FEAMC 2022: COMPASSION & GERIATRIC CARE

What a little bee and *"compassion in geriatric care"* have in common?

A Franciscan approach.

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Dear audience, first of all I would like to show some compassion with our translators. They are working constantly to increase the impact of our speakers to encourage us in our daily work.

Furthermore, I would like to acknowledge you all, fellow doctors and brothers and sisters in Christ. Like the "Fellowship of the Ring" of Tolkien's *Lord of the Rings*, we are working in different countries in different fields, but we are united in the love of Christ to show compassion with the sick and suffering. Not to feel pity with them, but to be a sign of faith, hope and love *in* their suffering. It is a Christlike love that does not abandon us in our weaknesses, but reaches a hand to walk together. I am proud of you all, and feel connected in our common mission to increase love and compassion in our work; for our patients and colleagues.

Today I am invited to share with you my experiences with **compassion and geriatric care**. I could start with definitions, with explanations, but I will start with a question and a little anecdote that – maybe – illustrate it even better.

I would like to invite you to consider my question ***"What a little bee and "compassion in geriatric care" have in common?"***

In the gospels the word "mercy" or "compassion" of Jesus is expressed in the Greek word "σπλάγχνον" (or "σπλάγχνα")[1]. It is literally derived from the very physical word "bowels" or "intestines", and expresses the experience of being moved in the guts, to our most inner core. It is both a sensitive as well as a physical experience that touches the heart, the body, and the soul.

But as promised I will first share this little anecdote:

"Last week I arrived a few days earlier in Rome. I spent a long day walking in an extremely hot, but beautiful Eternal City. I bought way too many souvenirs for friends and family. I was tired, sweaty, and my feet with blisters and back were hurting. The last part of the journey back to my accommodation included a steep climb, and I was reluctant to start it.

Suddenly, I saw this little old[2] bee on the road, lying on its back, struggling to get up. It was basically waiting to be run over by a car. I stopped and took a little piece of paper. After a few attempts it succeeded to stay on my hand.

[1] Luke 1,78: "διὰ σπλάγχνα ἐλέους θεοῦ", "because of the tender mercy".

[2] Old bees have shorter or damaged wings due to their hard work. Finally they will not be able to fly at all and die.

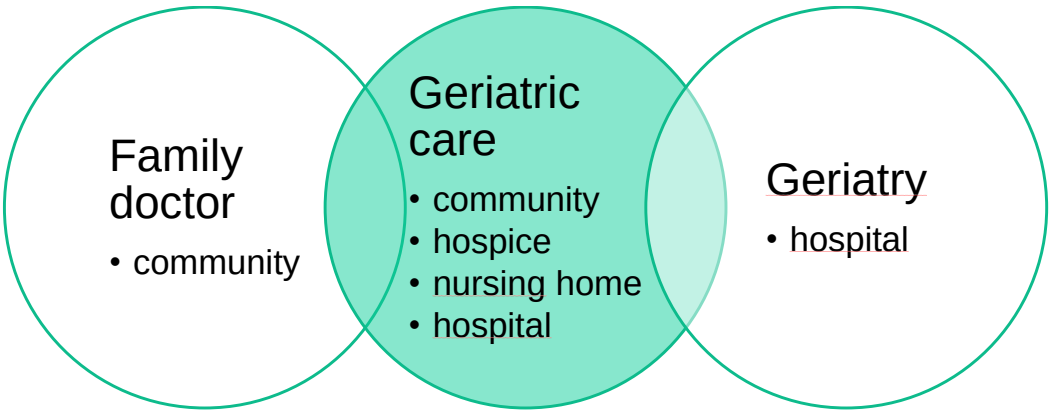
In the evening I shared this moment with some Dutch people I just met. They immediately said: "Why didn't you kill it? To end its suffering!"
I was surprised, it never occurred to me to kill this little creature that showed this will to live. Crawling over my arm and hand, me and my little friend, walked quickly to find a good and safe place with flowers, either to recover or to die.
Close to my accommodation I finally found these nice flowers and it happily hurried to suck out some of the nectar, gaining a bit of strength.

