sense of self-efficacy, and carried out with a personalised help in order to investigate the reasons, the professional and personal interests, identify the competences and aptitudes, evaluate the personal knowledge and the possibilities that can actually happen; (c) a final discussion, for a positive restitution to the individual of the data found, with a profile of current competences that can be used, aimed at supporting their level of autonomy, also with new forms of guided learning. In the final synthesis the individual carries out a reflection on his/her competences not only to increase his/her self-esteem and relative safety, but to also show to others the competences acquired during his/her life, offering memories a more concrete and credible substrata of experience. The method has its strong points in a series of factors that can be summarised as follows: the elderly explicitly show their will to participate, giving their consent; the working method is chosen with them, starting with a self-analysis assisted by an expert; there are the premises for an evolution of the image of the elderly, directing it positively; the data collected belong to the elderly and cannot be communicated to others without their consent. To evaluate experience, the following elements have been identified: the psychological effects on the elderly; the social effect of experience; the effects on the training of the operators; the defence of financial autonomy, intended in itself as a form of self-care, allows us to limit the costs, also in terms of consumption of healthcare resources.

[21] P. Gilbert, Schmidt, *Evaluation des competences et situations de gestion*, Economica, Paris 1999.

dependent, but their potential self-care. The worker's intervention in this logic must have a different aim, based on recognising the experiences of the elderly, who become a privileged source of common reflection[22]. Talking is not only venting and sometimes looking for comfort, but the moment of active remembrance of positive experiences. The retrospective approach aims at identifying episodes of the individual's life, when he/she had responsibility and was able to tackle it[23].They are the most important strategies to re-elaborate and apply them to the present. It's not so much the facts in themselves that are important, but the perception of events, according to a technique that integrates the subjective and the objective point of view and allows the more in depth exploration the relationship of the elderly with themselves, or, as it has been perceptively said, with the their ghost. Through his/her memory the subject reveals to the educator a very interesting space in which the possibility arises of highlighting the competences he/she once had, to interpret them and give them back to the subject, as a reassuring moment of what he/she is still able to do today.

To rethink old age in terms of permanent training requires also the identification of tools with which to take into account its process of adaptation to new events that mature both in the changes in exterior circumstances and in the different psycho-physical resources available.

The history of this formative stage for the elderly, the last in their lives, represents also the spiral of an educational circle that started many years before, and that found its efficacy when it began to link objectives, intended as specific needs, with adequate contents and appropriate didactic methodologies, to end with a coherent evaluation of the needs initially highlighted and the results achieved[24]. The elderly has the right to learn to be old as well and this right involved the obligation for someone to teach him/her, without necessarily seeing his/her limitations as an illness.

The acquisition of new competences, with the relative awareness, improves the image of self and reinforces self-esteem and confidence. It therefore becomes easier to maintain an internal control, as feeling masters of our own lives make it easier to overcome the limits of a stereotypical view of old age, which centres on the diagnosis of the limitations and only advocates medical interventions.

Becoming aware of ourselves and our image in connection with the external environment can present difficulties at any age and it is important for it to happen in the context of an empathic relationship, capable of guaranteeing welcome and support to the management of critical incidents, in which the perception of self is full of negativity[25]. The concept of care assumes from this point of view a particular value and it touches the most intimate aspects of our emotive life, loneliness, abandonment, if it finds in the other someone ready to listen to our problems. It is difficult to say at this point whose task it is: the geriatrician, or the nurse, the psychologist or the educator. It touches all the team in its united structure, even if it is delegated to the individual most capable of establishing a significant relationship with the elderly, overcoming the risk of

[22] J. Bruner, *La ricerca del significato*, Bollati-Boringhieri, Torino 1992.
[23] A. H. Maslow, *Motivazione e personalità*, Armando, Roma 1973.
[24] D. Demetrio, *Raccontarsi. L'autobiografia come cura di sé*. Raffaello Cortina Editore, Milan 1996.
[25] C. Dweck, E.L. Leggete, *A social-cognitive approach to motivation and personality*, Psychological Review, 1988, 95, pp.256-273.

group anonymity, in which anyone is fine, because no-one has expressed a real option for the individual.

What is necessary to stress is that, in the assessment of the elderly's competences, as well as the cultural and technico-scientific aspects, we must also explore the relational ones and the values. It is worth focusing on these last ones, because they represent the humus on which the elderly keep re-elaborating their personal history and judges it. It is difficult, that is, to positively interact with an elderly person if we don't know his/her values.

3. OLD AGE: INTERGENERATIONAL COMMUNICATION AND CULTURAL, SPIRITUAL/RELIGIOUS ASPECTS AND VALUES

3.1. INTERGENERATIONAL COMMUNICATION

What is the meaning of growing old as part of the vital cycle and in the framework of our individual biography? One of the facets more deserving of reflection is that of intergenerational communication, to be fundamentally intended as an exchange of meanings appropriate to the different phases of life and as a search for shared values in the various phases of existence. The cultural (namely, the lack of a network of shared meanings regarding the fundamental aspects of living: birth, procreation, death) and social (the current life conditions are such to make authentic forms of communication increasingly difficult) causes have been mentioned more than once – with regards to the inability of contemporary society to find this communicative sense of being alive, especially when life conditions are not optimal.

To support this process – that can be found in terms of creative ageing – could be useful to face our perception of old age through an historical and anthropological journey to help re-discover the images of the different societies and historical times, and that allow us to find the web of the symbolic meanings linked to old age – men and women. This journey seems important to re-build a relationship between generations that connects yesterday's world to today's world and its challenges. In this framework the concept of generativity – as characteristic of adult age - elaborated by Erik H. Erikson seems particularly important. As stated by Erikson, the adult who takes care of the following generations, takes on him/herself the generational task of giving strength to those coming after him/her. This concept brings us back, amongst other things, to the crucial relationship of the elderly with time. To overcome egocentrism and open ourselves to others means, in fact, coming out of the present and projecting ourselves into the future, going beyond the simple consumption of existence to create something new: more mature conditions of existence and more profound links with life.

Erikson's is a tentative attempt at giving meaning to the entire circle of life through the idea of a journey, a journey open and never completely finished, which takes shape in different phases and roles with a strong emphasis on the values of exchange and mutuality. In adult age, the crisis of development is marked by two antagonistic forces: generativity against stagnation. The conflict knows alternate phases and the individual's psychological balance is, therefore, unstable. This is, however, a normal stage of growth for which the individual must be pushed to make the sane forces prevail and resist the pathogenic stimuli.

But what is actually meant by generativity? It can be defined as the individual's predisposition to conceive individuals, products, ideas; enrich our personality and guide those who are growing. And, therefore, an ability that encompasses a wide scope of activities, projects and intentions, as it concerns not only the ability to have children or show the capabilities we have in various fields, but also the tendency to follow the rise of the young to an adult life. Generativity does not come, therefore, automatically from being parents, but is without a doubt a sign of profound psycho-sexual and psycho-social maturity we can see in adults when personal constructive forces prevail within them.

The stagnation, in which Erikson finds the pathological centre of adult life, is, on the contrary, a weakening of the tendencies that make the individual a productive and creative being, a regression to an unnatural intimacy accompanied by a widespread dissatisfaction, by a self-deprecation often induced by psychophysical deficiencies which cause anxiety.

From the antinomy between generativity and stagnation derives the virtue of care, a term that indicates a type of commitment and consideration that is continuously expanding, where the positive forces of the previous age can be found. It expresses the instinctive impulse to love, stroke anyone who, in a state of abandonment, shows his/her desperation.

As we can see, caring assumes a central importance in inter-human relationships, seen as the essence of the first and last phases of life: it gives life a sense of cycle, the meaning of returning.

Erikson warns us that he lists the stages of life starting with the last one, that of old age, to verify what meaning can have a look through the whole life cycle in the global context of its journey. He also re-affirms his conviction that, after having completed the inter-connection between all the stages, it is possible to start from any one of them to arrive to the others within the map that expresses their meanings and position. In this framework, we stress that adult age is the link between the life cycle of the individual and that of the generations.

An objective difficulty of the transition phase we are going through, which goes from the elite of the elderly to the mass of the aged, is that of the relationship between the change in the social conditions and the persistence of cultural images. And however the elderly can and must preserve an important generative function: in old age, in fact, according to Erikson, all the qualities of the past are enriched with new values. Therefore, great importance has the generative stage of the adult age that precedes old age even though, it must be remembered, in an epigenetic framework, the after only means the subsequent version of a previous level, not its loss.

Generativity includes in itself the characters of procreation, productivity and creativity, the ability, therefore, not only to create new individuals but also a sort of self-generative power relative to a further development of identity.

Erikson insists on the attitude of care that the elderly can have towards those he loves, an attitude that can keep and reinforce his/her identity as well as open him/her up to the relationship with other generations. It is a very interesting aspect and, generally, scarcely taken into account in the reflection on senescence as, when we talk about the elderly, especially the subjective dimension of self-care, of the preoccupation for our own destiny, is stressed.

Erikson has no doubts: the role of old age has to be re-considered and revised in light of the fact that the last stage of life assumes a big relevance for the first: in the most vital cultures, children mature mentally thanks to the

relationship they have with the elderly. We will therefore have to reflect for a long time on the importance that it will have, and must have in the future, this relationship when a mature old age will hold experience which is susceptible of being learnt according to a "creative ageing". The changes induced by time – amongst which the increase in life expectancy – require, in fact, new and more profound re-ritualization, able to ensure a more significant interchange between the beginning and the end of life, a more defined synthesis of the stages.

Erikson denounces the current disorganisation of family life as the cause that largely contributes to the loss, in old age, of that little vital involvement that is necessary to feel really alive. The lack of this involvement seems to him to be the nostalgic theme hidden in the apparent symptoms that push the elderly to recur to psychotherapy, the most common reason of their desperation, due to a prolonged sense of stagnation.

There is nothing natural, warns Erikson, in the loneliness of the elderly: it's not in their nature to give up the encounter with others, the exchange. On the contrary, they fully belong to the community, and with all the wealth of their personal history, it appears as one of the strongest needs of this stage of life. The isolation of the elderly is not, therefore, inevitable, as it is not the result of their inclination but of prejudice and cultural and social barriers, which we must commit to remove.

It's up to all of us – the problem of the elderly is not just their problem – to trace the project of a new culture, made of laws but also behaviours, that is able to see in ageing that moment in life when fuse and acquire meaning all the themes of what we have lived, learnt, suffered – like in a symphony or a tale that, with its enormous load of wisdom, could be a precious link between generations.

3.2. SPIRITUALITY AND RELIGION IN SENESCENCE

The condition of old age can be investigated in various fields – think, for example, of the state of health and the socio-healthcare services or the activities (work and fun) – even relatively to factors that play a role not less relevant in determining the concrete situation of a personal life[26]. We talk, namely, of elements that are "immaterial" but strongly influence the "materiality" of daily life, like: interpersonal relationships, spirituality (the meaning of life, death and transcendence) and religion with its load of attitudes and cultural practices, the sphere of personal and social values, the formation and promotion of the person also in old age, his/her creativity (Active Aging), also mentioning the preparation of the new generations to old age (geragogy)[27].