Moved from within, I felt compassion and sympathy for this little creature. I was not only moved internally by the brokenness and the frailty… it was got me into action. It united for a short while the paths of life, ***and*** of suffering. The word "compassion" is derived from the Latin *cum-patire* "to suffer with", or the word "sympathy" derived from the Greek *συμ-παθειν "to suffer with"*. It does not mean to feel pity over/for someone who is suffering. This means someone is more preoccupied with either one's own discomfort with suffering or an experience of superiority. Compassion and/or sympathy is the sincere experience of being connected in the human condition of life, especially in suffering. It is the experience that the suffering of the other could also have affected us. And in that awareness, to not abandon the other in his/her suffering, but to stay, to be with.

Geriatric Care in The Netherlands

After this introduction, I will continue a short explanation of my work. It is a relatively new specialty in The Netherlands, bridging between the General Practitioner (Family doctor) and Geriatric hospital care. It includes dementia care, chronic complex physical care, palliative care and geriatric

rehabilitation. Our working field can overlap with both the community, as well as hospital care, but is mainly stationed in nursing homes and hospices.



If we want to consider compassion in geriatric care, we should start to distinguish the "suffering that comes with ageing". I will use the model of Total pain as described by Cicely Saunders, the founder of modern palliative care. She stated that pain is hardly ever a mere physical experience. Therefore the bio-psycho-socio-spiritual approach is used to distinguish different sources of pain and suffering.

First, the physical suffering. Elderly are more prone to suffer from multiple diseases (multimorbidity), causing increasing frailty, polypharmacy, loss of self-sustainability and pain.

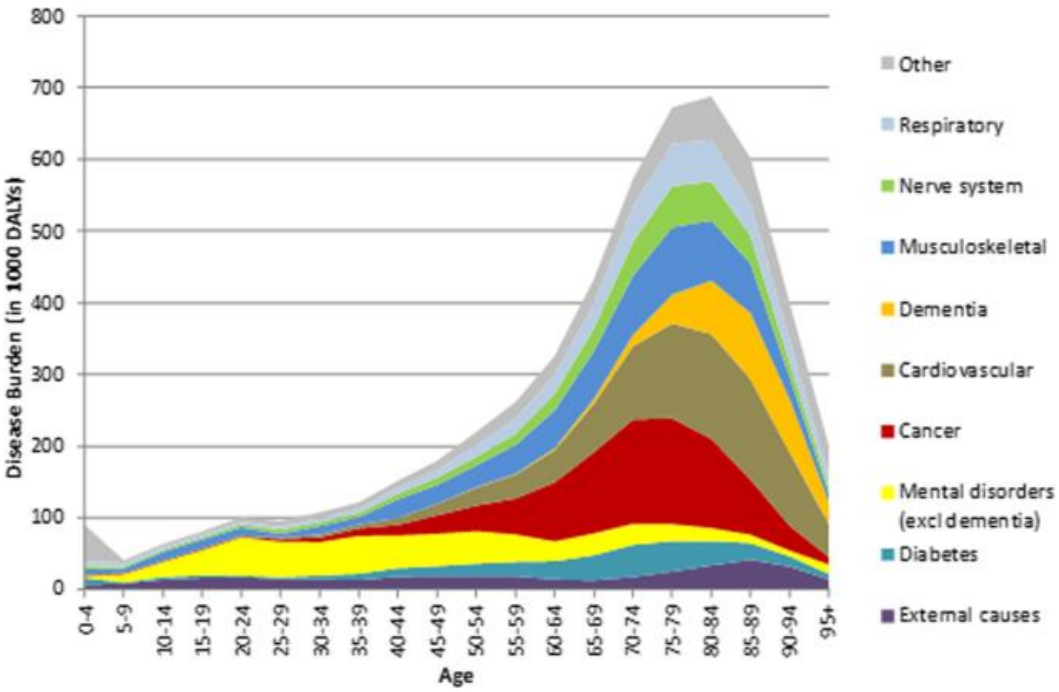


FIGURE 1 DUTCH DALYS, CURRENT AND FUTURE BURDEN OF DISEASE IN THE NETHERLANDS, HILDERINK ET AL, 2020.

Secondly, psychological suffering. Depression, anxiety, cognitive decline and dementia, as well as fear of suffering contribute to experiences of psychological suffering.