[26] Also in sectors that cannot be immediately referred to a religious/spiritual dimension, like biomedicine, said dimension find a relevant space. An investigation (of the 14.1.2005) of the databank of the National Library of Medicine of the American National Institute of Health (site: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi) using the lexical couples (elderly OR aging AND spirituality OR religion" gives, in fact 27,327 bibliographical references containing at least two of the four factors (the research included publications relative to the period between January 1966 and January 2005). Adding to the key-words mentioned also the couple "ethic OR bioethics" (but in a period between 1970 – the year in which the term "bioethics" was coined – and 2005), the result is still 16, 225.

[27] There is not much research on the condition of old age involving these aspects. In particular, in Italy are available tow investigations carried out on a sample (about three thousand elderly persons each), both carried out by the Universita' Cattolica del Sacro Cuore (UCSC). The first

Independently from the general philosophical notion according to which each of us considers life as a whole, the spiritual and religious dimension represents an element which is really difficult to ignore when we discuss man. And although this dimension recalls very wide and often heterogeneous semantic connotations, it is still unquestionable that spirituality and religion constitute a privileged horizon through which the person, and in particular the elderly person, can better understand a hurried and superficial daily life[28].

Therefore, the religiosity of the elderly represents a very interesting field of investigation – although it has been explored less than other fields in specialised literature – because it opens a view on a world that is mostly existential linked to many other factors (being satisfied with life, quality of life, perception of time, etc.).

In addition, we must consider that the spiritual component becomes more evident in old age that, often, is the time in which the desire to be reassured about a future life is stronger. From the studies available, it clearly emerges that religion greatly influences the quality of life of the elderly, whether they are self-sufficient or disabled. This is confirmed in a personalistic idea of the quality of life, according to which the person's well-being must be assessed globally, including also needs and desires, which are aimed at values that, alone, realise the plenitude of the person[29].

It has been stated that old age is the time of changes (socially, physically-biologically and with regards to values): these changes can be traumatising and

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(UCSC Molise), in the Molise region, at the end of the 1980s, within the "Subproject B" (Investigation of the ethical, religious and psycho-geriatrics problems of the elderly population of the Molise region with the scientific guidance of the UCSC's Centre of Bioethics) of the "Active Aging Research Project and the results of which are published in E. Sgreccia, S. Burgalassi, G. Fasanella (eds.), *Anzianità e valori*, Milan, Vita e Pensiero, 1991; L. Antico, R. Bernabei, F. Caretta., M. Petrini, A. Sgadari, *Anziano Salute Società*, Vita e Pensiero, Milan 1991; L. Antico, E. Sgreccia (eds.), *Anzianità creativa*, Vita e Pensiero, Milan 1989. The second (UCSC Calabria), still under the scientific guidance of the UCSC's Centre of Bioethics, carried out at the end of the 1990s in the Calabria region for the "Facite" Foundation in Catanzaro, the data of which are reported in C. De Rose, D. Sacchini (eds.), L'età *in gioco. Anziani in Calabria tra vecchie e nuove identità,* Soveria Mannelli, Rubbettino 2002.

[28] There is a vast literature on the importance of spirituality and religion in order to improve the quality of life of the elderly. Amongst others, cf. Petrini M., La spiritualità della persona anziana, in E. Sgreccia (ed.), *Persona e terza età: assistenza, inserimento, compartecipazione*, Edizioni Teotókos, Siracusa 1994, pp.187-206, p. 191; L. Sandrin, F. Caretta, M. Petrini, *Anziani oggi. Una sfida per la medicina, la società e la Chiesa*, Torino, Edizioni Camilliane, 1995; M. Petrini, *La spiritualità della persona anziana*, in Sgreccia, (ed.), Persona e terza età, pp. 187-206; M. Petrini, F. Caretta, L. Antico, R. Bernabei, *L'assistenza alla persona anziana. Aspetti teologici, etici, clinici, assistenziali, pastorali*, 3 volumes, CEPSAG, Rome 1994; R. Bleistein, *Il tempo libero e la terza età. Riflessioni per una pastorale degli anziani*, La Civiltà Cattolica 1998, III, pp.239-253; J. S. Levin, R.J Taylor., *Age differences in patterns and correlates of the frequency of prayer*, Gerontologist, 1997, 37, pp.75-88; S. Acquaviva, E. Pace, *Sociologia delle religioni. Problemi e Prospettive*, Carocci, Roma 1998, p.102; A Donghi., *La liturgia e la preghiera degli anziani*, Anime e Corpi, 1999, 204-205, p.429; V. Cesareo, R. Cipriani, F. Garelli, C.Lanzetti, G. Rovati, *La religiosità in Italia*, Arnoldo Mondadori Editore, Milan 1995; S. Burgalassi, C. Prandi, S. Martelli (eds.), *Immagini della religiosità in Italia*, Franco Angeli, Milan, 1993; S. Burgalassi, *La condizione anziana. Un approccio globale a livello antropologico e sociologico*, Medicina e Morale 1977, 3, pp.259-284 and, finally, a part of the research carried out by the Eurispes, The Third Report on the Condition of the Elderly in Italy, 1992 (http://www.mix.it/eurispes/EURISPES/168/default.htm and http://www.mix.it/eurispes/EURISPES/137/8a.htm#1).

[29] E. Sgreccia, *Bioetica, società, sanità e qualità di vita*, in ID., Manuale di bioetica. II. Aspetti medico-sociali, Vita e Pensiero, Milan 2002, p.16.

destabilising for the elderly, because they lack those points of reference characterising their whole life journey. With regards to this, the "ad hoc" investigations show that, for many, religion is one of those cornerstones that with age do not falter, they actually get stronger or, if they were not very solid in youth, they can have, in old age, more weight and space. Religiosity gives the elderly stability and a good dose of certainties that help them face possible problems related to age. The ethico-religious values given in the first instance by the family of origin and accepted, almost automatically, during youth, become in old age something integral to personal life.

The general process of secularisation in today's society has affected the elderly less, both for generational and existential reasons, as old age represents a life cycle "that inevitably leads to questioning the meaning of life and the destiny of man after death, namely, to develop or recuperate a sensibility for the central themes of each experience or religious message"[30].

In fact the elderly sees a series of traumatising changes that tend to overturn all their certainties, making them feel completely (or partially) inadequate to the new reality that is happening. The elderly realise that between their world and that of the new generations there is often no continuity (in this sense religiosity is a very indicative example), there is no real transferral of values.

Today's society has modified the values felt as important by the elderly. Personal dignity is substituted by criteria of pure efficiency, functionality and usefulness: "the other is appreciated not for what he/she is but for what he/she has, does, gives"[31]. It is evident that today's society is permeated by a strong pragmatic empiricism that leads man to value most of all, if not only, factuality rather than ideality. It is the homo oeconomicus o homo technicus (therefore of "doing") taking over the homo humanus (or of "being") that, alone, can guarantee to man the recuperation of his lost integrity[32]. All the currents of thought, religion and culture, which play their anthropological game on the value-person and, amongst those also the Christian vision, can work together to regain a sense of being.

Religion can represent, therefore, a valid instrument to regain a world of values that the industrialisation and modernisation process has progressively weakened. It is also for this reason that time for the elderly gradually loses the shape of real and tangible time and becomes transcendental and spiritual time, which focuses particularly on the eschatological world. The elderly are in this way put in the condition of giving meaning again to their lives, so strongly connoted by changes[33].

The logic that permeates contemporary reality has profoundly and radically changed the expectations and meanings to give to life. In this sense, the objective of the elderly becomes, more or less consciously, regaining the spiritual, interior and human world.

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[30] M.C. Romano, G.B. Sgritta, *Uguali ma diversi, diversi ma uguali*, in Anziani '98. Tra uguaglianza e diversità (Second Report on the condition of the elderly, by the Federazione Nazionale Pensionati CISL), Roma, Edizioni Lavoro, 1999, p. 93.

[31] Giovanni Paolo II, Lettera enciclica "*Evangelium vitae*", 25.3.1995, n. 23.

[32] Cfr. K. Wojtyla, *La visione antropologica della "Humanae vitae"*, Lateranum 1978, p.129.

[33] It must also be noted that both the tout court meaning of religion and accepting a certain church is more often found in women than men and among those of a mature age or old age than younger people (cf. Cesareo, Cipriani, Garelli, Lanzetti, Rovati, *La religiosita'in Italia*, Burgalassi, Prandi, *Immagini della religiosita' in Italia*, Martelli (eds.).

The re-emergence of the religious dimension represents – in many of the cases studied – a link with their past youth often connoted by a strong sense of religion. The continuity happens more easily in the spiritual dimension than in the physical-corporeal one where the elderly feels fragile and vulnerable, as well as contingent. Through the spiritual world we can regain the "civility of being", which reveals itself "at the contemplative moment, in the search for the sign and it can be found within the meaning"[34]. After all, wisdom and maturity that characterise old age, confer to this particular phase of human life a different meaning and purpose, as we should be aiming at realising a more profound interiority and searching for values that transcend material reality.

3.2.1. The universe of values in the life of the elderly

The moral dimension – both with regards to choices of personal values and ethical issues with mostly a social relevance – is a particularly interesting field of investigation. Not only, however, as such, but also in relation to other aspects: the education received within the family and in the classical educational "institutions": school, church, work. This gains more relevance not so much and not only for the elderly of today, but also for those of tomorrow. More recently, bioethics has also looked in depth into ethical issues arising during old age[35].

Overall, the available literature indicates some general tendencies. The values of today's elderly, at least in the European western latitudes, shows two main elements: 1. A dishomogeneity in comparison to their awareness of the relationship anthropology/value; 2. With regards to values, it would seem that there is a widespread homogeneity regarding the received ethical "models", with a significant prevalence of work on other aspects that could have previous bioethical relevance[36].

From what we have said so far, however, comes a question about why literature refers to a certain "isolation" from the decisional and educational processes of the original family, of a subtle "silencing" of the elderly's voice of experience. Maybe the solution could be found in regaining and promoting the culture of being, starting with focusing on the person in the environment where

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[34] E. Sgreccia, *Bioetica e tecnologia*, in ID., Manuale di bioetica. I. Fondamenti ed etica biomedica, Vita e Pensiero, Milan 1999, p. 779.