FIGURE 2 VINCENT VAN GOGH'S 1890 PAINTING, SORROWING OLD MAN ('AT ETERNITY'S GATE'), WHERE A MAN WEEPS DUE TO THE UNPLEASANT FEELINGS OF PSYCHOLOGICAL PAIN.

Besides that – and this may vary in your culture or country – there is social suffering. In a highly secularized and individualized society as the Dutch society, elderly suffer from the loss of their job or role in society. They may have financial concerns. The loss of a partner or friends or difficulty to join new communities causes incredible suffering in loneliness. According to Dutch research over 50% of people +75 years express themselves as lonely, whereas over 11% would call themselves extremely lonely.

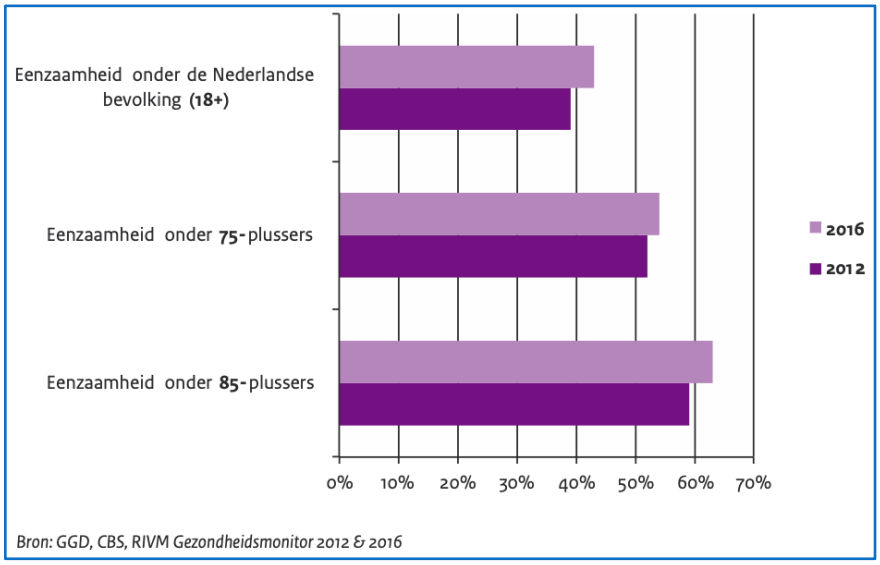
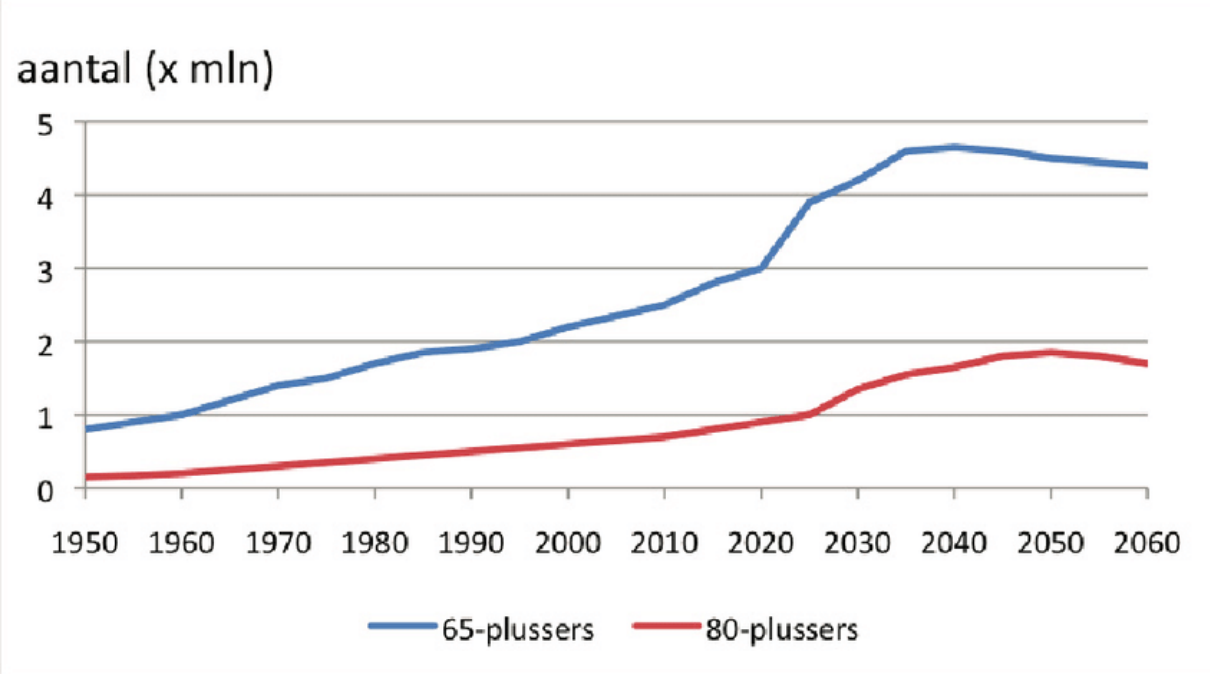