[35] This can also be found in encyclopaedic texts of reference like, for example, the contributions in Post S.G. (ed.), Encyclopedia of Bioethics, vol. 1, New York, MacMillan Reference USA – Thomson Gale, 2004, Jecker N.S.: *Societal Aging*, pp. 101-104; Cole T.R., Holstein M., Old Age, pp. 109-112 and *Anti-Aging interventions: ethical and social issues*, pp. 112-116. Cf. also: E. Sgreccia, *Bioetica, anzianità e invecchiamento delle popolazioni*, in ID., Manuale di Bioetica. II. Aspetti medico-sociali, Vita e Pensiero, Milan 2002,pp. 497-557; Soldini M., U. Accettella, S. Burgalassi (ed.), *La bioetica e l'anziano*, Edizioni ISB, Acireale 1999; G. Acocella, *Questioni di bioetica e terza età*, in Federazione Nazionale Pensionati CISL (ed.), Anziani 2000. *Third Report on the condition of the elderly*, Edizioni Lavoro, Rome 2000, pp.137-151; R. Cipriani, *La religione dei valori*, Salvatore Sciascia Editore, Caltanisetta-Roma 1992. For an investigation of the ethical problems arising in geriatrics, read also, M. Petrini, F. Caretta, L. Antico, R. Bernabei, *Etica e Geriatria*, CEPSAG, Rome 1993. Finally, interesting is also the study carried out on a sample of 250 women over seventy-five from the Marche, in which the theme of spirituality/religion was tackled, and found in the volume by A.M. Vissani, E. Salvi, *La donna marchigiana. Una femminilità vissuta in pienezza*, CEPSAG-UCSC, Rome 1998.

[36] This can be seen in, D. Sacchini, S.Giardina, E. Sgreccia, *Orientamento ai valori, etica sociale e qualità della vita*, in De Rose, Sacchini (ed.), L'età in gioco…, pp. 109-152.

all the phases of his/her existence in the world happen: the family. And culture of being means presuming that at its basis there is a plenary culture of life that necessarily leads then – not before – to its quality, which has sense and meaning only if related to life: in fact "quality is an attribute, a disposition that gains sense if referred to the substance"[37] and looks first of all at the plenitude of the person, the values that fund it.

From recuperating the being and existence of man in all his phases derives then the focus on the exquisitely human possibility of choice and, therefore, on the ethical dimension without which the values are seen only in their eudemonistic, economic quality, satisfied by needs. We must instead go further and recognise in the spiritual infrahuman values, in the moral value (and in the religious one as the last awaited passage) the objectives to reach as a mature expression of humanity, in youth and in old age. Therefore we must look for a "high" quantity of values, according to the precise scale of priorities just mentioned, otherwise we will breathlessly search to satisfy false, needless needs and never be fulfilled, following only the philosophy of Having that leads us inevitably to being a "one dimensional" man[38], a man who has lost the best part of himself. On the other hand, in a similar "logic" the elderly plays a game that is lost from the beginning, because of the characteristics of the existential and biological condition he lives. To confirm this, it is indicative that also relatively to suffering, from the studies emerges a very significant warning for all ages: being must be able to prevail on the culture of doing and producing to allow the human soul to go through all the steps of his/her evolution. It is only in this dimension, in fact, that "the elderly don't only go towards the darkness, but towards the full being of the person: the truth is at the end of the journey, truth and joy are found in the realised completeness"[39].

[37] Ibidem., *Bioetica e terza età: qualità della vita, valori, creatività e problematiche etiche*, in ID. (ed.), Persona e terza età…, pp. 227-253.
[38] H. Marcuse*, L'uomo a una dimensione* (1964), Torino, Einaudi, 1991.
[39] E. Sgreccia, *Anzianità: valori, creatività…* in Antico, Sgreccia (ed.), Anzianità creativa…, p. 106.

PART TWO: **THE NON-SELF-SUFFICIENT ELDERLY AND THE EHTICS OF CARE**

The varied and difficult world of the elderly seems the object of rhetorical and repetitive propositions, which are never actually realised.

The ONU initiatives, which in the last few years studied the extraordinary worldwide extent of ageing, are well known, with the elaboration of "Plans of action" and "Principles" founded on independence, participation, care, self-fulfilment and dignity, and in 2002 it called together the World Assembly on Ageing in Madrid. Since then, no concrete programme for the involvement of the elderly in the social, productive, economic and cultural life has been carried out (only fragmentary initiatives and reflections within other programmes like the fight against exclusion or discrimination, and healthcare resolutions like Alzheimer).

The hoped for "Society for all ages" does not happen if not in the propositions of a certain cultural elite, despite the fact that the suffering of the elderly grows, especially in developing Countries, where there's war, where revolutions and terrorism cause every day tens of victims: the required dignity, participations and independence, apart from praise-worthy considerations that should take into account the longitudinal evolution of life rather than standardised transversal situations, are still an option that benefits few fortunate people in the developed countries. It also does not seems widespread the value of an authentic solidarity, which every man – regardless of the society in which he lives and his beliefs – can and must show solidarity towards every other man, of which the elderly are objects of attention but also, and maybe mostly, active subjects, capable of offering whatever unique

4. AGEING

Ageing causes the progressive loss of the organism's ability to adapt to the environment, because of the depletion of functional reserves. In order to understand the complex mechanisms that cause it, various theories have been formulated, amongst the most accredited that of the "free radicals and crosslinking", of the "altered protein synthesis" and of the molecular clock or "Hayflick phenomenon"[40], which responds better to the demands of science.

The ageing process does not appear as a uniform and homogeneous phenomenon, especially from a psychological point of view. The factors affecting it are several: the genetic make-up, illnesses and traumas, education, experiences lived, losses suffered, the semantics of loved ones, the opportunities and difficulties encountered, the characteristics of the family and social environment and most of all the desire to "be and live". There is a life and an ageing for every person, each individual is unconsciously responsible for his/her own growth, also by facing the environment and the events that characterise it. In this phase of life, the family, social and care environment,

[40] The studies carried out on cultures of fibroblasts extracted from the lung of a foetus, lead to a rapid initial multiplication of these cells, followed by a slower growth (senescent phase), until they reach the end of the cellular divisions. Hayflick deduced that, as the fibroblasts cannot multiplicate beyond a certain number, there had to be a "molecular clock" able to regulate their reproduction. The only cells capable of going beyond this anticipated limit of multiplication are the neoplastic ones.

love and motivational components gain relevant importance. The life lived and the life we are living can affect further capabilities of growth without limitations until the last instant, as demonstrated by art history, literature, science, but also the individual's daily life, as he/she can find in him/herself, in the last part of life, the strength for "the last brush-stroke… the one that gives more light and maybe gives the final meaning to the painting"[41].

If certain biological determinants cannot be corrected, other factors are susceptible to change, for example the physical decay that follows inactivity and can cause that serious functional degradation called "hypokinetic syndrome", responsible or co-responsible for a great number of hospital admissions of elderly patients in rehabilitation centres. Physical activity is able to prolong survival by increasing aerobic capabilities, mobility and the stability of the spine and the muscular strength, of significantly attenuating the reduction of the hematic fluid in the brain and the inadequacy of cognitive performances that happen with retirement, of carrying out a protective action towards the susceptibility to coronary diseases and mortality, a significant role in the primary and secondary prevention of strokes, hypertension, peripheral arteriopathy and diabetic nephropathy, cancer of the colon, breast and female genitalia. It can cause an increase in the ability to communicate in patients affected by Alzheimer. The most important neuroscientific discoveries of the last years contributed to overcome the ancient assumption that saw the brain as an organ destined exclusively to involution and the loss of cells. If it is true that getting old there is a reduction in neurons, it is also true that the nervous cells are able to reconstruct and compensate for the missing parts and reactivate the acquiescent neuronal stations. In this sense, an appropriate environmental stimulation is very important for the recuperation of psychological competences, relational and social.

With regards to the different functions, it is sometimes possible to have a reduction in the psycho-motor skills, especially in relation to the time necessary to make decisions. Awareness does not seem to decrease in normal conditions, but there can be, more frequently than in youth, episodes of mental confusion that are not necessarily attributable to pathological states. Self-awareness, namely, the awareness of the Individual that intertwines and links with the so-called "feelings of the Individual", is generally influenced by serious psychological suffering. In the elderly, it can be connected to memory disorders, in particular with regards to iconic memory (sensory or very short term) and short-term memory, which is less active with a decrease in the ability to remember more recent facts, whilst the ability to remember past events remains particularly lively. In conditions of psycho-physical well-being, the elderly are able to learn[42] and know as well as the young and the adults, although they might need longer times to assimilate it. The motivations, in any case, are essential, as – on the contrary – not enough active participation considerably reduces memory and highlights learning difficulties. We can also observe a certain reduction in the attention span. The weakening of eyesight and hearing can lessen perceptive capabilities. Cultural isolation, a low

[41] Holmes Wendel, in R. Levi Montalcini, *L'asso nella manica a brandel*li. Baldini & Castoldi, Milan 1998. The whole quotation is as follows: "life is not like drawing conclusions, but life is like painting a picture, and therefore the last brush-stroke can be the one that gives more light and maybe gives the final meaning to the painting".

[42] Old age begins when the ability to learn stops. A. Morandotti, *Le minime di Morandotti Scheiwiller*, Milan 1980.

economic and social level, emphasise psychological decline. On the contrary, social integration and higher cultural levels are the premises for a better old age and longevity. Especially as the elderly are often able to supplement any deficiencies with other qualities like continuity, prudence, experience, motivation, the ability to control emotions, to reflect and synthetize, being more precise as well as preserving important functions, like language, thought, perception, attention and recognition[43].

Despite a general and progressive decline of sexual activity linked to age, sex and sexuality represent for the elderly an integral part of the experience of living, which does not mean only with a physical relationship, but it is associated to a psychological and emotional point of view with the creation of a profound intimacy between partners[44].The reduction in potency decreases slowly during the 7th decade and it becomes more marked in the 8th and can be of a certain relevance only after 75 years of age. The reduction is due not only to physiopathological and socio-environmental factors, but also by the rise or increase in pathologies able to interfere with sexual activity, which can stop due to different causes in the two sexes. In women it is generally linked to the husband's presence and capability, whilst for men it is almost always due to their incapability.

It is in any case important to overturn the prejudices regarding the sex life of the elderly as something non-existent, inconvenient, inappropriate and dangerous for their health and its cessation as an unstoppable event linked to the passing of time. In Italy relationships between elderly people are on the increase and start more frequently when work, children and family life are a part of the past[45]. According to sociologists, soon elderly couples who love each other and decide to start their last journey together (which in their enthusiasm is never the last) will no longer be a rarity or a novelty. However, cultural stereotypes mean that these relationships are often hidden, derided, or opposed, especially if the elderly involved are widowed and alone.

In synthesis, in old age, especially psychologically, nothing must be considered with approximation and relegated to the commonplace of the known, the diagnosis and the symptom[46]. Following the direction of the so-called ageism, namely, the stereotype according to which reaching a certain age is the same as being old, with all the burden of pathologies that can create functional dependence, is certainly out of place, because the third age is heterogeneous with regards to self-sufficiency, physical and mental health, quality of life: age cannot represent a criterion to identify a care and/or therapeutic choice and to exclude anybody from therapies aimed at recovery or

[43] R. Levi Montalcini, *L'asso nella manica a brandelli*, Baldini & Castoldi, Milano 1998.

[44] Contrary to common belief, from an investigation conducted by "Ageing Society" (2002), emerges that the elderly maintain, despite their age, an interest for sex. If 65.1% admits they do it very rarely, not for a lack of desire but because they find it difficult to find an available partner, 34.7% state that they maintain an intense sexual activity and 20% confesses they have had a "crush" after 60.