FIGURE 3 RIJKSOVERHEID: SAMEN TEGEN EENZAAMHEID, GGD, CBD, RIVM HEALTH MONITOR, LONELINESS, 2012 & 2016

As the Dutch are used to being independent, there is a reluctancy to be dependent on others. It is experienced as being a burden to others. This is part of a culture that at least is risking stigma of old age. Being young, independency and eternal youth are perceived as the ideal. Compared to this “old age” can be perceived as “being useless”, “best days are gone”, “future will be worse”, “being disabled”, “being a burden”, “being a waste of time and effort”. During the COVID pandemic there was this Dutch writer that concluded that “COVID only pruned the dead branches”. Fortunately, she was greatly criticized for this comment, but it would add to a culture that does not improve a positive perception of old age. In the last few weeks Pope Francis firmly rejects this “throw-away-culture” of the elderly in his general audiences on Wednesday (spring 2022).

Last, but not least I will address the spiritual suffering. As the Dutch culture is rapidly secularized a minority now beliefs in the existence of God. Spiritual suffering in people of faith may be: loss of faith, inability to pray or anger with God. In my practice I experience more often spiritual suffering in “loss of meaning of life or purpose”, “resignation” (giving up on life) and “fear of death”.

In 2020, The Netherlands counts about 3.5 million people over 65 years, which is 20% of society. In the next 10-20 years this will to about 5 million people over 65 years. It reveals a great challenge for the next few years, especially as many of the current ageing generation are raised with a positive opinion about euthanasia.

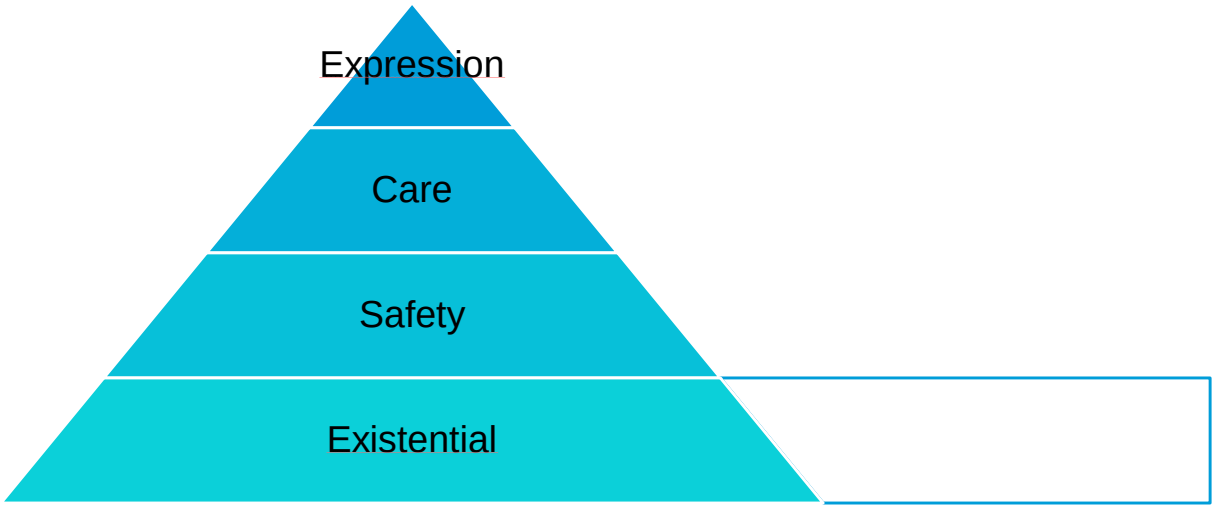


So how to be with this suffering?

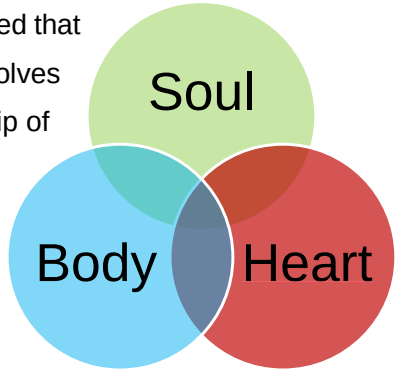
This may not be easy, it may feel even very uncomfortable. One may experience the impotency to cure a disease or treat a symptom. One may experience difficulty to be with suffering when treatments fail to alleviate the suffering sufficiently. Especially when patients or families are

expectant. Or in existential struggles it may be hard to show hope when someone has given up, especially if they have lost or never heard the language of faith, hope and love.

In my research project concluding the MSc Palliative Care I developed a model of needs based on different phenomenological characteristics: 1. Existential, 2. Safety, 3. Care, 4. Expression. First, "existential needs" consist the most fundamental elements of existence "to be or not to be". "Safety" is the domain of life that considers vulnerability and potential harm versus protection. "Care" consists everything that helps to sustain in life. And expression, elevates life from an individual survival to a relationship with your physical environment, with others, and a bigger context that transcends mere existence.



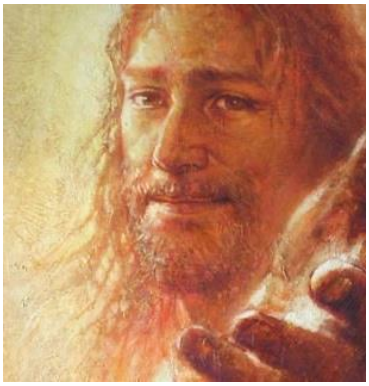
Apart from that, although some physicians may disagree, I am convinced that the human existence is more than mere physical (BODY). It also involves the HEART (relationship to self and others) and the SOUL (relationship of self to a bigger context than self, higher being, or God). In Deuteronomy 6 we are invited to love *"the Lord, our God, with all our hearts, and with all our souls, and with all our strength (body?)"*. When these three dimensions are invited to love God, they are apparently capable of loving and being loved as well.



> Hear, O Israel! The Lord is our God, the Lord alone! Therefore, you shall love the Lord, your God, **with all your heart, and with all your soul, and with all your strength**. Take to heart these words which I enjoin on you today.
> *Deuteronomy 6, 4-5*

In the next paragraphs I will suggest – not extensively - several ways to respond compassionately to those different needs combined with ways of suffering.

Existential needs and compassion



Our physical body may need medical treatments or care to survive a life-threatening condition. At least we should provide palliative care to alleviate physical symptoms of suffering. Unfortunately an estimated 70% of the world population has no access to sufficient palliative care due to several, but most political reasons. We as catholic doctors should try our utmost to promote this type of care for all people. Hippocrates stated that it is important to *"cure sometimes, treat often, comfort always".*

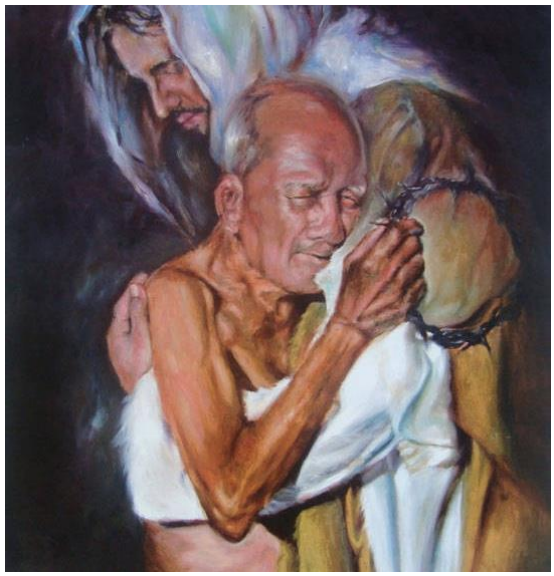
To support the existential needs of the heart we should really see someone, look in the eyes, listen to their (existential) concerns and to know their name. And to nurture the existential needs of the soul, we should promote a culture that acknowledges the intrinsic value of human beings, especially in broken or frail conditions of old age. I can really recommend the lectures of the general audience of Pope Francis on old age. We should protect our elderly against a culture of death and a throw-away-culture. A culture that tends to value people on their efficacy and efficiency is at risk to discard their elderly. Especially in The Netherlands, which are economically highly developed, there is a hunger for meaning and love. And this may me much more challenging to treat.