[45] F. Di Iusto, *et. al*., *La sessualità nella donna anziana*, Giornale di gerontologia, 51, 504, n. 6, 2003. Aiolli V.,Fuori tempo. Rizzoli, Milan 2004. L. Sotis, *Le nuove coppie dell'amore a settant'anni*, Corriere della Sera, 5/2/2004. P. Ravizza, *Gli affetti non finiscono mai*, Percorsi, n. 39, 2003. F.R. De Chateaubriand, *Amore e vecchiaia*, Robin Edizioni, Rome 2002. Ruggeri Fedele (ed.), *Anziani e affettività*. Le dimensioni della problematica in una ricerca proposta dal Sindacato pensionati Italiani CGIL. Franco Angeli, 2000.

[46] A. Tammaro, G. Casale, A. Fristaglia*, Manuale di Geriatria e Gerontologia*, McGraw-Hill, Milan 2000.

prolonging life. The period of active old age, which precedes regression by quite a while, requires an approach aimed at active ageing, namely, a creative ageing in good health.

For the so-called social ageing, there are no fixed rules by law, unlike for minors (who are such from the moment of birth to their 18th year of age). The law for pensioners regards the elderly, but not even in this case there are precise indications defining the elderly if not through mere taxation practices which can sometimes be interpreted in a variety of ways, a function of professional categories and very often particular situations: just think about baby pensions, forced early retirement or retirement plans agreed with the companies, to the conditions of the magistrates and university professors. If retirement can lead to an early and significant loss of value of the person through the "devaluation of the function of experience"[47], in the last twenty years the traditional models have progressively lost meaning as both knowledge and experience decrease with old age in relation to the changing of customs and the tumultuous progress of technology that the elderly are often unable to follow.

Generally, the ageing of the population is accompanied by a certain deterioration in professionalism, so that companies often consider elderly employees a burden, because they don't have the necessary professional up-to-date training and tend for this reason to remove them from work or isolate them from the decisional processes of the company through a progressive removal from tasks that can degenerate in the "mobbing" phenomenon. With regards to this, it seems necessary – as suggested by the OCSE reports since the 1990s – to invest more in permanent professional training, which would keep the elderly in touch with innovation and anticipate a flexible retirement, also in the perspective of the most recent policies, which tend to support the recuperation of the elderly in the workplace, especially as the statement according to which "work it is not only a need to earn, but a condition to live"[48] is also true in the third age.

In these conditions the elderly, although with their limitations, will have to be, according to today's trends, more and more a human, professional and cultural resource and for this reason the "threshold of social old age" will increasingly represent a value in itself for each individual, to be considered realistically on the basis of their desire and the ability to do, whilst age, in future years, will be an increasingly less significant indicator of the real conditions and the true needs of the individual. Much more realistically – also from this point of view – the absence of pathologies, self-sufficiency, the ability to be and no longer age, will be what makes a difference.

5. THE SELF-SUFFICIENT ELDERLY FREE FROM SERIOUS PATHOLOGIES

The elderly who are self-sufficient and free from serious pathologies do not present particular problems. Their condition of well-being depends especially on the possibility of preserving interests regarding and not regarding work, of maintaining contacts with the young, of talking with their mind aimed at

[47] F. Carrieri, R. Catanesi, Il suicidio dell'anziano, Rass. It. Criminol., 1, 51, 1992.
[48] G. Berlinguer, *Salute e disuguaglianza*,The Practioneer, ed.it. November 1989.

the future of the family and society, outside of the usual negative models of old age, without necessarily arising that "respect" that could be the beginning of embarrassment and tolerance, but also without opening the door to attitudes of mere forbearance or compassion.

Elderly women usually live within the family with the grandchildren who grow, and they are often the guide of the house also financially. With the husbands progressively self-insufficient, they are often able to take on the function of care-giver. The elements that can mark the life of women are the loneliness that follows widowhood, the scanter financial resources, a longer period of disability in relation to the longer life expectancy, the low level of education that can still be found in the older generation but which is progressively improving and will change again in the following decades, depression[49]. The statistics show that women have generally a more unfavourable situation, especially from seventy years of age and beyond, in relation to a worsening of chronic pathologies that are very individual and long-term. Women have a fewer "choices" during their lives compared to men (who more frequently suffer from more lethal and less lasting illnesses like tumours, brain and cardiovascular incidents) and this phenomenon would explain the higher level of suffering of women in old age.

This, even if there's no lack of examples, and in fact they are increasingly frequent, of middle-aged women different from the traditional ones, where women start their third life radically changing their interests, and are able to tackle new situations with original and constructive initiatives especially doing socio-cultural voluntary work, and they live in parallel – and not always in reduced dimensions – the life of younger women, free from any type of restrictions.

The feeling of detachment from the bodies in which women, but also men, do not recognise themselves anymore and feel as foreign, might have nothing to do with a nostalgia for beauty and youth and often it's not the little pathologies that limit their freedom! Much more often it's about – as already mentioned in the "First part" of this Document – of a crisis of identification, which puts self-image into question. When the illusion of eternal youth dissipates, a narcissistic trauma happens, which causes a depressive psychosis. Men and women, in the illusory attempt to find themselves again, to recuperate body and psyche, or at least find a new balance, to alleviate regret and depression, but also face the needs of social life and work, often go through the solutions offered by plastic surgery. The statistic data for plastic surgery and beauty treatments is increasingly significant, even though they mostly refer to ages below 65 years[50].The consequence is the fact that there is a third age, an unofficial age ignored by gerontology, the "timeless", those who trust surgery to erase the signs of time, and who achieve inexpressive faces that do not show a person's life51, a sort of aesthetic homologation. Ugo Ojetti's suggestion, "being able to grow old means being able to find an acceptable compromise between your face, which is that of an old person, and

[49] Depression, "Un male tutto femminile". Eurispes Survey 28th April 2003. La cura e il ricorso ai servizi sanitari. ISTAT: Indagine Multiscopo sulle famiglie (years 1999-2000), 2003.
[50] American Society for Aesthetic Plastic Surgery, 2002. Only about 5% of the surgery involves women over 65 years of age. Congress of the European Academy of Dermatology and Venereology, Florence November 2004.
[51] M. Venturi, *Segni particolari: ritoccati*, Esperienza 54, 9, 2004.

your heart and brain, which are those of a young person"[52], is still valid and it can represent the turning point that is able to give women a new "untouched" beauty, really lived for the years that will come. Whilst the image of the elderly woman victim of physical decay and serious intellective problems, which comes from a literature that is now anachronistic or studies centred on hospital or hospice patients, must be considered mostly out of date at least for those below eighty years of age.

Sometimes healthy elderly live in public or private institutions. The psychological-social problem of the institutionalised elderly is often seen, and wrongly, as a contrast between family and institution, so that the institution represents an unwanted solution imposed by circumstances or by a family that, for legitimate reasons too, cannot meet the needs of the elderly relative. But we must not overlook the fact that today (and not only from today) the Retirement Home can represent a conscious choice by quite a few self-sufficient elderly, even financially, widowed or not, who want to guarantee themselves an independent life also from a social and emotional point of view. Where, however, they are forced into it, the elderly could have to tackle situations of profound discomfort also in relation to the will to live, socio-cultural training, etc. The impact can be pitiful for a series of problems[53]: living with strangers in relation to the ability to socialise, the risk of withdrawing into themselves and having aggressive crisis towards other residents, the lack of affection, the obligation to follow rules and at times orders, can give the elderly a sense of impotence and "objectuality"; the psycho-physical dependence can lead them to passively abandon themselves to care because of uneasiness, need of affection or company. Obviously such an unfortunate impact can start involutive process through a vicious circle that highlights the feeling of lack of self-esteem and dependence from others.

For the self-sufficient elderly, an emerging problem is finally represented by the fact that grandparents are often penalised by their children's separation or divorce with regards to an eventual forced interruption of the relationship with the grandchildren. Likewise, the children can suffer another trauma for the loss of the grandparents as historic and emotive memory, which allowed them to perceive the sense of their roots and the continuity of life. Jurisprudence has often confirmed the "grandparents' right to visit"[54] and stressed the importance of an adequate protection of the bond between grandparents and grandchildren, which is rooted in the family tradition recognised in Art. 29 of the Constitution.

6. THE FRAGILE ELDERLY

The biggest problems, also from a bioethical point of view, regard the elderly at the limits of self-sufficiency or non-self-sufficient, the so-called fragile elderly, especially where they don't have their family's support and have precarious financial conditions. In our country the equation that the elderly can be seen as a patient or an invalid according to the classic aphorism "senectus

[52] U. Ojetti, Sessanta. 1937.
[53] S. Spiridigliozzi, P. Antonelli, A. Bossi, P. Abetti, *L'anziano istituzionalizzato, problematiche e possibili soluzioni*, Difesa Soc, 77,175, 1998.
[54] Civil Cassation, Section I, 26th September 2003, n. 14345, Civil Cassation 25.6.1998 n.9606, Court of Appeal in Lecce section 1, 3rd May 2002, n.10, and others.

ispa morbus", in fact does not seem fully out-dated, at least from a strictly psychological point of view. It is in fact still dominant the attitude of those who feel that the elderly's illnesses are the consequence of ageing and often destined to evolve fatally. Carelessness and ignorance lead to confuse the onset of old age with pathologies that can still be treated which, if not diagnosed and cured, can be responsible for the loss of self-sufficiency and very high social and human costs. Avoiding this dramatic evolution is the proper duty of geriatrics, which distinguishes it from other medical specialisations.

It must also be considered that geriatrics trials regard essentially cognitive pathologies prevalent in the third age, for which the effort is highest and the results promising, whilst the specific study on the effects of drugs for common pathologies beyond what is known to internal medicine is overlooked, where however the trial subjects rarely are over fifty. The elderly are therefore deprived of the results of adequate studies on drugs and treatments and often treated on the basis of inadequate therapeutic and care treatments, furthermore, with considerable and unjustified financial issues. Regardless of this, the elderly are particular patients, different from adults, a patient often affected by polypathologies the evolution of which can lead to disability. The administration of drugs should therefore be carried out carefully and linked to the specificity of the subject and the particular framework of the disease, with great attention to the collateral effects, and it should not simply follow generic recommendations and precautions. The limited pharmacological trials on the elderly should be considered a discrimination, as if care in old age is not worthy of specific funding, rather than being thought of as the consequence of a prudential attitude in relation to the age of the trials' subjects. Experience instead shows that in old age is still possible to intervene and cure successfully, also surgically, some pathologies (like cardiac ones), with the result of offering to the elderly patient further years of life in good health conditions. Amongst the examples recurring in practice, we mention the lack of geriatrics or psycho-geriatrics support in the surgical treatment of serious degenerative or traumatic pathologies of the hip. In these cases, even if the prosthesis is perfectly successful, the development of a latent psychopathology is possible, and it could be avoided with an adequate and preventive support[55].

Financial incongruences also emerge in the number of hospital admissions of elderly people that are not in line with the ELA ("Essential Levels of Assistance")[56]: according to the AS (Ageing Society) the elderly "parked" in hospital, the lack of provisions on the national territory, the perception of being treated only if they are in hospital, "cost" Italy, every year, 18 million days of unnecessary hospital stays, which could be avoided with a saving of 5.7 billion euros, the amount that, according to the organisation invigilating the State budget, would be necessary to re-address the deficit in this sector. For example: the treatment at home of the over eighties affected by stroke has been found as efficient as that in hospital, with the essential difference of guaranteeing a better quality of life and a certainly lower number of depressive reactions or negative developments of latent psychopathologies.

[55] L.M. Pernigotti, M. Simoncini, I costi della vecchiaia: dove nascono nuovi obiettivi di ricerca in Geriatria. G. Gerontol. 53, 6, 2005.

[56] From the report on the "Stato di saputе e prestazioni sanitarie nella popolazione anziana", Direzione Generale della Programmazione Sanitaria del Ministero della Salute, April 2003.

Of considerable bioethical interest, as well as financial, is the fact that elderly patients are responsible for over half of the pharmaceutical expense of the NHS (51.9%) and of prescriptions by GPs (53.2%), even though they make-up only 21.5% of the patients[57]. These data could be less worrying if the "Report on the State of healthcare in the Country 2001-2002" did not highlight that the treatments are "inappropriate in 25% of cases and cause the waste of 8 billion euros a year". The Italian Society of Geriatrics and Gerontology emphasized how there are 150,000 hospital admissions a year due to the secondary effects of medicines, wrong or inappropriate mixing, taking the wrong medicines[58]. It is an alarming sign of the situation of fragility and insufficient care in which a lot of the elderly live. Often they are risks associated to the impossibility of going out of the house to go to the doctor or to the need to sort things out by themselves in some way. To this data, we must add that of the mistakes in hospital prescriptions, which are almost all avoidable: they are 15 out of 100 prescriptions (preliminary communication by the ISHM, in the absence of official national statistics[59]).

The integrated home care (IHC) could guarantee in Italy as well, as happens in other countries, a more accurate socio-welfare-healthcare support, even though it is not easy to access reliable data for a comparison with other European countries, because the generic term "home care" includes a broad and diversified range of services, often with different objectives and methods, given by a variety of institutions, public and/or private, within each country. The largest use of this type of care can be found in Denmark (24.6%), the average in northern countries is in any case over 10%, and it is much lower in the South (only 3% of the elderly). According to the 2004 Censis report, less than a third of the Italian population over sixty is aware of the existence of the "integrated home care" (IHC) service. To complicate the situation, there is the fact that a large part of the South of Italy (about a quarter[60]) does not have it. In addition, if the service can be activated quickly in the North East (within 48 hours, or at the latest within a week) following a request to the appropriate local health authority and after an assessment by the Geriatrics Assessment Unit integrated by specialist assistance, in the South the time is certainly longer (even over a month).

Nevertheless, the IHC is preferred by all European governments to fight the risk of institutionalisation, to guarantee the elderly a better quality of life and still allow, wherever possible, a certain social involvement. The care is better from a point of view of services and costs and it is largely preferred by the patients, who can stay in their environment, surrounded by the people and things they love, with the memories of happy moments, and recurring to hospitalisation, even if only in the daytime, in case of a worsening of the pathology or the need for tests. It is evident that home care cannot be imposed to the patients and their families. The generosity and love of the family – although essential to keep within a human dimension the condition of isolation that often the patient and the elderly have to bear – are not always sufficient to

[57] 2001 Report by the Arno Project (Cineca, Consorzio Mario Negri Sud), 24 Ore Sanita', 27.5.2003.

[58] Studio Sofia, National Congress of the Italian Society of Geriatrics and Gerontology, Florence 3.11.2004.

[59] Italian Society of Hospital Medicine (ISHM), XXV national Congress, Rome, March 2005.

[60] Italian Caritas and Zancan Foundation, 2004 Report on "Esclusione sociale e cittadinanza incompiuta", Feltrinelli, 2004.

tackle complex problems which, even when not emergencies, can require particularly challenging provisions. For example, the influence of architectural barriers can be a serious obstacle for the needs of disabled elderly people and for the rehabilitation treatment carried out with the IHC. The centre of all action and decisions, natural link between the healthcare institution and the patients, is the GP, who suggests and supports specialist interventions, in agreement with the patient as long as he/she is able to understand and express a valid consent. It is evident that basic medicine sometimes is unable to tackle the problems of the elderly, in fact in our universities there is no teaching towards the appropriate instruments to assess the psychophysical and social capabilities of the elderly, the multidisciplinary approach in the study of the elderly patient, the use of simple diagnostic means in the surgery or at the patient's home, the communication with the elderly patient that has its peculiarities, the identification of behavioural changes and the possibility of a fast and appropriate treatment. The geriatrics doctor should then be the main figure of reference in the treatment of the elderly patient[61], but often he/she isn't, as geriatrics is assimilated to any other medical field. And internal medicine cannot assume this role, as it is directed essentially to the study of acute pathologies, devoid of specific references to the polypathology of the elderly, to geriatrics rehabilitation, to the peculiarities of nutrition for the elderly, etc.

With regards to residential institutions (Residenze Assistenziali [RA], e Residenze Sanitarie Assistenziali [RSA], according to the Italian terminology) the comparison with other countries is complex because of the dishomogeneity of a variety of organisational and economic characteristics, and because of the functions they absolve. A good example however is Denmark, which – like other North European countries – trialled interesting initiatives: since 1988, after a twenty year experience, took hold the political choice of building more RSA and protected houses and change the existing ones into housing for the elderly with flexible services in line with their needs. The experience of these countries is such that their structural standards relative to comfort were ahead of the Italian ones already in 1967[62]. It is more than evident that the difference must be resolved as soon as possible in order to improve availability, accessibility, organisation, standard of living, quality of care in those fundamental institutions that are the RAs and RSAs, taking into account that northern countries in the last ten years are increasingly focusing their attention on improving the quality of the environment and services, eliminating, where possible, the most unpleasant aspects of shared accommodation and favouring intimate spaces, personalised care, respect for the normal rhythm of daily life, to overcome the concept of residential structure with the offer of "protected accommodation". These often come from transforming the traditional shared residences adapted to the needs of those who lose their autonomy and can carry on living independently with the help of home care and the guarantee of more safety also for the spreading of information technology or telematics applied to the accommodations and automated instruments to help carry out daily activities. The flexibility and personalisation of the services with regards to

[61] G. Salvioli, *Gli anziani oggi*, G. Gerontol., 52, 162, 2004.

[62] 98.5% of the rooms were single rooms (in Italy they house up to four beds), 75% of the rooms was at least 15 square meters (in Italy they are generally 12 square meters), 75% of the rooms had an en-suite bathroom (in Italy there is a bathroom every two rooms), 80% of the rooms was accessible, without help, to the elderly in wheelchairs.

social and healthcare integrated services is guaranteed by personalised care, according to the policies regarding keeping the elderly in their homes.

In South European countries however, the interest for traditional residential structures is continuing to grow very slowly at least in Italy, which is late in the care strategies for the elderly and not yet able to concretely pursue choices of significant bioethical interest with the dual aim of reducing the costs of care and guaranteeing a better quality of life at the elderly's home. The National Healthcare Service in any case, despite the well-known daily difficulties, remains one of the few in the world that guarantees to the citizens, free of charge, integrative healthcare assistance.

A further aspect to take into account is the fact that the nursing staff, and especially social-healthcare staff, is unfortunately often low in numbers. The problem regards all the European countries where in the last decade the number of unqualified employees in residential and home services has increased six times. There can be a variety of problems linked to staff, frequent, in particular, the so-called burn out[63], which can lead to serious crisis of depression and especially when in contact with terminally ill patients affected by neoplasia and dementia, and that represents the major cause of defections. The characteristics of the mentally ill patient (aggression and violent behaviours) can cause considerable stress to the staff, which can lead to a climate of mutual violence.

Voluntary work is obligatory, also to compensate for the deficiencies, and, with an increase of about 120% in the last years, so much so that it provides care for eight million elderly and patients[64], often beyond the simple "healthcare action". For the further developments of care, we can only wait for the concrete provisions of the European Parliament in reference to the proposals put forward and the most recent resolutions[65].

Of particular importance are the psychiatric pathologies that affect the elderly. According to the OMS, depression represents the main cause of invalidity (12% of cases), partly also because of the low cultural level, the precarious financial situation and the pathologies that affect the elderly. Dementia affects a little less than a million Italians, but the number is destined to double by 2050 for the combined effect of the longer life expectancy and the better state of health of the general population. The 60-70% of cases of serious cognitive deterioration that can be observed in old age are of the Alzheimer's type (AD), the incidence of which increases exponentially with age. The direct

[63] C. Maslach, A. Pines, *The burn out syndrome in the day care* setting, Child Care Quarterly, 6, 100, 1977. M. Piccione, *L'etica nella pratica psichiatrica*, Masson, Milan 1999.

[64] Ilesis, with the contribution of Farmindustria, "Primo rapport sull'esperienza sociale del volontariato sanitaria e assistenziale". Il Sole 24 Ore sanita', 2-8 December 2003. The Istat carried out the fourth survey on voluntary organisations registered in the different regions and autonomous provinces on the 31st of December 2001.

[65] The second European Conference of the Regional Healthcare and Social Affairs Ministers (our regional councillors), Milan 2002, Sole 24 Ore Sanita', 19th of November 2002, suggested the institution of a new professional figure of "elderly assistant", something between a minder and a specialist nurse, provided with a specific diploma. In May 2004, the EU Commission adopted the report on the healthcare for the elderly. The common objectives are the following: 1) guarantee the access to treatments based on the principles of equality and solidarity, 2) promote a high level healthcare for a better quality of life, suggest treatments of verified scientific validity, checks and tests of verification, 3) ensure that the healthcare system is financially sustainable.

and indirect costs are up to 35-50 thousand euros a year per patient[66].They can often feel persecuted or jealous, which can lead to dramatic gestures seen as unavoidable. The changes that involve the physical and especially psychological personality of the elderly can unleash antisocial behaviours mostly if isolation is compounded by unfavourable environmental circumstances and alcohol abuse[67].The criminal activities of the elderly generally involve GBH against partner and family, up to murdering their wife[68],paedophilia and sexual crimes[69]. In some cases they are the expression of behavioural problems, depression or paranoia.