As Mother Teresa puts it:

> ***"The hunger for love is much more difficult to remove than the hunger for bread"***

Safety needs and compassion

On the level of safety, first, we should acknowledge that a physical or psychosocial vulnerability can make us feel weak and depending on others. Apart from the perspective of self, others can abuse this condition to their benefit. Therefore we – as physicians – should be aware to provide a safe environment. First, we should provide safety in care provision, secure mobility and sufficient communication. Furthermore, we need to avoid aggressive, harmful or futile treatments. Elderly, and especially people with dementia, will more often experience harm from interventions that would not be a problem in other populations (e.g. trip to a hospital, diagnostic procedures, invasive treatments). Depending on their life expectancy, they may not even benefit the outcomes. It requires a good understanding of both the impact of the medical interventions as well as the condition and wishes of your patient to decide whether a treatment is still appropriate. On the other hand we should avoid under treatment out of indifference or abusive use of the term “there is no quality of life”.



We should provide safety in providing a safe space or refuge. Our soul needs a place to be safe. This can be a friend, a family member, as well as a physical place of safety. In people with dementia, like Alzheimer’s disease, cognitive decline may affect all parts of the brain, including our perception. Therefore, it is important to realize there may be an altered or diminished perception of the sensory input. This may affect their experience of safety.

In my daily practice we first will explore the different sensory systems: sight, hearing, touch, taste, smell, vestibular system, and proprioceptive system. Then, we will stimulate these systems with an appropriate stimulus. One can think of freshly ground coffee, or baked bread to stimulate the appetite. Or, bright red cups improving fluid intake due to visual stimulation. A contrasting black toilet seat is more inviting to sit on than an abyss of white porcelain and tiles. A weighted blanket may stimulate the propriocepsis[3] increasing a sensation of safety. Just think what it was like when your parents used to put you to bed and gently pressed the covers. We use life and robotic animals that respond to touch and petting. And my nurses are real magicians in using physical touch, hugs or dances to make people feel at home. Music is an important stimulus that may evoke both emotions as well as old memories. The Dutch musician André Rieu has probably comforted more

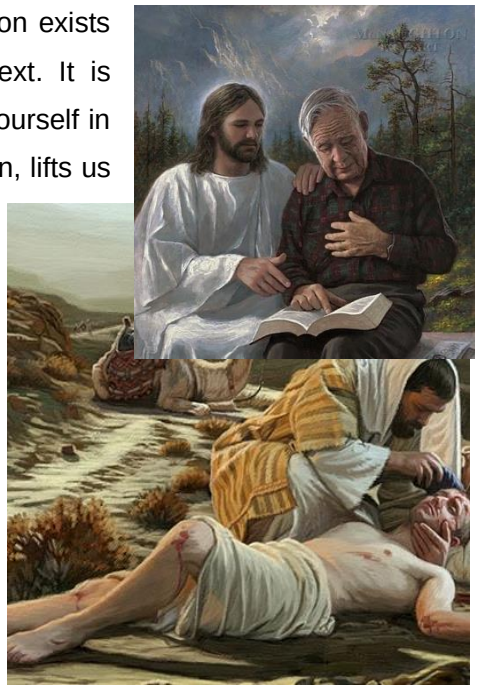
[3] Experience of self in the physical environment.

demented people than he will ever realize. And a last example is the use of unique “front door”-stickers that will help people to find their own room.