Sometimes retirement itself – in predisposed subjects – can cause considerable depressive reactions for the feeling of belonging to an age group that is socially marginalised, which often means loss of affection and finances, especially when it coincides with structural changes in the family (grown up and independent children who don't look up to the father as their point of reference anymore). The serious sense of uneasiness that sometimes affects the elderly can be favoured and worsened by a series of other phenomena like technological progress, changing cultural models, institutional crisis, progressive loss of certain and shared ideals able to alter the intellectual reality of the elderly and cause a further distancing. This complex situation can create and support a worrying state of tension with a loss of aims and trust, fear, dejection, inefficiency, states of anxiety and considerable levels of depression that can be the beginning – in predisposed subjects – of violent behaviours that the elderly can carry out especially against themselves. Usually men are affected, but women can also be affected when family involvement does not remain alive and prevalent, as work represents more and more frequently not just a way to financially support the family, but an internal need, a need to confront ourselves and show our qualities also outside of the family.

The problems stopping the weaker age groups from fully accessing the services are the difficulty of access or the lack of integration between the primary care given by family doctors and other territorial services for psychiatric care, especially in the southern regions, where the consequences of the lack of collaboration (in over half the cases) between family doctors and Mental Hygiene services are worrying. A very serious consequence is taking away from these particularly fragile people an indispensable therapeutic continuity.

Faced with the deficiencies of state care, families turn to the international work market that gives opportunities at accessible prices. Private initiative takes the place of state care through the so-called helpers[70], to whose instinct we entrust the precious thing that is our loved ones. These cohabitations are born out of need, sometimes they go against what the elderly want but often reach an acceptable balance, creating connections of affections and solidarity.

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[66] Italian Caritas and Zancan Foundation, Feltrinelli, 2004.

[67] F. Carrieri, O. Greco, R. Catanesi, La vecchiaia. Aspetti criminologici e psichiatrico forensi. Giuffrè, Milano, 1992.

[68] N. Maurri, L. Malavolti, G. Tartaro, *Uxoricidi nel settorato medico legale fiorentino*, Rass. Criminol., 18, 621, 1987.

[69] G.B Traverso, F. Carter. *Considerazioni criminologiche sul reasto di violenza carnale in Italia*, Riv.It.Med.Leg. 1,486,1979. V. Oddone, *Delinquenza con i capelli bianchi*, Minerva medicoleg. 34, 159, 1984.

[70] We must strongly stress how the term "helper" is offensive for the elderly: it implies the idea of a personal inferiority and a paternalistic and authoritarian view, only falsely "caring". The NBC believes that the term must be substituted, not only in acts and documents, but also, hopefully, in common talk. A possible alternative is "care assistant".

We cannot overlook, also from a bioethical point of view, the problems the elderly face in prison, even though they can seem of secondary importance due to the small percentage of over-sixty detainees, whilst the law guarantees a quality and continuity of care equivalent to that offered to the rest of the population. Bureaucracy is however slow and clunky: often the clinical record is not filled in properly in the biggest prisons also for a lack of continuity of care from doctors and specialists; the delay in carrying out the check-ups can be considerable, especially if they require transferring the detainee in a state hospital, which happens with difficulty and at times fatally late from the time of request. The advice of the legal doctor and other specialists nominated by the judicial authority, but also in this case the investigation can be long for the need of related assessments that, often, even if simple, require excessive waiting, which can only be explained by an inefficient bureaucracy. Sometimes there are a variety of consultancies, including those requested by the detainee, and the more serious the crime and the detention regime, the more months they take. Their condition can worsen, the admission into a centre that is fully equipped for the pathology can be late and death can paradoxically "eliminate" any problems with regards to providing care. Overcrowding, promiscuity, infective diseases, violence between inmates, lack of privacy in shared cells and the humiliating living conditions of the detainees, especially elderly, definitely affect negatively the chance of a true social rehabilitation, so that the stay in prison becomes increasingly a journey towards marginalisation. Even though we don't have specific statistics for the third age, the incidence of psychiatric disorders like depression and the growth in deaths due to suicides are relatively frequent.

Finally, we must mention the problem of frauds that in the last years afflict an increasing number of elderly people (a 471% increase from 2001 and 2003[71]). The moral and psychological damage is great, both because of depression due to the feeling of uselessness, and for the loss of objects of high personal significance even though at times of little value. The scope of the phenomenon is such that it requires specific interventions, but the little inclination to report frauds, considerably worsens the risk of meeting unscrupulous people.

6.1. OPERATORS, SERVICES, PEOPLE: RESOURCES FOR THE ELDERLY

Following the considerations on the peculiarities of old age, it is important to consider who the operators caring for the elderly are today. A better understanding of their peculiarities can allow an evaluation of the professional resources available today to the elderly, as well as, naturally, the GP or family doctor or the geriatrics doctor.

The nurse responsible for the general nursing care, previously called "professional nurse", is the professional responsible for the care, both nursing and basic care. To achieve this, he/she uses care projects for the individual or group or community, based on nursing diagnosis[72]. These projects start from identifying the needs of the individual, to assess his/her need or not or care; then, following this assessment, the nurse can identify the specific problems for

[71] Agenzia d' informazione Auser vol.8, 13, 2005.
[72] Cf. J. Juall Carpenito, *Diagnosi Infermieristiche*, Sorbona, Milano 2001.

which the person needs nursing care and/or basic care, planning to resolve this with appropriate interventions. This planning therefore will include interventions that will have to be carried out directly by the nurse and those that will be entrusted to the SHO: these will vary according to the context, the conditions of the person in care, the presence or not of other people as resources.

Together with the district nurse, many Italian cities are developing pilot trials suggested by the National Federation of the Ipasvi Colleges, which aim at actualising taking charge of the elderly. In line with already consolidated European experiences, in nursing care there are suggestions for the family nurse, that is, a professional who, together with the GP, takes charge and follows in time the evolution of the person's state of health, offering continuity of care and also personalised care, to exceed the standardised offer of services, therefore rigid in a certain way and focused on the provisions to offer instead than on the person to assist. The family nurse follows a certain number of individuals, verifying in time the evolution of their situation, activating and/or highlighting to the doctor the need to have human (professional and ad hoc operators) and material (e.g. integrated care) resources for each single case.

The socio-healthcare operator (Sho) is a figure supporting care, who acts in collaboration with the nurse and social security, directly looking after basic care, namely, the care once given by the patriarchal family, but today disappeared for the evolution towards mono-nuclear families. Without a doubt, the appearance on the socio-healthcare scene of personnel to support care, has meant a step forward in taking charge and managing the needs of the elderly population, too often afflicted by chronic-degenerative pathologies in addition to the effects of old age. So it happens that the person lives in conditions of mortification and decline of their dignity of person: for example for the impossibility of washing regularly because of lowering in strength and functional competence, or feeding themselves regularly because of the lack of self-sufficiency in doing the shopping and cooking the meals.

The welfare assistant is the professional who operates in prevention, patient's support and recovery, for groups or communities who find themselves in situations of need and social difficulty. Through aimed projects and a network approach, it deals with creating opportunities of recovery for disadvantaged individuals, also in relation to problems of the specific community he/she has been entrusted with: in fact he/she acts on a national basis or within structures of reference. Within the Healthcare Residences, the welfare assistant is often present as the Manager, taking care of daily issues and the more general choices of people sometimes alone and/or far from their loved ones despite their wishes.

Relatively to the services for the elderly, we distinguish:

The socio-healthcare district, in its more precise meaning of group of people, geographic area and network of services, it is the place where there's a tendency to maintain the well-being of the citizens by offering information, advice, services for the population. It is therefore not a building that houses operators and services, which are offered following a request by an interested individual, but the houses, schools, factories, offices where people pass their daily life, using the help of operators (GPs, nurses, welfare assistants, Sho, psychologists, etc.). The activities of prevention, care and rehabilitation are in this way taken directly to the individual's home (healthcare and social home care), or in the study and work environment (educational interventions in schools, checks, health and safety in the workplace, etc.) or finally centralised

in purpose built structures, namely, socio-healthcare centres. The services that can be given at home include, integrated, medical care, specialist doctors, nursing, functional rehabilitation and/or recovery, as well as those of a social nature. Some regions consider complementary services those regarding meals, clothes washing, ironing, organised by the district. The access to the service can be requested by the interested individuals, by the GP, the hospital the individual is staying at, directing the assisted towards a return home, according to the different cases, day hospital or Assisted Healthcare Residence. The visits are spread throughout the week, with variable frequency according to the cases, including also festive shifts.

Assisted Healthcare Residence (Rsa) is a place that offers nursing and basic care, as well as protection and housing rehabilitation and care to individuals with incurable pathologies, at home. Within the Rsa the guests must be able to find a situation as much as possible similar to the one at home; internal and external communal spaces, but also areas more appropriate to a minimum of privacy, are essential requisites of these structures. They are part of the network of national services that depend on the district's socio-healthcare activities; their organisational and housing organisation is given to a manager who is not a doctor. With regards to personnel, it will include nurses, health support personnel, therapists, educators. The personnel for specialist activities however is not full time.

The Residence for the Elderly (Ra) is instead generally used to house elderly people, who are still self-sufficient; in these cases it is especially the social issue that is at the basis of the need to access it. Consequently, the internal organisation will provide housing comforts and recreational activities that are generally intense. A particular experience with regards to this is that of the Social centre or the Residential centre for the Elderly, which has been realised (and at times called) differently in the various regions.

To substitute the all-encompassing rest-homes, typical of a few years ago, some places have developed Centres for the Elderly, which join the function of housing and day centre. In this way, more needs are looked after without however arriving at the structure for the non-self-sufficient: it is for totally or partially self-sufficient elderly who mostly have housing issues (e.g. notice to leave their home, architectural barriers, no lift, forced cohabitations), or loneliness, or problems of psychological safety. The residents, who live in small accommodations, are offered essential services like a canteen, bar, environmental cleaning. Whenever possible, the elderly remain the owners of their home, caring personally for their daily needs. In this type of climate, in addition, cooperation between the elderly is facilitated, and this positively affects maintaining the levels of autonomy also for individuals who are very old. There is care, but it certainly does not assume the rhythms and ways of care that are typical of other structures, so that it does not repress individual freedom. This type of structure is inspired to Anglo-Saxon and Scandinavian models, with the building of Centres for the Elderly in cities, so that they include individuals who are otherwise marginalised in still lively social situations, avoiding eradicating the elderly from their previous housing context.

The day centres welcome people who need forms of assistance, care, integration (elderly, disabled, drug-addicts, psychiatric patients) for a period of time limited to a day. Their purpose is to favour socialisation and recovery with simple crafts and manual work (ceramics, drawing on fabric, woodwork, other) using also the support of specific operators (event organisers, educators,

occupational therapists). The Centre must be given spaces for recreational activities and a canteen. The permanence in the Centre for some hours in the day alleviates and supports, at the same time, also the user's family; those who take responsibility for these individuals undergo considerable stress, therefore their quality of life must also be protected, as much as possible, as well as the patient's.

The Family Homes are structures of limited dimensions, destined to welcome people of various ages, so that they recreate a climate of cohabitation typical of the family. The organisation of the internal spaces and the life that goes on in it is very similar to a domestic context.

The Day Hospital is the structure that welcomes users who need complex therapeutic or diagnostic treatments, for a limited amount of time. Normally, it is annexed to the hospital, and it uses its general services. Its opening times to the public last between seven and twelve hours. The personnel that works in it (doctors, nurses, other professionals according to the type of intervention: rehabilitation therapists, podologists, dieticians) is permanently assigned to this service and in any case to the hospital OU of reference. The day hospital is born to answer treatment needs and it requires an extended stay in the premises, but not a full time stay; users can in this way have their needs satisfied without undergoing a protracted stay. Examples of this are the day surgery, which today is increasingly substituting hospital stays for general surgery: they are units dedicated to surgery of limited extent, which can be carried out in a day and therefore it avoids the client a stay in hospital. From this, derives that the organisation of this facility must be able to use the hospital's general services (laundry, kitchen, other), but to conclude in any case the day's activities. This means savings with regards to resources, personnel, buildings, as well as advantages easily gained by the users (staying in their homes, less discomfort for the family, real times answers to care needs).

The hospital today is destined to review its aims, to focus particularly on individuals in acute and post-acute phases, with professional human resources and instruments of advanced level. These are medium sized hospitals, which generally include the basic sectors of Medicine and Surgery, as well as other operative units of variable dimensions and quantity. In comparison to the importance it has always had in our NHS, today its position is decidedly less important. The current state of health of the population, the development of alternative services allowed by medicine to reduce the acute phases, make it today a place reserved to a few limited cases, which however need advanced resources and care methods. Therefore hospitals are getting ready to be increasingly less usual places of care, to become services destined to high intensity treatment needs. From a structural point of view, the hospital building is slowly evolving towards more flexible units, with different levels of care: an intensive one, or high care, and one for convalescence or monitored stabilisation, or low care. The accredited structures operate in close synergy with public structures, and equally called to respond to the same standards expected by public structures.

7. MARGINALISED ELDERLY

Loneliness can come from widowhood, the loss of children and family, poverty; it's especially the complex heterogeneous dynamics of the big

metropolitan cities that favour phenomena of marginalisation or self-marginalisation especially for elderly people who can live vegetating, get ill, commit suicide, die in the street or in conditions of material and moral degradation[73]. Not unusually the elderly are forgotten in institutions or communities, in imaginary hospices, even in their homes and within the family they are deprived of affection, sometimes forced to give proxies and donations, or blackmailed to give a house, sometimes victim of the family's neurosis, blamed for their inabilities and needs, mistreated, scorned, malnourished, mocked and even pushed to commit suicide. Dying alone is frequent, especially during the summer and the body can be found by the family members after many days, when they come back from their holidays or by firemen called by a neighbour. But we have not found that in case of death, even when due to the family's abandonment, this has been reported to the police.

We must not forget, in the more general problem of the state of abandonment and marginalisation, the accidents at home. Less numerous than suicides, they are often the symptom of the state of need and vulnerability that is dramatically expressed with an accident, mostly avoidable and containable in its gravity, if the elderly were helped quickly. Often abandonment continues in the morgue, as it happened in France in August 2003 and sadly shown in the news. The fact that the families forget their parents or grandparents, denying them also the funeral and not only for financial reasons, is unfortunately frequent also in our country, so much so that forced interment often happens without the family's involvement, paid for by the Council and with a magistrate's order, at times after months or years, for the need to free the cells.

And if society is indifferent towards the socially useless elderly, governments, the parliament, the regions often issue plans that mostly are not applied or cannot be applied even though they represent the marginalised elderly – away from culture, productivity and increasingly from the social context -, a reality in any case numerically important.

8. MISTREATMENT OF THE ELDERLY

The mistreatment of the elderly is contemplated in the law as crimes of domestic violence (Art. 610 penal code) and personal injury accidents (articles 582 and 583 penal code). Many dramatic events remain "buried" within the family or institution, especially if the crime is carried out by the family and the victim does not report it because affected by cognitive problems or afraid of further violence. Legally relevant is the abandonment of an incapable person (Art. 591), an eventuality that can regard also the elderly. As it is a crime that can be prosecuted ex officio in these cases a report detailing a complaint is compulsory.

Not reporting the phenomenon of the mistreatment of an elderly is due, at times, to the understandable reservation of the victim, to his/her hope that the aggressor will have a different attitude, to shame, to the not infrequent complicity of third parties within the family.

The forensic doctor who operates in public structures could be very useful to colleagues and in particular to the GP to diagnose and assess cases of

[73] According to ISTAT data (2001) the elderly represent 56.1% of the people who live alone (31% are male, 69% female).

violence that are difficult to interpret also in order to decide to send the report to the legal authorities. But this possibility is not taken into consideration by the Local Health Authorities, despite it has been hoped for at times.

Relevant is the mistreatment in Institutions to which we have to add the carelessness and superficiality of the doctors, the inattention of the educators, and sometimes the lack of training of the police. The phenomenon, although widely known, has been so far underestimated both from a quantitative point of view and with regards to gravity. In the USA, according to the National Elder Abuse Incidence Study[74], at least one and a half millions elderly people every year are abused even though, probably, the phenomenon is much bigger. Psychological violence escapes any control, especially as in many cases it happens within the family or in an isolated victim-aggressor relationship of subjugation. Carelessness is a very frequent form of mistreatment that involves personal needs, clothes, food, lack of care, lack of cleanliness, drug poisoning or overdoses due to distraction, inadequate healthcare assistance. Very frequent the use of physical restraint, verbal and emotional abuse, foul language, the theft of personal belongings, blackmail, manipulation, etc. Significant also the incidence of "institutional" causes indirectly responsible for the discomfort of the elderly residents, linked to the lack of funds destined to care, a run-down environment, the lack of training of the care personnel. Often - as already stated – those responsible can be the care operators and the orderlies[75], generally badly paid, in insufficient numbers in comparison to the resources, often subjected to the burn-out phenomenon, with a progressive lack of interest for work, victims of a condition of psychological strain (and often also physical), of the progressive loss of ideals, a feeling of impotence and failure for the overwhelming imbalance between needs and resources, between ideal and reality, between what the assisted ask for and the possibilities of answering even elementary needs[76].

It's sufficient to check the media to have an idea of the conditions of the elderly in some public and private institutions, whether paid for as part of the National Health Service or not, and of the serious physical harm to the guests that ends in death. Repeated inspections by the NAS in the last few years have highlighted dramatic deficiencies. According to the Ministry of Health in the summer of 2003 on 685 institutions undergoing an inspection, 281 were not in line with the law.

The conditions of mistreatment are evidently different, peculiar and more serious in developing countries[77], in particular African countries where elderly people (especially women) are often subjected to physical violence as they are accused of bringing bad luck to the community and being the cause of floods, droughts, diseases and death. For these reasons they can be ostracised, tortures and mutilated, and sometimes they are murdered if they refuse to leave the village.

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[74] The National Elder Abuse Incidence Study. Final Report, September 1998.

[75] K. Pillemer, D.W. Moore, *Abuse of patients in nursing Homes. Findings from a survey of staff*, Gerontologist 29, 314, 1989; D.M. Goodridge, P. Johnston, M. Thomson, *Conflict and aggression as stressors in the work environment of nursing assistants*, J. Elder Abuse 8, 49, 1996.

[76] L. Sandrin, *"Aiutare senza bruciarsi. Come superare il burn-out nelle professioni di aiuto",* Edizioni Paoline, Milan 2004.

[77] Second World Assembly on Ageing. Madrid, Spain, 8-12 April 2002.

Elderly people can also be directly involved in the consequences of wars, revolutions and ideological intolerance when they are painfully forced to escape; but they can also suffer indirectly when they are not taken into consideration and they are overlooked by the plans of humanitarian assistance. In refugee camps the elderly come off worse and suffer discriminations when forced to compete for the distribution of food and healthcare. Violence linked to HIV/AIDS is frequent in those countries that have been more strongly affected by it: elderly women are those who carry most of the burden of assisting relatives who are dying and orphaned children and can be forced into isolation as family members of the diseased, by whom they are often infected for having looked after them.

Suicide is a phenomenon of considerable importance and, without a doubt, linked to situations of personal discomfort but also to an objective condition of maladjustment and social and family marginalisation which the elderly can find themselves in. If the suicide of a young person causes great emotion, the elderly or aged who commits suicide is often overlooked not only by public opinion, but even by the institutions[78]. Suicide is sometimes seen as a rational choice that implies a sort of evaluation of our existence, of the suffering due to debilitating chronic illnesses, even psychiatric, prevention remaining in any case insufficient. The rate of suicides increases vertiginously with age, as demonstrated by the statistics of the different medico-legal schools in our country. Old age, loneliness, relationship problems, chronic illnesses, are the most important factors that lead to suicide, worsened by mistreatment and marginalisation. Taking into account the data on the population, the percentage of suicides committed by unemployed people is shocking compared to that of working people[79].

9. THE ELDERLY FROM A LEGAL POINT OF VIEW

If the law defines the minor, it rightly does not deal with the elderly, whose state can be clarified by medicine, psychology, sociology, but certainly not by codes that include generic regulations referring also to the inabilities of the elderly, but not specifically to them (like lack of civil rights, incapacitation, ability to write their testament, natural incapability). The Cassation Court clarified that "old age" as such is not a physical or mental illness[80].In effect, identifying the elderly and differentiating them from other adult citizens could have been a form of discrimination: the elderly who is able and active is therefore, and rightly, an individual like any other from a legal point of view, maintaining the full entitlement to his/her rights as citizen. Even though, not uncommonly, in daily life, there is a subtle line of marginalisation from a psychological point of view.

[78] D. De Leo, A. Caneva, M. Predieri, M. Cadamuro, I. Pavan, WHO European Multicentric Study on Parasuicide. Rilevamenti dell'unità operativa di Padova nel primo anno di sorveglianza epidemiologica. In De Leo D., Aspetti clinici del comportamento suicidiario. Liviana, Padova 1990.

[79] Abroad the phenomenon can be considerable, especially in France, where the rate of mortality for the over-seventy-fives is 150 on 100000. In our country, with regards to the socio-working conditions, the number of suicides amongst "retirees" is high, in 2000, according to the Istat, 1156 cases, in comparison to 997 suicides amongst the "workers", even though they are much more.

[80] G. Iadecola, *La tutela dell'uomo, del paziente, della* famiglia, G.Gerontol., 51, 425, 2003.

Only the needy elderly, ill and invalid, are taken into account in the law, but only because they become part of certain categories at risk (the poor, the chronically ill, those who are not self-sufficient, the unable, etc.), maintaining certain protective measures "also in order to prevent and remove the conditions that can contribute to their marginalisation"[81].

Law number 6 in 2006, which has a very relevant ethical and practical meaning, has instituted the role of the support administrator who proposes to support and limit the ability to act of those who find it "impossible, even partially or temporarily, to look after their own interests" like the elderly, the terminally ill, the blind, alcoholics, drug addicts, those in prison, without recurring to interdiction or incapacitation.