Care needs and compassion

We move on to the level of care. Care needs include the daily care that we need to sustain ourselves: food, drinks, medication, washing, clothing, sleep. Our hearts need to be acknowledged. They can be nourished by someone spending attentive time of just being present, listening, or being interested in your life history. Our soul longs for a sense of belonging, to be part of a group, to be invited by someone.

Expressive need and compassion

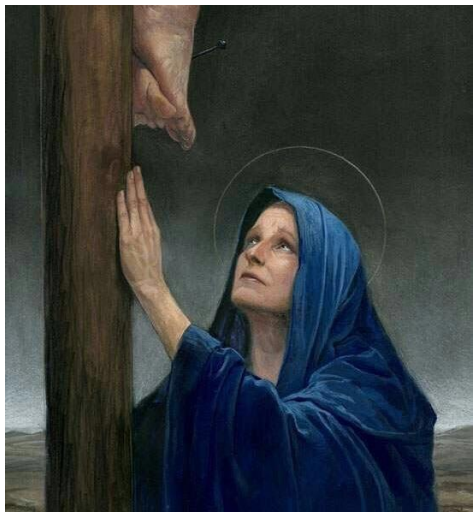


Our fourth and last level of needs is expression. Expression exists only in relation to another person, environment or context. It is physical expressed in embodiment: the ability to express yourself in the physical realm. Expression in interaction and connection, lifts us out of our individuality that so often knows a deep loneliness. Beauty, nature/pets, creativity, giving to others, loving and being loved, friendship: All consist of a relationality to another being or reality and puts us in a context that either provides meaning or elevates us from our self-centered perspective. A relationship with God or Jesus can thus be a strong source of power, especially in suffering. However, since The Netherlands are increasingly secular I encourage any support of sources of “faith, hope, and love” or meaning.

On Youtube I found this very touching short film of Marta[4]. Marta Cinta González Saldaña used to be a former ballet dancer. When she hears the music of Tsaikovsky’s Swan Lake, she immediately responds with an impressive choreography.

Medical spirituality

[4] Marta Cinta González Saldaña: https://www.youtube.com/watch?v=wlAXKJfesBM (shorter) https://www.youtube.com/watch?v=2BaoSZYZJoQ (longer, with comparison with history)



As doctors or health care workers we may experience difficult situations and deep suffering in our patients. However, we may always know that we can and do meet Christ in each patient that we serve. Christ allows us – He called us to take care of Him, sometimes in the most suffering and weakest brothers and sisters. Sometimes He invites himself on your ward or practice in the suffering or distressed (but challenging) family and loved ones. We can serve Him in them as well. They represent Mary under the Cross "impotently" *being* with the suffering of their loved ones. According to Scripture, we can comfort Jesus as Simon of Cyrene did when he took a bit of the burdensome weight of the cross, or as Mary did when she remained with her suffering Christ. According to the Tradition, like Veronica we can console Jesus washing His face, showing little gestures of love that will reduce the fatigue, pain or loneliness.

So we can experience Christ in our patients. On the other hand– as catholic physicians – we may always be a sign of Gods hope and love and patience. We may bring Christ-like signs of life, of light, sometimes even joy, peace and laughter.

From compassion to synodality

I started with a question "What a little bee and *"compassion in geriatric care"* have in common?". We considered the words "compassion" and "sympathy" as ways of "being with the suffering". I think compassion is very important in health care. However, to me its essence occurs a bit static and momentarily. As if time did not exist. I would like to make a plea for the word "synodality". "Synodality" is a relatively new word in our Church. It is built up of the Greek words "συν" (together) and "ʽοδος" (the way) meaning "going the way together". Synodality would emphasize more the dynamic aspect of compassion in geriatric care, walking together the path of life.

As with my little friend, "sister bee". Although I could offer my strength, my vitality, and my knowledge, she offered me company, joy, and a bit of distraction of my own "suffering". When I finally arrived at my accommodation, I had totally forgotten about my hurting feet and back. We shared a bit of the road of life together.

Medicine in elderly patients can be complex and challenging, especially when people suffer. But we can share our lives as a gift of God. And if you ever treat an older brother or sister in Christ and we cannot *"add more years to life, (we) better add more life to years"* (cf. Blaise Pascal).

Thank you!