Amongst the legal issues that can arise in old age because of common pathological conditions, of particular importance is the eventual inability to give a valid consent to medical-surgical intervention[82], also considered that wife and children don't have any rights with regards to this. As with any adult individual who is not interdicted, only the doctor can assess if in his/her particular case the patient is in a condition of "natural incapacity" and eventually request the intervention of the judge supervising a guardianship. Keeping in mind that in urgent cases the doctor must in any case intervene within the limits of the treatments that cannot be procrastinated and are indispensable to get over an emergency.

Another aspect that deserves to be taken in consideration from a bioethical point of view is that of compensation due to liability that, in the case of the elderly, can have perspectives that are strongly penalising. As well known, a biological damage[83] causes the loss of the right to health that is constitutionally guaranteed as an inviolable human right (Art. 2), specifically protected (Art. 32) in a dynamic and functional sense (Art. 3). The forensic doctor, as well as indicating the days of the illness and the percentage of invalidity in reference to the so-called "static" biological damage that is compensated according to charts determined by law (57/2001, 273/2002) that fix an amount that increases in relation to the percentage of invalidity and decreases in relation to age, it must describe all the negative consequences of the "way of being" of the damaged, like the limitations of dynamic relational possibilities, the things he/she must give up, the effect on the quality of life, the chances of survival, etc. These injuries, which could be compensated by the judge without limitations (law 57/2001), have been strongly devalued by the 273/2002 in the sense that the amount given as compensation cannot be over

[81] Law No. 833 of the 23.12.1978, which instituted the National Healthcare Service, Art. 2, Art. 14.

[82] Also see the NBC document "Information and consent to the medical intervention" of the 20th of June 1992.

[83] F. D. Busnelli, *Natura del danno biologico: profili giuridici. Atti del Convegno nazionale "Il danno alla persona: tutela civilistica e previdenziale a confronto"*, Florence, pp.17-19, October 1996. M., Bargagna F.D. Busnelli (eds.), Rapporto sullo stato della giurisprudenza in tema di danno alla salute, CEDAM, Padova 1996. Fiori A., *La stima personalizzata del danno alla salute: a chi compete e con quale* metodo, Dir. Econ. Ass., 343, 1998. F.D. Busnelli, *Il punto di vista del giurista*, Danno e Resp. 728, 1999. G. Umani Ronchi, N.M. Di Luca, G. Bolino, *Alcune puntualizzazioni circa la valutazione medico legale del danno biologico e del danno biologico da morte*, Jura Med. 12,167, 1999. M.Bargagna, M. Canale, F. Consigliere, L. Palmieri, Umani Ronchi G., *Guida orientativa per la valutazione del danno biologico permanente*, III ed. Giuffré, Milan 2001. G.B. Petti, *Il risarcimento dei danni, biologico, genetico, esistenziale*, Utet, Turin 2002.

a fifth of that given for a static biological damage. Having said that, there are two significant problems in compensating harm to the elderly: 1. The progressive reduction of the compensation for the "static biological damage" with the increase in age on the basis that the person has fewer years to live (but the law does not take into account the mechanisms of adaptation and compensation that in the young can considerably reduce the effective injury, whilst the entity of the damage tends to be greater for the elderly); 2. The fact that in the elderly the consequences of what is a small lesion for a young person (for example the fracture of a metatarsus) can considerably alter the quality of life for the elderly and make it impossible to have the pleasure of a short walk and give them in any case daily life problems that can be compensated only partially by the judge. Not to mention the unfair devaluation of the aesthetic damage to the elderly (sometimes responsible for relevant psychological effects) who, like everyone else, have the right to look after their appearance. Also an eventual damage to the sexual capacity risks of being essentially overlooked, especially for women, even though sex and sexuality are an integral part of the experience of living for the elderly too.

CONCLUSIONS

The NBC felt the need to raw attention once again – within the limits of our task – to the "moral" condition of the elderly, the full understanding of which is the premise for an effective emphasis on friendship and support for the people who, in ever increasing numbers, live to old age.

We cannot in fact reason merely in demographic and economic terms about the ageing population and the relative consequences for public and private budgets, without considering – also – the "equal dignity" of the citizens, regardless of age, health conditions and the contribution they can make with their "presence" to the global well-being of society.

This equal dignity also includes a series of "rights", which must be intended as requisites to the support that is right for the community – on the basis of the "social citizenship pact" – to ensure with the widest redistributive range possible also to those who have contributed to the collective well-being in the past and continues, in some form, to produce in the present. A community that has amongst its duties that of looking at the elderly with a mind empty of false as well as dangerous commonplaces and stereotypes.

As in the past the minor's "right to rights" was identified, it is fair today to talk about the elderly's "right to rights", interpreting the intentions of Art. 25 of the Charter of Fundamental Rights of the European Union in which "the Union recognises and respects the rights of the elderly to lead a life of dignity and independence" in which for the first time the right of the elderly as individual is recognised, a legitimised individual. This right derives from old age because it is thought that the person is in a phase of biological life in which he/she can be in conditions of diminished capacity of self-support and is exposed to more risks. For this reason his/her rights must be protected, recognised and satisfied.

In this framework, the NBC hopes for the institution of an OBSERVATORY ON THE CONDITION OF THE ELDERLY to verify the adoption of national and international regulations regarding them.

1.The following propositions summarise the context of these rights:

- The elderly are people and as such they must be respected;
- The elderly have the right and duty to promote their human and especially spiritual resources;
- Society has the ethical duty to facilitate the promotion of a dignified life for the elderly;
- The elderly have the right to be treated according to principles of fairness and justice, regardless of their level of self-sufficiency and health.

2.From the point of view of healthcare and medical training, it must be said that not always degree courses teach geriatrics well. Often they are instead lacking in the multidisciplinary approach necessary to manage elderly patients, inadequate in the practical use of simple diagnostic means, insufficient in the culture and ethics of communication with the patient that is often overlooked, as the doctor limits him/herself to contact in the surgery with the family. It is necessary to re-train the teaching of geriatrics and geriatric sciences also for the purposes of a rehabilitation of the elderly, the prevention of latent psycho-pathologies and disability. It is important to develop and broaden specialist schools, considering the fact that geriatric doctors should be the point of reference for integrated homecare. It is also appropriate to reinforce experimentation, also outside of anti-dementia drugs, in order to avoid depriving the elderly of the results of appropriate studies rather than entrust themselves to generic therapeutic and care protocols, inadequate and expensive. With regards to the role of the doctor in the tragic problem of mistreatment, the NBC hopes that the forensic doctor, involved in public healthcare assistance, will bring his/her experience to the study of this phenomenon in institutions and within the family, not only as an expert who is eventually legally entrusted with the task, but mostly as a specialist who, fully respecting privacy, is available to doctors and GPs to assess cases that are difficult to interpret. The forensic doctor is able to advise the GP, taking into account that mistreatments are often hidden and in general kept quiet by the patient, who fears worse problems and, despite everything, being removed from the family.

3.It seems clear that experience, at least in our Country, the (psychological, social, economic) well-being of the elderly is strongly linked to the family context in which they generally live, where intra-family relationships can have for the elderly a particular relevance after retirement. It seems increasingly evident that the “crisis” of the intra-family relationship has an apparent effect on the “fragility” of the condition of old age. The percentage of the elderly who live alone is increasing.

The recent institution of the support administrator is certainly proof that society is sensitive also to needs that – especially for the elderly who live alone, without a family – are present in daily life when self-sufficiency is at least partially lost.

We also want to stress that family’s affection and care, first of all, are still today the “natural” elements that reassure and support the elderly. But it seems increasingly evident that also the sensitivity, altruism, enthusiasm of those who operate public and private healthcare and social services, can help the elderly to fight isolation, demoralisation for the loss of self-sufficiency and reinforce the conviction of being of value and still having “value” for others.

4.For operational purposes, the distinction between self-sufficient elderly and non-self-sufficient (dependant) elderly has valid justification, although there are middle ways between these extreme states.

For the self-sufficient elderly, wanting to remain active and continue to produce an income for their family, we should provide the chance of work, proportionate to the abilities and physical and mental resources available. The NBC is aware of the difficulties inherent to the practical realisation of this objective, which however must be supported (also due to the positive result offered for example by groups of active voluntary work and social cooperatives formed by the elderly, fully involved in productive activities, etc.) also for the message of “intergenerational solidarity” that it can give.

5.The NBC is fully aware that the condition of the non-self-sufficient elderly is particularly delicate – from a bioethical as well as organisational and political point of view. The NBC concludes this reflection stopping on the brink of terminal illness, palliative care, death, because these topics are – if anything – the object of other, more specific reflections (on some of which, in addition, the NBC has already produced previous documents: see for example Definition and Detection of Human Death (15th of February 1991); Opinion on the Resolution Proposal Concerning Assistance to Terminally Ill Patients (6th of September 1991); End-of-Life Issues in Bioethics (14th July 1995); Pain Therapy: Bioethical Guidelines (30th of March 2001); NBC Opinion on Advanced Treatment Statements (18th of December 2003); Nourishment and Hydration of Patients in Persistent Vegetative State (30th of September 2005).

The NBC in any case stresses the fragile condition of the elderly, which worsens – in the natural development of life – sliding in time, almost without fail, into dependence, a phenomenon of personal and social bioethical interest, more relevant as life expectancy increases.

The NBC stresses however, that in any age and in any circumstance, the non-sufficient elderly preserve their inalienable characteristics of human being and citizen, a dual “value” that protects their dignity, rights and interests.

6.The NBC notes that the evolution of the international debate on the “rights of the elderly” has produced documents of considerable interest, but their application remains always the choice of individual countries, as much as it is allowed by their legislations and finances. For our country, what has been elaborated and established in the “Objective project for the elderly” remains an unavoidable point of reference.

APPENDIX

CHARTER OF THE RIGHTS OF THE ELDERLY, (EISS, 1995)

Art. 1 Right of the elderly to access the “total quality” of human life that constitutes the basis of the common good.

Art. 2 Right to maintain the personal circumstances of the elderly at the highest possible level of mental, psychological and physical self-sufficiency.

Art. 3 Right of preventive and rehabilitative care of first, second and third degree.

Art. 4 Right to free care and the necessary tools to maintain contact with the social environment and avoid physical and psychological degradation: hearing aids and dentures, glasses and other help aimed at preserving the functionality and decorum of their person.

Art. 5 Right to live in a familiar and welcoming environment.

Art. 6 Right to be welcomed in hospices or hospitals by all the personnel, including executives, with courteous, caring, considerate attitudes, respectful of the dignity of the human being.

Art. 7 Right of the elderly to be respected everywhere in their personal identity and not be offended in their sense of decency, safeguarding their personal privacy.

Art. 8 Right to have a guaranteed income that allows not only mere survival, but the continuation of a normal social life, integrated in their context and including the right to self-determination and self-promotion.

Art. 9 Right that the potential, resources and personal experiences of the elderly are valued and used for the common good.

Art. 10 Right that the State – with the generous contribution of voluntary workers and the equal co-operation of non-profit sectors – provides new information-cultural services and facilities to encourage the learning of new skills aimed at keeping the elderly active and protagonists of their life, as well as participating to the civic development of the community.